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Health Law 2012 Legislative Update

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Introduction:

This Legislative Update provides readers with a summary of Connecticut legislation affecting healthcare providers and other healthcare related entities or agencies. Please note that this Legislative Update only summarizes what we believe to be the legislative highlights or the most significant new laws from the General Assembly's latest session and, thus, should only be used as a starting or reference point when determining what steps to take, if any, for complying with new laws as they apply to you.

The specific Public Acts are summarized herein for your reference and convenience along with the link to the specific Public Act. The Table of Contents below lists the specific Public Acts that are covered along with a reference to the page in this Legislative Update where its corresponding summary is located.

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1 While all other Public Acts referenced within this Legislative Update are from the Connecticut General Assembly's 2012 Regular Session, Public Act 12-1 is from its June 12, 2012 Special Session.

Summaries:

1. AN ACT CONCERNING NOTIFICATION OF FINANCIAL STABILITY OF NURSING HOME FACILITIES AND MANAGED RESIDENTIAL COMMUNITIES TO PATIENTS AND RESIDENTS. **See Public Act No. 12-6.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00006-R00SB-00139-PA.htm

    a. **Section 1**: **Notification of Receivership or Petition for Relief (effective 10/1/2012)**. Public Act 12-6 (the "Act") requires a nursing home that has been placed in receivership or has filed a petition for relief under the United States Bankruptcy Code to notify each person that has been admitted or is seeking admission as a patient of such receivership or petition.

    b. **Section 2: Notification of Petition for Relief (effective 10/1/2012)**. The Act requires a managed residential community (a "Community") that has filed a petition for relief under the United States Bankruptcy Code to notify each person residing in or seeking residence in the Community that it has filed such a petition.

2. AN ACT AUTHORIZING FLAVORING AGENTS FOR PRESCRIPTION PRODUCTS. **See Public Act No. 12-12.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00012-R00SB-00252-PA.htm

    a. **Section 1: Use of Flavoring Agents in Prescription Products (effective 7/1/2012).** Public Act 12-12 provides that a "flavoring agent"[2] may be added to a prescription product by: (i) a pharmacist upon the request of the prescribing practitioner or patient (or the patient's agent); or (ii) a pharmacist acting on behalf of a hospital.

3. AN ACT CONCERNING CRITICAL CONGENITAL HEART DISEASE SCREENING FOR NEWBORN INFANTS. **See Public Act No. 12-13.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00013-R00SB-00056-PA.htm

    a. **Section 1: Infant Screenings (effective 10/1/2012).** Public Act 12-13 (the "Act") requires that on and after January 1, 2013, each "institution"[3] caring for newborn infants administer a screening test for critical congenital heart disease as soon after birth as is medically appropriate, unless, as allowed by law, the infant's parents object on religious grounds. No written consent by the infant's parents is required by the Act.

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2 For purposes of Public Act 12-12, "flavoring agent" means an additive used in food or drugs that: (i) is used in accordance with good manufacturing practice principles and in the minimum quantity required to produce its intended effect; (ii) consists of one or more ingredients generally recognized as safe in food and drugs, has been previously sanctioned for use in food and drugs by the state or the federal government, meets United States Pharmacopeia standards or is an additive permitted for direct addition to food for human consumption pursuant to 21 CFR 172; (iii) is inert and produces no effect other than the instillation or modification of flavor; and (iv) is not greater than five percent (5%) of the total weight of the product.

3 For purposes of Public Act 12-13, "institution" means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for the mentally retarded licensed pursuant to C.G.S. §17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded.

4. AN ACT CONCERNING LETTERS OF PROTECTION. **See Public Act No. 12-14.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00014-R00SB-00099-PA.htm

   a. **Section 1: Required Disclosures (effective 10/1/2012).** Public Act 12-14 requires all licensed physicians and physical therapists to disclose, in writing, prior to providing treatment to a patient who has suffered a personal injury: (i) whether the physician or physical therapist would provide services to the patient based on a letter of protection issued by the patient's attorney, promising that any bill for services will be paid from the proceeds or any recovery received from a settlement or judgment or, if there is no recovery or the recovery is insufficient, that such bill will be paid by the patient; and (ii) the estimated cost of providing an opinion letter concerning the cause, diagnosis, treatment and prognosis of the personal injury, including a disability rating.

5. AN ACT CONCERNING THE CONNECTICUT UNIFORM ADULT PROTECTIVE PROCEEDINGS JURISDICTION ACT. **See Public Act No. 12-22.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00022-R00HB-05150-PA.htm

   a. **Sections 1-6: Interacting with Out-of-State Probate Courts (effective 10/1/2012).** Public Act 12-22 (the "Act") provides rules and procedures for a probate court (a "Probate Court") to observe when interacting with probate courts in other states[4] regarding conservatorship proceedings. The Act permits a Probate Court to request that an out-of-state probate court take certain actions, such as, but not limited to, hold an evidentiary hearing, order a person to produce evidence or give testimony, or order an evaluation or assessment of a respondent. A Probate Court may also respond to similar requests from an out-of-state probate court, subject to the laws of this state.

   b. **Sections 10-14: Jurisdiction (effective 10/1/2012).** The Act provides that a Probate Court has jurisdiction to appoint a conservator for a respondent if, among other requirements, the respondent resides in Connecticut, Connecticut is a "significant-connection state"[5] on the date a petition is filed, and the respondent does not have a home state. The Act also provides that a Probate Court lacking jurisdiction may exercise special jurisdiction to do the following: (i) appoint a temporary conservator in an "emergency"[6]; or (ii) appoint a temporary conservator for a conserved person for whom a provisional order of transfer of the proceedings from another state has been issued. In addition, the Act permits a Probate Court having jurisdiction to decline to exercise it if it determines at any time that a probate court of another state is a more appropriate forum. The Act provides that if at any time a Probate Court determines that it acquired jurisdiction due to unjustifiable conduct of a party, it must either: (i) decline jurisdiction and dismiss the case; or (ii) rescind any order issued and dismiss the case, except it may exercise limited jurisdiction up to ninety (90) days to fashion an appropriate remedy to the health and affairs of the respondent.

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4 Pursuant to Public Act 12-22, a "state" includes the other forty-nine (49) states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, a federally recognized Indian tribe, or any other territory or insular possession subject to U.S. jurisdiction. The Act also permits courts to treat foreign countries as a "state" for application of certain provisions.

5 For purposes of Public Act 12-22, "significant-connection state" means a state, other than the home state, with which a respondent has a significant connection other than mere physical presence and in which substantial evidence concerning the respondent is available.

6 For purposes of Public Act 12-22, "emergency" means a circumstance that will result in immediate and irreparable harm to the mental or physical health or financial or legal affairs of the respondent.

c. **Sections 17 & 18: Transferring Conservatorships (effective 10/1/2012).** The Act permits a Probate Court to transfer a conservatorship to another state. A notice of petition must be given to the persons that would be entitled to notice in this state for the appointment of a conservator and a hearing on the petition must be held. A Probate Court is required to issue a provisional order granting a petition to transfer a conservatorship and to direct the conservator to petition for conservatorship in the other state, if the Probate court is satisfied that the conservatorship will be granted by a probate court of another state and the Probate Court finds, among other things, that the conserved person is physically present in or is reasonably expected to move permanently to the other state or that an objection to the transfer has not been made, or if made, it has not been established that the transfer would be contrary to the interests of the conserved person. The Act also provides similar guidelines for a Probate Court to receive transfers of conservatorships from other states.

d. **Sections 19-21: Registration of Conservator Order (effective 10/1/2012).** The Act permits a conservator appointed by a probate court of another state to register as a conservator in a Connecticut Probate Court. The Act requires each Probate Court to maintain a publicly available registry of conservator orders. Upon registration, the conservator may exercise all powers authorized in the order of appointment, with certain limitations. The registration of a conservator expires after one hundred twenty (120) days, but may be extended for another one hundred twenty (120) days for good cause.

6. AN ACT CONCERNING THE APPOINTMENT OF A GUARDIAN AD LITEM FOR A PERSON WHO IS SUBJECT TO A CONSERVATORSHIP PROCEEDING OR A PROCEEDING CONCERNING ADMINISTRATION OF TREATMENT FOR A PSYCHIATRIC DISABILITY. **See Public Act No. 12-25.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00025-R00HB-05287-PA.htm

a. **Section 1: Prohibition Against Appointment (effective 10/1/2012).** Public Act 12-25 (the "Act") limits the circumstances under which judges or magistrates can appoint a guardian ad litem (a "Guardian") for any minor or incompetent, undetermined or unborn person. The Act prohibits judges or magistrates from appointing Guardians for: (i) an individual subject to involuntary psychiatric medication or hospital treatment, prior to a determination by a court that the individual is incapable of giving informed consent; (ii) an individual undergoing conservatorship proceedings, prior to a determination that the individual is incapable of caring for himself or herself or incapable of managing his or her affairs; or (iii) an individual who is mentally ill that has filed a writ of habeas corpus claiming that he or she is being held or medicated unlawfully.

b. **Section 1: Exceptions to Prohibition Against Appointment (effective 10/1/2012).** The Act also provides several exceptions to the general prohibition against appointing a Guardian in the situations mentioned above. Under the Act, a judge or magistrate may appoint a Guardian for a conserved person subject to the above when: (i) the judge or magistrate makes a specific finding of need to appoint a Guardian for a specific purpose or to answer specific questions to assist in making a determination; or (ii) the conserved person's attorney cannot ascertain the preferences of the individual. If a Guardian is appointed, the judge or magistrate is required to (i) limit the appointment in scope and duration; and (ii) direct the Guardian to take on the specific conduct necessary to assist the judge

or magistrate make a determination. The Act also requires that any appointment of a Guardian terminate upon the Guardian's report to the judge or magistrate or earlier upon the order of the judge or magistrate.

7. AN ACT CONCERNING THE USE OF TELEPHARMACY BY HOSPITALS. **See Public Act No. 12-28.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00028-R00HB-05329-PA.htm

   a. **Section 1: Expansion of Telepharmacy (effective 7/1/2012).** Previously, Public Act 11-242 established a pilot program in which participating hospital pharmacies were permitted to use electronic technology or telepharmacy at their satellite or remote locations for purposes of allowing a clinical pharmacist to supervise pharmacy technicians in the preparation of intravenous ("IV") admixtures. Public Act 12-28 (the "Act") updates Public Act 11-242 by making the telepharmacy pilot program permanent and expanding it to all licensed hospital pharmacies. In addition, the Act permits the use of electronic technology or telepharmacy to monitor the dispensing of "sterile products"[7], rather than the preparation of IV admixtures as was formerly the case.

8. AN ACT CONCERNING PRESCRIPTION DRUG ADMINISTRATION IN NURSING HOME FACILITIES. **See Public Act No. 12-30.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00030-R00HB-05516-PA.htm

   a. **Section 1: Establishment of Protocols for Prescription Drug Formulary System (effective 10/1/2012).** Public Act 12-30 (the "Act") provides that a medical director of a nursing home facility (a "Nursing Home") may establish protocols for a prescription drug formulary system in accordance with American Society of Health-System Pharmacists guidelines[8] and any applicable collaborative drug therapy management agreements.

   b. **Section 1: Substitution of Prescribed Drugs to Patients (effective 10/1/2012).** The Act also permits a medical director that implements a prescription drug formulary system to make substitutions for drugs prescribed to a patient of the Nursing Home. Prior to making a substitution, a medical director must notify the prescribing practitioner of his or her intention to make a substitution. If the prescribing practitioner does not authorize or otherwise objects to the proposal, the medical director is not permitted to make the substitution.

   c. **Section 1: Administering Drugs to State Medical Assistance Recipients (effective 10/1/2012).** The Act requires a Nursing Home to administer drugs in accordance with the Department of Social Services' ("DSS") preferred drug list, prescription drug formularies under Medicare Part D, or the patient's health insurance policy, as deemed appropriate by the medical director, when administering prescription drugs to patients receiving benefits from a medical assistance program administered by DSS.

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7 For purposes of Public Act 12-28, "sterile products" mean any drugs that are compounded, manipulated or otherwise prepared under sterile conditions during the dispensing process, are not intended for self-administration by a patient and are intended to be used in a hospital, or its satellite, remote or affiliated office-based locations.

8 A copy of the guidelines is available at: http://www.ashp.org/DocLibrary/BestPractices/FormGdlPTCommFormSyst.pdf

9. AN ACT CONCERNING MINOR AND TECHNICAL REVISIONS TO STATUTES AFFECTING CHILDREN AND YOUTH. **See Public Act No. 12-35.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00035-R00HB-05346-PA.htm

   a. **Section 1: Restriction on Duty to Disclose (effective 10/1/2012).** Public Act 12-35 (the "Act") further limits the circumstances under which the Department of Children and Families ("DCF") may disclose to its employees certain records related to children in the care and custody of DCF. Previously, DCF could disclose such records, without the consent of the person who is the subject of the record, to a DCF employee for any purpose reasonably related to the "business of the department." The Act now requires that such a disclosure may be made only if it is reasonably related to the "performance of such employee's duties."

10. AN ACT CONCERNING PHYSICIAN ASSISTANTS. **See Public Act No. 12-37.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00037-R00HB-05515-PA.htm

   a. **Section 1: Personal Review of Physician Assistants in Hospital Setting (effective 10/1/2012).** Public Act 12-37 (the "Act") revises current supervision requirements for physician assistants ("PAs") in hospital settings. The Act eliminates the requirement that the supervising physician conduct personal reviews of a PA on a weekly basis or more frequently as needed to ensure quality patient care. Instead, the Act now requires the personal review of a PA to occur on a regular basis as necessary to ensure quality patient care, in accordance with a written delegation agreement.

   b. **Section 1: Personal Review of PA in Non-Hospital Settings (effective 10/1/2012).** The Act also updates current supervision requirements for PAs in non-hospital settings by requiring the personal review of a PA to occur at a facility or practice location where the PA or supervising physician performs services, in accordance with a written delegation agreement.

   c. **Section 2: Written Delegation Agreements (effective 10/1/2012).** Currently, the functions that a supervising physician may delegate to a PA must be implemented in accordance with written protocols established by the supervising physician. The Act now requires that such delegation occur through a written delegation agreement (the "Delegation Agreement") between the supervising physician and PA.[9] The supervising physician must establish the terms of the Delegation Agreement, which must include: (i) a description of the professional relationship between the supervising physician and the PA; (ii) identification of the medical services the PA may perform; (iii) a description of the manner in which the PA's prescribing of controlled substances will be documented in patient medical records; and (iv) a description of the process for the supervising physician to evaluate the PA's performance, including (a) how often the supervising physician intends to review the PA's practice and performance of delegated medical services, and (b) how often, and in what manner, the supervising physician intends to review the PA's prescription and administration of schedule II or III controlled substances. In hospital settings only, the Delegation Agreement must include or reference applicable hospital policies, protocols and procedures. The Act also requires supervising physicians to review Delegation Agreements at least annually. Supervising physicians must also revise the Delegation Agreements as necessary to reflect changes in: (i) the supervising physician's professional

9 Shipman & Goodwin's model Delegation Agreement is available at http://shipmangoodwin.com/files/15560_PA%20Delegation%20Agreement%20-%20S&G%20Model.PDF

relationship with the PA; (ii) the medical services the PA may perform; or (iii) how the supervising physician evaluates the PA.

d. **Section 2: Documentation of PA Prescriptions (effective 10/1/2012).** The Act also revises current law regarding PA prescription of schedule II or III controlled substances. Previously, the supervising physician was required to document his or her approval in the patient's medical record within one (1) calendar day. The Act now requires such approval to be documented in the manner prescribed in the Delegation Agreement.

11. AN ACT CONCERNING THE PALLIATIVE USE OF MARIJUANA. **See Public Act No. 12-55.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00055-R00HB-05389-PA.htm

a. **Section 2: Qualifying Patients (effective 10/1/2012).** Public Act 12-55 (the "Act") requires a "qualifying patient"[10] to register with the Department of Consumer Protection ("DCP") prior to engaging in the "palliative use"[11] of marijuana. The Act provides that a qualifying patient with a valid registration certificate from DCP and who abides by the terms of the Act will not be subject to arrest or prosecution or penalized in any manner for the palliative use of marijuana if: (i) the qualifying patient's physician has issued a "written certification"[12] for the palliative use of marijuana after the physician has determined it is not in the qualifying patient's best interest to prescribe, prescription drugs to address the symptoms or effects for which the written certification is being issued; (ii) the combined amount of marijuana possessed by the qualifying patient and the "primary caregiver"[13] does not exceed an amount reasonably necessary to ensure uninterrupted availability for a period of one month; and (iii) the qualifying patient has not more than one primary caregiver at any time.

b. **Section 3: Primary Caregivers (effective 10/1/2012).** The Act provides that no person may serve as a primary caregiver for a qualifying patient, unless the qualifying patient has a valid registration certificate. A primary caregiver cannot be responsible for the care of more than one qualifying patient, unless the primary caregiver and qualifying patient have a parental, guardianship, conservatorship or sibling relationship. Under the Act, any person that has been convicted of a violation of a law related to the illegal manufacture, sale or distribution of a controlled substance may not serve as a primary caregiver. The Act also provides that a primary caregiver that has a valid registration certificate from DCP will not be subject to arrest or prosecution or penalized in any manner for the acquisition, distribution, possession or

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10 For purposes of Public Act 12-55, "qualifying patient" means a person who is eighteen (18) years of age or older, is a resident in Connecticut and has been diagnosed by a physician as having a debilitating medical condition.

11 For purposes of Public Act 12-55, "palliative use" means the acquisition, distribution, transfer, possession, use or transportation of marijuana or paraphernalia relating to marijuana, including the transfer of marijuana and paraphernalia relating to marijuana from the patient's primary caregiver to the qualifying patient, to alleviate a qualifying patient's symptoms of a debilitating medical condition or the effects of such symptoms, but does not include any such use of marijuana by any person other than the qualifying patient.

12 For purposes of Public Act 12-55, "written certification" means a written certification issued by a physician pursuant to the terms of the Act.

13 For purposes of Public Act 12-55, "primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician, who is eighteen (18) years of age or older and has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the palliative use of marijuana, provided (i) in the case of a qualifying patient lacking legal capacity, such person shall be a parent, guardian or person having legal custody of such qualifying patient, and (ii) the need for such person shall be evaluated by the qualifying patient's physician and such need shall be documented in the written certification.

transportation of marijuana or paraphernalia on behalf of his or her qualifying patient, provided that: (i) the combined amount of marijuana between the primary caregiver and qualifying patient does not exceed an amount reasonably necessary to ensure uninterrupted availability for one month; and (ii) such amount is obtained solely from a "licensed dispensary"[14] in Connecticut.

c. **Section 4: Physicians (effective 10/1/2012).** The Act provides that a physician may issue a written certification authorizing the palliative use of marijuana to a qualifying patient. The written certification must be in the form prescribed by DCP and include a statement signed and dated by the qualifying patient's physician stating that in his or her professional opinion, the qualifying patient has a "debilitating medical condition"[15] and the potential benefits of the palliative use of marijuana to the qualifying patient would likely outweigh the health risks. Under the Act, a written certification is valid for up to one (1) year from the date it is signed and dated by the physician, and all marijuana in the qualifying patient and primary caregiver's possession must be destroyed within ten (10) calendar days of the expiration of the written certification. In addition, the Act provides that a physician will not be subject to arrest or prosecution or penalized in any manner for providing a written certification if: (i) the physician has diagnosed a qualifying patient as having a debilitating medical condition; (ii) the physician has explained the potential risks and benefits associated with palliative use; (iii) the written certification is based upon the physician's professional opinion after a complete medically reasonable assessment of the qualifying patient's medical history and current condition made in the course of a bona fide physician-patient relationship; and (iv) the physician has no financial interest in a licensed dispensary or "licensed producer"[16] of marijuana.

d. **Section 5: Registration (effective 10/1/2012).** The Act provides that each qualifying patient that is issued a written certification, along with his or her primary caregiver, must register with DCP. The registration will be effective from the date DCP issues the certificate of registration until the expiration of the written certification issued by the physician. Pursuant to the Act, a qualifying patient or primary caregiver must report any changes in information to DCP within five (5) business days after such change. DCP is required to keep information obtained through the registration process confidential, and such information is not subject to disclosure under the Freedom of Information Act, except under certain circumstances.

e. **Sections 9 & 10: Licensure of Dispensaries and Producers (effective 5/31/2012).** The Act provides that no person may act as a licensed dispensary or a licensed producer without a license from the Commissioner of DCP (the "Commissioner"). The Commissioner is required to determine the number of licensed dispensaries and licensed producers appropriate in the state, adopt regulations covering the licensure and standards for licensed dispensaries and licensed producers, and determine the maximum number of licensed dispensaries and licensed producers that may be licensed.

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14 For purposes of Public Act 12-55, "licensed dispensary" or "dispensary" means a person licensed as a dispensary pursuant to the Act.

15 For purposes of Public Act 12-55, "debilitating medical condition" means (i) cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or (ii) any medical condition, medical treatment or disease approved by the Department of Consumer Protection pursuant to its authority under the Act.

16 For purposes of Public Act 12-55, "licensed producer" or "producer" means a person licensed as a producer pursuant to the Act.

f. **Sections 11 & 12: Limitations on Dispensaries and Producers (effective 10/1/2012).** The Act prohibits licensed dispensaries and producers, or their employees, to acquire or distribute marijuana to anyone other than: (i) another licensed dispensary or producer; (ii) a qualifying patient; or (iii) a primary caregiver. The Act also protects licensed dispensaries and producers, as well as their employees, from arrest or prosecution, or any other penalty, for acting within the scope of their employment under the Act.

g. **Section 13: Membership and Responsibilities of Board of Physicians (effective 5/31/2012).** The Act requires the Commissioner to establish a Board of Physicians (a "Board") consisting of eight (8) physicians or surgeons with knowledge about the palliative use of marijuana and certified by the appropriate American board in one of several enumerated specialties. The Board is required to: (i) review and recommend to DCP for approval a list of debilitating medical conditions that qualify for the palliative use of marijuana; (ii) accept and review petitions to add medical conditions, treatments or diseases to the above mentioned list; (iii) convene at least twice per year to conduct public hearings and to evaluate petitions for the purpose of adding medical conditions, treatments or diseases to the above mentioned list; (iv) review and recommend protocols for determining the amount of marijuana that may be reasonably necessary to ensure uninterrupted availability for one (1) month to DCP; and (v) perform other related duties upon the request of the Commissioner.

h. **Section 14: Minimum Requirements (effective 5/31/2012).** The Commissioner is required to adopt regulations to implement pertinent provisions of the Act, which must, at a minimum: (i) govern the manner in which DCP considers applications for the issuance and renewal of registration certificates for qualifying patients and primary caregivers, and establish any additional information to be contained in such registration certificates; (ii) define the protocols for determining the amount of usable marijuana that is necessary to constitute an adequate supply to ensure uninterrupted availability for up to one (1) month; (iii) establish criteria for adding to the list of debilitating medical conditions that qualify under the Act; (iv) establish a process under which members of the public may submit petitions regarding the addition of medical conditions, treatments or diseases to add to the list; (v) establish a process for public comment and public hearings before the Board regarding the addition of medical conditions, treatments or diseases to add to the list; (vi) add additional medical conditions, treatments or diseases to the list that qualify for the palliative use of marijuana as recommended by the Board; and (vii) develop a distribution system for marijuana that provides for: (a) marijuana production facilities operated by licensed producers in the state; and (b) distribution of marijuana for palliative use to qualifying patients or primary caregivers by licensed dispensaries. The Act requires the Commissioner to submit such regulations to the standing legislative regulation review committee by July 1, 2013.

i. **Section 16: Coverage Not Required (effective 10/1/2012).** The Act does not require health insurance coverage for the palliative use of marijuana.

12. AN ACT CONCERNING THE LICENSING, INVESTIGATION AND DISCIPLINARY PROCESSES FOR PHYSICIANS AND NURSES. **See Public Act No. 12-62.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00062-R00SB-00186-PA.htm

a. **Section 1: Increase in Membership of Medical Examining Board (effective 10/1/2012).** Public Act 12-62 (the "Act") provides that on and after October 1, 2012, the membership of the Connecticut Medical Examining Board (the "Board") will

increase from fifteen (15) to twenty one (21) members. The Act also increases the pool of individuals who may serve on medical hearing panels from twenty four (24) to thirty six (36). The Act also revises the required specialties for physician members of the Board and the hearing panel pool.

b. **Section 2: Waiver of CME Requirements (effective 10/1/2012).** With certain exceptions, physicians applying for license renewal are required to have completed at least fifty (50) contact hours of continuing medical education ("CME") during the twenty four (24) months prior to applying for renewal. The Act now permits the Commissioner of the Department of Public Health to waive up to ten (10) contact hours of CME for a physician who engages in activities related to (i) membership on the Board; (ii) membership on a medical hearing panel; or (iii) assisting the Department of Public Health with its duties to professional boards and commissions.

13. AN ACT ADJUSTING COMMUNITY HEALTH CENTER RATES FOR CAPITAL INVESTMENTS. **See Public Act No. 12-85.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00085-R00HB-05285-PA.htm

a. **Section 1: Medicaid Rate Adjustments (effective 10/1/2012).** Public Act 12-85 (the "Act") permits the Commissioner of the Department of Social Services (the "Commissioner") to alter the rates paid by the state to "community health centers"[17] and free-standing medical clinics participating in the Medicaid program. In particular, the Act provides that the Commissioner, beginning on October 1, 2012 and annually thereafter, may add to a community health center's Medicaid rate a capital cost rate adjustment associated with major capital projects. The adjustment is to be equivalent to the community health center's actual or projected year-to-year increase in total allowable depreciation and interest expenses associated with the projects divided by the projected number of service visits. Pursuant to the Act, the Commissioner may revise the adjustments retroactively based on actual allowable depreciation and interest expenses or actual service visit volume for the rate period.

b. **Section 1: Adjustments Based on Services Provided (effective 10/1/2012).** The Act also requires the Commissioner to establish separate capital cost rate adjustments for each Medicaid service provided by a community health center.

c. **Section 1: Approval Required (effective 10/1/2012).** The Act prohibits the Commissioner from granting an adjustment for any depreciation or interest expense that the U.S. Department of Health and Human Services or another federal or state government agency with health services-related capital expenditure approval authority disapproves.

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17 For purposes of Public Act 12-85, "community health center" means a public or nonprofit private medical care facility which (1) is not part of a hospital and is organized and operated to provide comprehensive primary care services; (2) is located in an area which has a demonstrated need for services based on geographic, demographic and economic factors; (3) serves low income, uninsured, minority and elderly persons; (4) makes its services available to individuals regardless of their ability to pay; (5) employs a charge schedule with a discount based on income; (6) provides, on an ongoing basis, primary health services by physicians and, where appropriate, midlevel practitioners, diagnostic laboratory and x-ray services, preventive health services and patient care case management; (7) provides for needed pharmacy services either on-site or through firm arrangement; (8) has at least one-half of the full-time equivalent primary care providers as full-time members of its staff; (9) maintains an ongoing quality assurance program; (10) is a participating Medicaid and Medicare provider; (11) has a governing board of at least nine and no more than twenty-five members with authority and responsibility for policy and conduct of the center, the majority of whom are active users of the center and of the nonuser board members, no more than half may derive more than ten per cent of their annual income from the health care industry; (12) provides primary care services at least thirty-two hours per week; and (13) has arrangements for professional coverage during hours when the center is closed.

d. **Section 1: Debt Service (effective 10/1/2012).** The Act also permits the Commissioner to allow actual debt service rather than allowable depreciation and interest expenses associated with capital items funded with debt obligation if the debt service amounts are deemed reasonable considering the interest rate and other loan terms.

14. AN ACT CONCERNING COVERAGE OF TELEMEDICINE SERVICES UNDER MEDICAID. **See Public Act No. 12-109.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00109-R00HB-05483-PA.htm

a. **Section 1: Establishment of Demonstration Project (effective 1/1/2013).** Public Act 12-109 (the "Act") permits the Commissioner of the Department of Social Services (the "Commissioner") to establish a demonstration project to offer "telemedicine"[18] as a Medicaid-covered service at federally qualified health centers. Under the demonstration project, in-person contact between a health care provider and a patient will not be required for health care services delivered by telemedicine that otherwise would be eligible for reimbursement under the state Medicaid plan program, to the extent permitted by federal law and where deemed "clinically appropriate"[19].

b. **Section 1: Establishment of Cost Reimbursement Rates (effective 1/1/2013).** The Act provides that the Commissioner may establish cost reimbursement rates for telemedicine services provided to Medicaid recipients under the demonstration project.

c. **Section 1: Data and Records (effective 1/1/2013).** The Act also provides that the transmission, storage and dissemination of data and records related to telemedicine services under the demonstration project must be done in accordance to applicable federal and state laws regarding privacy, security, confidentiality and safeguarding of individually identifiable information.

d. **Section 1: Required Reports (effective 1/1/2013).** The Act requires the Commissioner to submit a report on the services offered and the cost-effectiveness of any demonstration project established pursuant to the Act. The report must be given to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services.

15. AN ACT CONCERNING A MORATORIUM ON CERTAIN LONG-TERM CARE BEDS. **See Public Act No. 12-118.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00118-R00SB-00232-PA.htm

a. **Section 1: Extension of Moratorium (effective 6/15/2012).** Public Act 12-118 (the "Act") extends the Department of Social Services' ("DSS") moratorium on requests for additional nursing home beds from the previous date of June 30, 2012 to June 30, 2017. Under the Act, the DSS cannot accept or approve any requests for additional nursing home beds through June 30, 2017, except for those relating to: (1) beds restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury; (2) beds associated with a continuing care facility which guarantees life

18 For purposes of Public Act 12-109, "telemedicine" means the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment. It does not include the use of a facsimile or audio-only telephone.

19 For purposes of Public Act 12-109, "clinically appropriate" means care that is: (i) provided in a timely manner and meets professionally recognized standards of acceptable medical care; (ii) delivered in the appropriate medical setting; and (iii) the least costly of multiple, equally-effective alterative treatments or diagnostic modalities.

care for its residents; (3) Medicaid certified beds to be relocated from one licensed nursing facility to another; (4) a request for no more than twenty (20) beds submitted by a licensed nursing facility that participates in neither the Medicaid or Medicare programs, admits residents and provides health care to such residents without regard to income and demonstrates its financial ability to provide lifetime nursing home services to such residents without participation in Medicaid; (5) a request for no more than twenty (20) beds associated with a free standing facility dedicated to providing hospice care services for terminally ill persons operated by an organization previously authorized by DSS to provide hospice services; and (6) new or existing Medicaid certified beds to be relocated from a licensed nursing facility in certain municipalities, provided such Medicaid certified beds do not exceed sixty (60) beds.

b. **Section 2: Long-Term Care Hospitals (effective 6/15/2012).** The Act provides that from the passage date of the Act, until June 30, 2017, the department will not issue or renew a license for any hospital certified under Medicare as a long-term care hospital, unless it was certified as such as of January 1, 2012.

16. AN ACT WAIVING ADVANCE PAYMENT RESTRICTIONS FOR CERTAIN NURSING FACILITIES. **See Public Act No. 12-130.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00130-R00HB-05283-PA.htm

    a. **Section 1: Advanced Payments (effective 6/15/2012).** Public Act 12-130 (the "Act") provides that the Commissioner of the Department of Social Services (the "Commissioner") may make a payment in advance of normal bill payment processing to a nursing facility eligible for payment under Medicaid, provided that (1) such advance does not exceed estimated amounts due to such nursing facility for services provided to eligible recipients over the preceding two (2) month period, and (2) the Commissioner will recover such payment through reductions to payments due to the nursing facility or cash receipt no later than ninety (90) days after the issuance of the payment.

    b. **Section 1: Waiver (effective 6/15/2012).** The Act also provides that the Commissioner may waive the advance payment limitation or the ninety (90) day deadline for recovery (above) for nursing facilities that have been placed under receivership.

17. AN ACT CONCERNING REGULATIONS RELATING TO HOSPICE CARE. **See Public Act No. 12-140.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00140-R00HB-05499-PA.htm

    a. **Section 1: Licensed Hospices (effective 6/15/2012).** Public Act 12-140 (the "Act") authorizes an organization licensed as a hospice by the Department of Public Health ("DPH") to: (1) operate a hospice facility that provides inpatient hospice services, including a hospice residence; or (2) provide hospice home care services for terminally ill persons. The Act also requires a hospice facility to provide a home-like atmosphere for patients and to cooperate with DPH to develop licensure and operation standards.

18. AN ACT CONCERNING TREATMENT FOR A DRUG OVERDOSE. **See Public Act No. 12-159.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00159-R00HB-05063-PA.htm

    a. **Section 1: Administration of Opioid Antagonists (effective 10/1/2012).** Public Act 12-159 provides that a licensed health care professional who is permitted to prescribe

"opioid antagonists"[20] may, if acting with reasonable care, prescribe, dispense or administer an opioid antagonist to treat or prevent a drug overdose without being liable in a civil or criminal proceeding for doing so.

19. AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING AN ALL-PAYER CLAIMS DATABASE PROGRAM. **See Public Act No. 12-166.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00166-R00HB-05038-PA.htm

    a. **Section 1: All-Payer Claims Database Program (effective 6/15/2012).** Public Act 12-166 (the "Act") requires the Office of Health Reform and Innovation ("OHRI") to establish an "all-payer claims database"[21] program for collecting, assessing and storing data relating to medical and dental insurance claims, pharmacy claims and information from enrollment and eligibility files from reporting entities. The Act also requires any "reporting entity"[22] who administers healthcare claims and payments to provide relevant health care information for inclusion in the database.

20. AN ACT CONCERNING THE OFFICE OF HEALTH CARE ACCESS. **See Public Act No. 12-170.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00170-R00HB-05321-PA.htm

    a. **Section 1: Revised Considerations (effective 10/1/2012).** Public Act 12-170 (the "Act") revises current law by providing that when evaluating a certificate of need application, the Department of Public Health's Office of Health Care Access ("OHCA") must consider whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant.

    b. **Section 3: Extension of Deadline (effective 10/1/2012).** The Act extends the date by which a hospital must annually file its policies regarding the provision of charity care and reduced cost services to indigents, its debt collection practices, audited financial statements, and other documentation involving uncompensated care to indigents to OHCA to March 31st of each year.

    c. **Section 5: Biennial Study (effective 10/1/2012).** The Act requires OHCA to conduct a biennial, rather than annual, state-wide health care facility utilization study. The study may include an assessment of: (i) current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (ii) geographic and subpopulations that may be underserved or have reduced access to specific types of health care services; and (iii) other factors OHCA deems pertinent.

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20 For purposes of Public Act 12-159, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.

21 For purposes of Public Act 12-166, "all-payer claims database" means a database that receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.

22 For purposes of Public Act 12-166, "reporting entity" means (i) an insurer licensed to do health insurance business in Connecticut, (ii) a health care center, (iii) an insurer or health care center that provides coverage under Part C or Part D of Medicare to residents of Connecticut, (iv) a third-party administrator, (v) a pharmacy benefits manager, (vi) a hospital service corporation, (vii) a nonprofit medical service corporation, (viii) a fraternal benefit society that transacts health insurance business in Connecticut, (ix) a dental plan organization, (x) a preferred provider network, or (xi) any other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments. "Reporting entity" does not include an employee welfare benefit plan that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

d. **Section 6: Removal of Authority (effective 10/1/2012).** The Act also removes OHCA's authority to require a hospital's independent auditor to review discounted rates and charges it negotiated with a "payer"[23].

e. **Section 7: Submission of Data (effective 10/1/2012).** The Act requires each hospital to submit data related to the hospital's verification of net revenue and any other data required by OHCA, including hospital budget system data for the hospital's twelve (12) months' actual filing requirements, to OHCA by March 31st of each year.

21. AN ACT CONCERNING DEDUCTIBLES FOR SCREENING COLONOSCOPIES AND SCREENING SIGMOIDOSCOPIES. **See Public Act No. 12-190.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00190-R00SB-00098-PA.htm

    a. **Sections 1 & 2: Deductibles for Colonoscopies and Sigmoidoscopies (effective 1/1/2013).** Public Act 12-190 (the "Act") prohibits an individual health insurance policy or a group health insurance policy from imposing: (i) a deductible for a procedure that a physician initially undertakes as a screening colonoscopy or a screening sigmoidoscopy; or (ii) a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of the Act do not apply to a high deductible health plan.

22. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES. **See Public Act No. 12-197.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00197-R00HB-05514-PA.htm

    a. **Section 3: Pathology Reports (effective 10/1/2012).** Current law requires hospitals, clinical laboratories and health care providers in the state to report every tumor that is diagnosed or treated to the Department of Public Health ("DPH") for inclusion in the Connecticut Tumor Registry. Public Act 12-197 (the "Act") now requires a pathology report to be included in such reports to DPH, along with the other information required by existing law. The Act also requires that reports of tumors be submitted to DPH on or before July 1st of each year.

23. AN ACT CONCERNING THE ADMINISTRATION OF INJECTABLE VACCINES TO ADULTS IN PHARMACIES. **See Public Act No. 12-207.** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00207-R00SB-00371-PA.htm

    a. **Section 1: Administration of Adult Vaccines (effective 10/1/2012).** Public Act 12-207 provides that a licensed pharmacist may administer, to an adult, any vaccine approved by the U.S. Food and Drug Administration that is listed on the National Centers for Disease Control and Prevention's Adult Immunization Schedule, provided that the vaccine is administered pursuant to an order of a licensed health care provider.

24. AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR BEGINNING JULY 1, 2012. **See Public Act No. 12-1 (June 12, 2012 Special Session).** http://www.cga.ct.gov/2012/ACT/PA/2012PA-00001-R00HB-06001SS2-PA.htm

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23 For purposes of Public Act 12-170, "payer" means any person, legal entity, governmental body or eligible organization that meets the definition of an eligible organization under 42 U.S.C. Section 1395mm (b) of the Social Security Act, or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital. It also includes any legal entity whose membership includes one or more payers and any third-party payer.

a. **Section 11: Delegation of Administration of Medications (effective 7/1/2012).** Public Act 12-1 (the "Act") provides that a registered nurse may delegate the administration of medications that are not administered by injection to homemaker-health aides ("Aides") that are certified for medication administration, unless the prescribing practitioner specifies that only a licensed nurse may administer the medication.

b. **Section 11: Regulations (effective 7/1/2012).** The Act requires the Department of Public Health ("DPH") to adopt regulations regarding the delegation of certain tasks to Aides. The regulations must require each "home health care agency"[24] to: (i) adopt practices that increase and encourage client choice, dignity and independence; (ii) establish policies and procedures regarding the delegation of certain tasks to Aides by registered nurses; (iii) designate Aides to obtain proper certification for the administration of medication; and (iv) ensure that such certifications are received. In addition, regulations must establish certification requirements and criteria, such as appropriate education and training, for medication administration for Aides. Each home health care agency must ensure that the delegation of nursing care tasks to Aides is allowed within the agency and that appropriate policies are adopted by January 1, 2013.

c. **Section 11: Disciplinary Action (effective 7/1/2012).** The Act shields a registered nurse who delegates medication administration to an Aide pursuant to its provisions from disciplinary action based on the performance of the Aide, unless the Aide acts pursuant to instructions from the registered nurse or the registered nurse fails to leave instructions when he or she should have done so, provided that the registered nurse: (i) documented that the medication administration could be properly and safely performed by the Aide in the patient's care plan; (ii) provided initial direction to the Aide; and (iii) provided ongoing supervision of the Aide. In addition, a registered nurse who delegates nursing care to another person pursuant to the Act will not be subject to action for civil damages for the performance of the person, unless the person acts pursuant to instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so.

d. **Section 11: No Coercion (effective 7/1/2012).** The Act prohibits any person from coercing a registered nurse into compromising patient safety by requiring the nurse to delegate the administration of medication against his or her assessment of the patient. A registered nurse who makes a reasonable determination based on such assessment against delegation cannot be subject to any employer reprisal or disciplinary action.

e. **Section 17: Coverage of Chiropractic Services Under Medicaid (effective 10/1/2012).** The Act provides that chiropractic services may be covered for recipients of Medicaid, provided that the Department of Social Services ("DSS") does not spend more than two hundred and fifty thousand dollars ($250,000) annually for this coverage. The services may be coordinated with other initiatives under the Medicaid program. The Act also requires DSS to establish policies and procedures to implement the provisions of the Act.

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24 For purposes of Public Act 12-1, "home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four (24) hours per day, in the patient's home or a substantially equivalent environment: Homemaker-home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four (24) hours per day.

f. **Section 18: Increase in Reimbursement for Independent Pharmacies (effective 10/1/2012).** The Act requires DSS, upon receiving federal approval, to reimburse "independent pharmacies"[25] for dispensing brand name drugs to Medicaid recipients at a higher rate than it pays chain pharmacies. DSS must pay independent pharmacies the lower of: (i) the rate the Centers for Medicare and Medicaid Services establishes as the federal acquisition cost, (ii) the average wholesale prices minus fourteen percent (14%); or (iii) an equivalent percentage as established under the Medicaid State Plan. The Act requires DSS to submit a Medicaid State Plan amendment by October 1, 2012 in order to establish the new rate for the independent pharmacies.

g. **Section 22: Behavioral Health Managed Care Program (effective 6/15/2012).** The Act permits the Commissioner of the Department of Mental Health and Addiction Services (the "Commissioner") to maintain the authority to operate and audit the behavioral health managed care program for recipients of the state-administered general assistance program for claims and services provided through June 30, 2012. The Act also keeps the program's regulations effective as necessary for the Commissioner to conduct program audits on, including but not limited to, services provided, prior authorizations, payments for services and medical records. The Commissioner is required to analyze the audit results and to identify discrepancies and errors regarding services and payments in areas that involve program implementation and operation problems. In addition, the Commissioner may recover reimbursements made to providers based on audit results and impose progressive sanctions as warranted for any provider that is not in compliance with regulations. Providers may appeal withheld reimbursements or sanctions in accordance with the Uniform Administrative Procedures Act.

h. **Section 213: Childhood Immunizations (effective 10/1/2012).** Previously, Public Act 11-242 established a pilot program, operated by DPH, for certain health care providers who administer vaccines to children under the federal Vaccines For Children ("VFC") program to choose any vaccine licensed by the Food and Drug Administration as long as certain requirements were met. DPH is required to evaluate the pilot program, and if there was not a significant reduction in child immunization rates or an increased risk to children's health and safety, it is to expand the program to include all VFC providers. The Act shifts the date by which the program expansion must occur from July 1, 2012 to October 1, 2012. The Act also extends the choice of vaccine selection to health care providers who administer vaccines to children under the state childhood immunization program. All health care providers who administer vaccines to children must obtain vaccines from DPH starting January 1, 2013. The provisions of the Act that expand vaccine choices do not apply in the event of a public health emergency, attack, major disaster, emergency or disaster emergency.

i. **Section 213: Exceptions (effective 10/1/2012).** The Act provides that a health care provider participating in the VFC or state childhood immunization programs is not required to procure or administer a vaccine provided by DPH if: (i) DPH directs the provider to procure the vaccine from another source; or (ii) the provider determines, based on his or her professional judgment, that administering the vaccine is not medically appropriate or it is more medically appropriate to administer another vaccine DPH is not authorized to or does not supply. The Act also prohibits a health

25 For purposes of Public Act 12-1, "independent pharmacy" means a privately owned community pharmacy that has five (5) or fewer stores in the state.

care provider from receiving remuneration for or selling any vaccine provided by DPH. However, it does allow a provider to bill or charge for administering any such vaccine.

j. **Section 213: Reporting (effective 10/1/2012).** DPH must report on the effectiveness of the expanded vaccine choices and universal health care provider participation to the state legislature by January 1, 2014.

Questions or Assistance? If you have any further questions regarding the legislation outlined above, please feel free to contact one of the members of our Health Law Practice Group as listed on page 1 of this summary.

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