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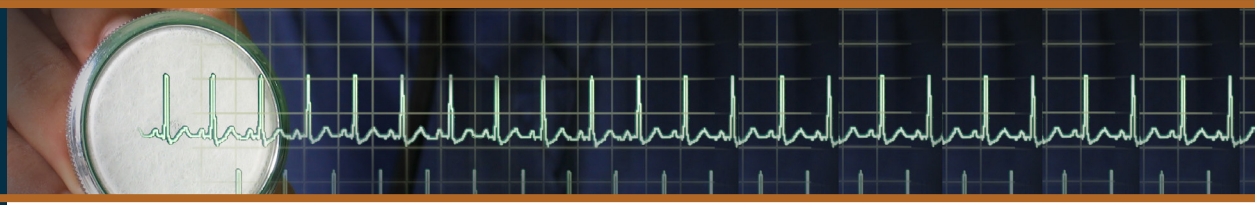
HEALTH LAW 2013 LEGISLATIVE UPDATE

August 2013



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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 enacted during the 2013 legislative session. 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 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.

Table of Contents:

SUMMARIES

1. AN ACT CONCERNING GUN VIOLENCE PREVENTION AND CHILDREN'S SAFETY. **See Public Act No. 13-3.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00003-R00SB-01160-PA.htm

   a. **Section 10: Notification of Voluntary Admission *(effective 10/1/2013)***. Public Act 13-3 (the "Act") requires psychiatric hospitals to notify the Department of Mental Health and Addiction Services ("DMHAS") of all individuals (i.e. not just DMHAS patients) who are voluntarily admitted to their institution for the treatment of psychiatric disabilities. Notification is not required if the admission is for only the treatment of alcohol or drug-related dependency. The hospital's notification to DMHAS must include the individual's name, address, sex, date of birth and date of admission.

      ***S&G Note**: Such disclosures are required by law and, thus, permitted under HIPAA.*

   b. **Section 11: Advisement of Firearms Status *(effective 7/1/2013)*.** The Act provides that DMHAS will notify psychiatric hospitals of the status of an individual's firearm application, permit or certificate when the individual voluntarily admits him/herself.

***S&G Note**: Prior to the Act, DMHAS only had such an obligation when individuals were involuntarily committed.*

c. **Section 67: Assertive Community Treatment Programs *(effective 7/1/2013)*.** The Act requires DMHAS to implement assertive community treatment programs in three cities that do not currently have such a program. The programs will use a person-centered, recovery-based approach and will offer: (i) assertive outreach; (ii) mental health services; (iii) vocational assistance; (iv) education concerning family issues; (v) information to develop wellness skills; and (vi) peer support services. The services will be offered by mobile, multi-disciplinary teams in community settings.

d. **Section 69: Establishment of Regional Behavioral Health Program *(effective 4/23/2013)*.** The Act requires the Department of Children and Families ("DCF") to establish a regional behavioral health consultation and care coordination program for primary care providers who serve children. The program will offer: (i) timely access to a consultation team including a child psychiatrist, social worker and care coordinator; (ii) patient care coordination and transitional services for behavioral health care; and (iii) training and education concerning patient access to behavioral health services.

***S&G Note**: There is no information yet as to who would qualify for the services or how the services can be accessed.*

2. AN ACT CONCERNING EXPENSES RELATING TO THE SALE OF NONPROFIT HOSPITALS. **See Public Act No. 13-14.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00014-R00SB-00967-PA.htm

   a. **Section 1: Payment of Attorney General Bills *(applicable to any application filed on or after 1/1/2013)***. When evaluating the proposed sale of a nonprofit hospital, the Attorney General may contract with experts or consultants for assistance in reviewing the proposal and may submit bills for such assistance to the purchaser. Public Act 13-14 increases the maximum amount of such bills from $300,000 to $500,000.

   ***S&G Note**: This provision is likely to be one more disincentive to for-profit hospitals to enter Connecticut.*

3. AN ACT CONCERNING GRANTS FROM THE BIOMEDICAL RESEARCH TRUST FUND FOR STROKE RESEARCH. **See Public Act No. 13-18.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00018-R00SB-00063-PA.htm

   a. **Section 1: Expansion of the Biomedical Research Trust Fund's Scope *(effective 7/1/2013)*.** Since 2001, the Department of Public Health ("DPH") has awarded grants-in-aid from Connecticut's Biomedical Research Trust Fund for the purpose of funding biomedical research for heart disease, cancer, Alzheimer's, diabetes and tobacco-related diseases. Public Act 13-18 expands the scope of the Biomedical Trust Fund by allowing DPH to also make grants-in-aid for stroke research.

4. AN ACT CONCERNING AN ADVISORY COUNCIL ON PALLIATIVE CARE. **See Public Act No. 13-55.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00055-R00SB-00991-PA.htm

   a. **Section 1: Establishment of Advisory Council *(effective 10/1/2013)*.** Public Act 13-55 establishes a Palliative Care Advisory Council within DPH. The council will analyze the current state of palliative care in Connecticut and will advise DPH on improving palliative care in the state and the quality of life for persons with serious or

chronic illnesses. The council will be composed of individuals from the health care industry, including, among others, social workers and individuals with experience with inpatient palliative care and palliative care for young adults.

***S&G Note**: We do not know whether the council's recommendations will result in new mandatory benefits, new service provider categories or new models of care.*

5. AN ACT CONCERNING TRAINING NURSING HOME STAFF ABOUT RESIDENTS' FEAR OF RETALIATION. **See Public Act No. 13-70.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00070-R00SB-00519-PA.htm

   a. **Section 1: Training Manual *(effective 10/1/2013)*.** Public Act 13-70 (the "Act") requires the Connecticut Long Term Care Ombudsman Program to create, and update as needed, a training manual to provide guidance on structuring and implementing a staff training program for chronic and convalescent nursing homes and rest homes with nursing supervision.

   b. **Section 2: Training in Patients' Fear of Retaliation *(effective 10/1/2013)*.** The Act requires chronic and convalescent nursing homes and rest homes with nursing supervision to include training about patients' fear of retaliation from employees or others in the facility's annual in-service staff training program that is to be provided to any and all of the facility's staff members. The facility's administrator must ensure that the training includes discussion of: (i) a patient's right to file complaints and voice grievances; (ii) examples of what might constitute or be perceived as employee retaliation against patients; and (iii) methods of preventing employee retaliation and alleviating patient fear of such retaliation.

      ***S&G Note**: We think that such training should educate staff that legal protections extend to retaliation against patients for grievances brought by family members.*

6. AN ACT REQUIRING LICENSED SOCIAL WORKERS, COUNSELORS AND THERAPISTS TO COMPLETE CONTINUING EDUCATION COURSE WORK IN CULTURAL COMPETENCY. **See Public Act No. 13-76.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00076-R00SB-00366-PA.htm

   a. **Sections 1 - 4: Cultural Competency *(applicable to registration periods beginning on and after 10/1/2014)***. Public Act 13-76 amends the continuing education requirements for licensed social workers, professional counselors, alcohol and drug counselors and marital and family therapists to require not less than one contact hour of training or education each registration period on the topic of cultural competency.

7. AN ACT CONCERNING THE TIME FOR PARENTAL NOTIFICATION WHEN A CHILD IS ADMITTED TO A HOSPITAL FOR DIAGNOSIS OR TREATMENT OF A MENTAL DISORDER. **See Public Act 13-130.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00130-R00HB-05727-PA.htm

   a. **Section 1: Parental Notification *(effective 10/1/2013)***. Connecticut law requires hospitals to notify a parent or guardian of a child age 14 or older or in the custody of DCF that the child was admitted for the diagnosis or treatment of a mental disorder without a parent's or guardian's consent.[1] Public Act 13-130 reduces the time in which a hospital is required to make such notification from five days to twenty-four hours.

1 Connecticut law permits a hospital to admit a child age 14 or older for diagnosis or treatment of a mental health disorder without parental consent if the child agrees in writing. DCF can admit any child under its custody to a hospital without going through probate court if (a) the child's legal counsel consents in writing and (b) if age 14 or older, the child agrees.

8. AN ACT CONCERNING THE JOINT PRACTICE OF PHYSICIANS AND PSYCHOLOGISTS. **See Public Act 13-157.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00157-R00SB-01069-PA.htm

    a. **Section 1: Psychologist/Physician Professional Corporations *(effective 10/1/2013)*.** Public Act 13-157 authorizes physicians and psychologists to form a professional service corporation together to offer their services. All of the shareholders must be licensed or legally authorized to provide these services.

9. AN ACT CONCERNING THE ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM. **See Public Act 13-172.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00172-R00HB-06406-PA.htm

    a. **Section 1: Expanded Scope *(effective 6/21/2013)***. The Department of Consumer Protection's ("DCP's") electronic prescription drug monitoring program (the "Rx Program") was established to collect prescription data for Schedule II through Schedule V drugs into a central database, the Connecticut Prescription Monitoring and Reporting System ("CPMRS"), which can then be used by providers and pharmacists in the active treatment of their patients. The purpose of the CPMRS is to present a complete picture of a patient's controlled substance use, including prescriptions by other providers, so that the provider can properly manage the patient's treatment, including the referral of a patient to services offering treatment for drug abuse or addiction when appropriate. Pursuant to Public Act 13-172 (the "Act"), the Rx Program shall now also apply to (in addition to pharmacies and outpatient pharmacies in hospitals or other institutions) "nonresident pharmacies"[2] and all other "dispensers."[3] The Act also permits DCP to identify other products or substances to be included and covered by the Rx Program.

    b. **Section 1: Notification *(effective 6/21/2013)*.** Previously, all entities or individuals covered by the Rx Program were required to file their prescription data into the CPMRS at least twice per month. The Act now requires such data to be filed at least once per week.

    c. **Section 1: Interference Prohibited *(effective 6/21/2013)***. The Act now expressly provides that no person or employer shall prohibit, discourage or impede a prescribing practitioner or pharmacist from requesting controlled substance prescription information from the CPMRS.

    d. **Section 1: Rx Program Not Applicable to Samples *(effective 6/21/2013)***. The Act now expressly provides that the Rx Program shall not apply to samples of controlled substances dispensed by a physician to a patient.

    e. **Section 2: Registration *(effective 6/21/2013)***. Under current law, any practitioner who distributes, administers or dispenses any controlled substance or who proposes

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2 *"'Nonresident pharmacy'* means any pharmacy located outside this state which ships, mails or delivers, in any manner, legend devices or legend drugs into this state pursuant to a prescription order." See C.G.S. § 20-627(a).

3 *"Dispenser"* means any practitioner who delivers a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling or compounding necessary to prepare the substance for the delivery. *"Practitioner"* means: (A) A physician, dentist, veterinarian, podiatrist, scientific investigator or other person licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state; (B) a pharmacy, hospital or other institution licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state. See C.G.S. § 21a-240.

to engage in distributing, prescribing, administering or dispensing any controlled substance within Connecticut must obtain a controlled substances registration from DCP. In addition to this registration, the Act now also requires all such practitioners to register for access to the Rx Program.

10. AN ACT CONCERNING SERVICES THAT MAY BE PROVIDED BY PROFESSIONAL CORPORATIONS. **See Public Act 13-198.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00198-R00HB-06445-PA.htm

    a. **Section 1: Podiatrist/Physician Professional Corporations *(effective 10/1/2013)*.** Public Act 13-198 authorizes physicians and podiatrists to form a professional service corporation together to offer their services. All of the shareholders must be licensed or legally authorized to provide these services.

11. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES. **See Public Act 13-208.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00208-R00HB-06644-PA.htm

    a. **Section 3: Long-Term Care Facility Volunteer Background Checks *(effective 10/1/2013)*.** Public Act 13-208 (the "Act") requires volunteers at long-term care facilities to submit to background checks when the long-term care facility reasonably expects such volunteer to regularly perform duties that are substantially similar to those of an employee with direct access to clients. The background checks must be conducted prior to the volunteer commencing service at the facility.

    b. **Section 4: Additional Requirements for Short-Term Hospital Special Hospice and Hospice Inpatient Facilities *(effective 10/1/2013)***. The Act extends certain statutory requirements which currently apply to "health care institutions" to short-term hospital special hospice and hospice inpatient facilities[4] including with respect to the patient bill of rights and patient notification requirements.

    c. **Section 7: Compliance with DPH Regulations *(effective 10/1/2013)***. The Act removes the one-year time period within which DPH-licensed health care institutions must comply with any regulations DPH adopts. The Act retains the existing requirement that they comply within a reasonable time (the Act does not define what is meant by a reasonable time).

    d. **Section 7: DPH Investigations *(effective 10/1/2013)***. The Act addresses the DPH facility inspection process. Specifically, within 10 days after receiving a notice of non-compliance from DPH, the Act requires health care institutions to submit to DPH a written corrective action plan that includes the: (i) corrective measures or systemic changes the institution intends to implement to prevent a recurrence of each identified non-compliance issue; (ii) effective date of each corrective measure or systemic change; (iii) institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and (iv) title of the institution's staff member responsible for ensuring its compliance with the

4 *"Short-term hospital special hospice"* is an entity which provides hospice care services for terminally ill persons on a twenty-four hour basis in all settings including, but not limited to, a private home, nursing home and residential care home or specialized residence that provides supportive services. See CT Regs. Sec. 19a-495-5b.

"Hospice inpatient facility" is a facility or hospice residence that provides palliative care for hospice patients requiring short-term, general inpatient care for pain and symptom management, end of life care or respite care and provides the services required pursuant to 19a-122b of the Connecticut General Statutes. See CT Regs. Sec. 19a-495-6a.

plan. Under the Act, the corrective action plan is deemed the institution's representation of compliance with the statutes and regulations identified in DPH's noncompliance notice. An institution's failure to submit a corrective action plan that meets the above requirements may result in disciplinary action, such as license revocation or suspension, censure, letter of reprimand, or probation.

***S&G Note**: This statute is a codification of existing DPH practice.*

e. **Section 8: PAs and PICCs *(effective 10/1/2013)*.** The Act allows a licensed physician assistant employed or contracted by a nursing home that operates an intravenous (IV) therapy program to "administer"[5] a peripherally-inserted central catheter (PICC) as part of the facility's IV therapy program.

***S&G Note**: Providers should consider establishing protocols for the proper placement of the PICC line.*

f. **Section 11: PAs in the National Guard *(effective 10/1/2013)***. The Act allows a physician assistant who is licensed in another state and an active member of the Connecticut Army or Air National Guard to provide patient services under the supervision, control, responsibility, and direction of a Connecticut-licensed physician while in Connecticut.

g. **Section 13: Continuing Education Requirements for Optometrists.** Beginning with registration periods commencing on or after October 1, 2014, the Act requires optometrists to complete at least 20 hours of continuing education each registration period.

h. **Section 13: License Renewal for Optometrists.** Beginning with registration periods commencing on or after October 1, 2014, the Act requires each licensee applying for renewal to sign a statement attesting that he or she completed the continuing education requirements. Each licensee must have an attendance record or certificate of completion from the continuing education provider for all hours successfully completed. He or she must retain this documentation for at least three years following the date the continuing education was completed or the license was renewed. (This Act does not indicate if the documentation retention requirement continues to the earlier or the later of those two events).

i. **Section 13: Continuing Education Exemptions and Waivers for Optometrists.** Beginning with registration periods commencing on or after October 1, 2014, a licensee applying for his or her first renewal is exempt from the continuing education requirements. A licensee not actively engaged in the practice of optometry is also exempt, provided he or she submits a notarized exemption application before the end of the registration period on a form DPH prescribes. In this case, the licensee cannot resume practicing optometry until completing the continuing education requirements. DPH may also grant a waiver from the requirements or an extension of time for a licensee who has a medical disability or illness. The licensee must apply for a waiver or time extension to DPH and submit a licensed physician's certification of the disability or illness and any documentation DPH requires. The waiver or extension cannot exceed one registration period. DPH may grant additional waivers or extensions if the initial reason for the waiver or extension continues beyond the waiver or extension period and the licensee applies.

5 *"Administer"* means to initiate the venipuncture and deliver an IV fluid or IV admixture into the blood stream through a vein, and to monitor and care for the venipuncture site, terminate the procedure and record pertinent events and observations.

j. **Section 13: Licensure Reinstatement for Optometrists.** Beginning with registration periods commencing on or after October 1, 2014, a licensee who applies for the reinstatement of his or her license after his or her license was voided must submit evidence that he or she completed 20 contact hours of continuing education within the year immediately preceding the application.

k. **Section 14: Continuing Education Requirements for Dental Hygienists *(effective 10/1/2013)*.** The Act requires each licensee applying for renewal to complete at least 16 hours of continuing education within the preceding two years (the same requirement as under current DPH regulations). The continuing education subject matter must reflect the licensee's professional needs in order to meet the public's health care needs. Continuing education activities must provide significant theoretical or practical content directly related to clinical or scientific aspects of dental hygiene. A licensee may substitute eight hours of volunteer dental practice at a public health facility for one hour of continuing education, up to a maximum of five hours in one two-year period. Up to four hours of continuing education may be earned through an online or distance learning program.

l. **Section 14: License Renewal; CE Exemptions and Waivers for Dental Hygienists *(effective 10/1/2013)*.** The Act's continuing education documentation requirements upon renewal, exemptions, and waivers for dental hygienists are the same as those for optometrists (see Section (i) above).

m. **Section 14: Licensure Reinstatement for Dental Hygienists *(effective 10/1/2013)*.** A licensee who applies for licensure reinstatement after his or her license was voided must submit evidence that he or she successfully completed: (i) for licenses voided for two years or less, 24 contact hours of continuing education within the two years immediately preceding the application; or (ii) for licenses voided for more than two years, the National Board of Dental Hygiene Examination or the Northeast Regional Board of Dental Examiners' Examination in Dental Hygiene during the year immediately preceding the application.

n. **Section 23: Tumor Registry *(effective 6/21/2013)***. The Act now requires that reports to the Connecticut Tumor Registry include, along with other information already required by existing law, available follow-up information on (i) pathology reports and (ii) operative reports and hematology, medical oncology, and radiation therapy consults, or abstracts of these reports or consults.

   ***S&G Note**: The statute is silent regarding the duration of an entity's obligation to provide follow-up information to the registry.*

o. **Sections 24-60: Definition of Residential Care Home *(effective 7/1/2013)*.** The Act removes residential care homes from the statutory definition of "nursing home facility" and establishes a separate definition for these facilities. The Act redefines a residential care home as a facility that (i) furnishes, in single or multiple facilities, food and shelter to two or more people unrelated to the proprietor and (ii) provides services that meet a need beyond the basic provisions of food, shelter, and laundry. The Act also modifies various requirements for residential care homes, including, among others, the patient bill of rights and notifying DPH of criminal convictions of facility employees.

   ***S&G Note:** This statute establishes a new provider category for residential care homes, but these providers will continue to be subject to many nursing home regulations and requirements.*

p. **Section 63: Disclosure of Patient Information by Health Care Providers *(effective 10/1/2013).*** The Act clarifies that all DPH-licensed health care providers, except as set forth below, cannot disclose any patient information or communications without the consent of the patient or his or her authorized representative except: (i) according to statute, regulation, or court rule; (ii) to the health care provider's attorney or liability insurer for use in the provider's defense of an actual or reasonably likely malpractice claim; (iii) to DPH as part of an investigation or complaint, if the records are related; or (iv) if the health care provider knows, or has a good faith suspicion, that a child, senior, or person with a disability is being abused. The Act specifies that these disclosure requirements do not apply to psychologists, psychiatrists, professional counselors, social workers, marital and family therapists, DMHAS-contracted providers, and researchers, each of which have their own statutory disclosure requirements.

S&G Note: *Previously, the statute was ambiguous regarding whether it applied to all DPH-licensed health care providers or only to physicians and surgeons.*

q. **Section 66: Definition of Nuclear Medicine Technologist and Scope of Practice *(effective 7/1/2013).*** The Act defines a "nuclear medicine technologist" as a person who holds and maintains current certification in good standing with the (i) Nuclear Medicine Technology Certification Board ("NMTCB") or (ii) American Registry of Radiologic Technologists ("ARRT"). Under the Act, the practice of nuclear medicine technology includes the use of sealed and unsealed radioactive materials, as well as pharmaceuticals, adjunctive medications, and imaging modalities with or without contrast as part of diagnostic evaluation and therapy. The technologist's responsibilities include patient care, quality control, diagnostic procedures and testing, administration of radiopharmaceutical and adjunctive medications, in vitro diagnostic testing, radionuclide therapy, and radiation therapy. The Act allows a nuclear medicine technologist to perform nuclear medicine procedures under the supervision and direction of a DPH-licensed physician if: (i) the physician is satisfied with the technologist's ability and competency; (ii) such delegation is consistent with the patient's health and welfare and in keeping with sound medical practice; and (iii) such procedures are performed under the physician's oversight, control, and direction. The Act prohibits a nuclear medicine technologist from (a) operating a stand-alone computed tomography imaging system (CT scan), except as provided below or (b) independently performing a nuclear cardiology stress test, except that the technologist can perform the imaging portion of the test and administer adjunct medications and radio pharmaceuticals.

S&G Note*: Providers are advised to check reimbursement rules to confirm the level of supervision and documentation that is necessary for nuclear medicine technologists.*

r. **Section 68: Computed Tomography Imaging Systems *(effective 7/1/2013)***. The Act permits a nuclear medicine technologist to operate a CT or magnetic resonance imaging ("MRI") portion of a hybrid-fusion imaging system, including diagnostic imaging, in conjunction with a (i) positron emission tomography or (ii) single-photon emission CT imaging system. The nuclear medicine technologist must (a) have successfully completed the individual certification exam for CT or MRI administered by the ARRT and (b) hold and maintain in good standing a CT or MRI certification by the ARRT.

s. **Section 69: Emergency Coronary Angioplasty Reporting Requirement *(effective 6/21/2013).*** The Act requires hospitals that have obtained a certificate of need from DPH's Office of Health Care Access ("OHCA") to provide emergency, but not elective, coronary angioplasty services to report monthly to DPH on the number of people who received an emergency coronary angioplasty and were then discharged to another

hospital to receive (i) an elective coronary angioplasty or (ii) open-heart surgery. The monthly reports commence October 1, 2013 and continue through September 30, 2014.

S&G Note: *OHCA has recently denied several hospital Certificate of Need applications related to elective angioplasty given the geographic proximity of the hospital to other hospital's with the capability to perform elective angioplasty. Presumably, OHCA desires to continue its study of this issue.*

t. **Section 70: Marital and Family Therapist Licensure Requirements *(effective 10/1/2013)*.** The Act modifies application requirements for a marital and family therapist license to require new applicants to demonstrate completion of a practicum or internship training program that is accredited by the Commission on Accreditation for Marriage and Family Therapy Education and offered by a regionally accredited institution of higher education.

12. AN ACT CONCERNING CONTINUING EDUCATION COURSES FOR PHYSICIANS. **See Public Act 13-217.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00217-R00SB-00466-PA.htm

    a. **Section 1: Continuing Medical Education *(effective 7/1/2013)*.** Public Act 13-217 (the "Act") reduces the frequency with which physicians must take mandatory topics for continuing medical education ("CME"). Under prior law, physicians had to take at least one contact hour (50 minutes) of CME in each mandatory topic every two years. Now, the Act requires one contact hour in each mandatory topic during the first renewal period for which CME is required (the second license renewal), and once every six years after that.

    b. **Section 1: Behavioral Health Education *(effective 7/1/2013).*** The Act adds behavioral health to the list of mandatory CME topics.

    c. **Section 1: Record Retention *(effective 7/1/2013)*.** The Act requires physicians to retain CME attendance records or certificates of completion for at least six years, rather than three years.

13. AN ACT CONCERNING THE RETURN OF A GIFT TO A PERSON IN NEED OF LONG-TERM CARE SERVICES. **See Public Act No. 13-218**. http://www.cga.ct.gov/2013/ACT/PA/2013PA-00218-R00SB-00523-PA.htm

    a. **Section 1: Penalty Periods *(effective 7/1/2013)*.** Connecticut law requires the Department of Social Services ("DSS") to impose a penalty period (period of Medicaid ineligibility) on institutionalized individuals[6] who transfer or assign their assets for less than they are worth in order to shift their care costs to the Medicaid program. The penalty period (i) applies only when such transactions occur within five years before a person applies for Medicaid long-term care and (ii) generally is not imposed if the entire amount of the transferred asset is returned to the institutionalized individual. Public Act 13-218 (the "Act") requires DSS, to the extent permitted by federal law, to reduce the penalty period if part of the transferred assets is returned to the individual and the penalty period's original end date does not change.

    b. **Section 1: Conveyances *(effective 7/1/2013)*.** Under current Connecticut law, a conveyance and subsequent return of an asset to shift costs to the Medicaid program

6 Institutionalized individuals are people who apply for or are receiving long-term care facility or Medicaid waiver home- and community-based services.

is deemed a trust-like device, and the asset is considered available for determining Medicaid eligibility. The Act specifies that this does not apply to a conveyance and return of an asset made exclusively for a purpose other than qualifying for Medicaid long-term care services.

c. **Section 1: Penalties *(effective 7/1/2013)*.** The Act also repeals a provision requiring DSS to penalize a nursing home resident for an improper asset transfer in which the entire amount is returned.

14. AN ACT ADDRESSING THE MEDICAL NEEDS OF CHILDREN. **See Public Act No. 13-228.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00228-R00SB-00833-PA.htm

a. **Section 1: Rights Regarding Medical Decisions *(effective 10/1/2013)***. Under current law, select entities, agencies and persons such as foster parents, DSS and DCF, may file petitions with a Connecticut Superior Court (the "Court") claiming that a child or youth has been neglected, uncared-for or abused. As a result of such petitions, the Court may, depending on its findings and the specific facts and circumstances of the matter, grant temporary custody and care over the youth or child to the entity, person, or agency while the petition is being resolved. Under Public Act No. 13-228, such custodians shall now have the following express rights and duties in relation to the child or youth: (a) the obligation of care and control; (b) the authority to make decisions regarding emergency medical, psychological, psychiatric or surgical treatment; and (c) such other rights and duties that the Court may order.

15. AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH. **See Public Act No. 13-234**. http://www.cga.ct.gov/2013/ACT/PA/2013PA-00234-R00HB-06705-PA.htm

a. **Section 112: Nursing Facility Notification Requirement *(effective 6/19/2013)*.** Under Connecticut law, no nursing home facility[7] shall admit any person, irrespective of source of payment, who has not undergone a preadmission screening process to determine whether the person is mentally ill in accordance with DMHAS and DSS rules and procedures. Pursuant to Public Act No. 13-234 (the "Act"), DSS may now require a nursing facility to notify DSS, within one business day, of the admission of a person who is mentally ill and meets admission criteria.

S&G Note: *This statute is notable because it permits DPH to require such notifications. We anticipate further guidance on this issue from DPH.*

b. **Sections 128-130: Nursing Home Facility Actions to Collect Debts relating to Unpaid Care *(effective 10/1/2013)*.** Pursuant to the Act, nursing home facilities may bring collection actions[8] against persons who have been involved with or benefitted from a transfer of assets for less than fair market value for the purposes of obtaining Medicaid eligibility (an "Improper Transfer"). Persons who have been determined to have made Improper Transfers are ineligible to participate in Medicaid for specified periods of time pursuant to federal law (the "Penalty Period"). Pursuant to the Act, an Improper Transfer that results in the establishment or imposition of a Penalty Period shall create a debt that shall be due and owing to a nursing home facility for the unpaid cost of care provided during the Penalty Period to a nursing home facility resident who

7 *"Nursing home facility"* means a chronic and convalescent home or a rest home with nursing supervision.

8 Please note that Sections 128-130 of the Act do not affect any other rights or remedies of the involved parties.

has been subject to the Penalty Period. A nursing home facility may bring an action to collect a debt for unpaid care given to a resident who has been subject to a Penalty Period, provided: (i) the debt recovery does not exceed the fair market value of the transferred asset at the time of transfer; and (ii) the asset transfer that triggered the Penalty Period took place not earlier than two years prior to the date of the resident's Medicaid application. The nursing home facility may bring such action against the transferor or transferee. In such actions a court may award actual damages, court costs and reasonable attorneys' fees to a nursing home facility if such court determines, based upon clear and convincing evidence, that a defendant incurred a debt to a nursing home facility by: (a) willfully transferring assets that are the subject of a Penalty Period; (b) receiving such assets with knowledge of such purpose; or (c) making a material misrepresentation or omission concerning such assets. Court costs and reasonable attorneys' fees shall be awarded to a defendant who successfully defends such an action. Upon commencement of any action, a nursing home facility shall mail a copy of the complaint to the Attorney General and DSS and, upon entry of any judgment or decree in the action, shall mail a copy of such judgment or decree to the Attorney General and DSS.

c. **Section 141: DPH Funds for FQHCs *(effective 7/1/2013)*.** The Act requires DPH, within available appropriations, to establish and administer a program to provide financial assistance to community health centers (a/k/a federally qualified health centers, federally qualified health center look-alikes or collectively "FQHCs"). DPH shall develop a formula to disburse program funds to FQHCs based on, but not limited to, factors such as: (i) the number of uninsured patients served by the FQHC; and (ii) the types of services provided by the FQHC. DPH may also establish requirements for participation in the program, provided DPH provides reasonable notice of such requirements to all FQHCs. The FQHCs will only be permitted to use the funds for DPH-approved purposes.

   S&G Note: *While not expressly set forth in the Act, we presume that such funds will be in the form of grants that come with "strings" or requirements, but not in a loan format that would require the FQHCs to reimburse DPH.*

d. **Section 144: Additional Certificate of Need Considerations *(effective 10/1/2013).*** In addition to the other requirements of Section 19a-639 of the Connecticut General Statutes, in any deliberations involving a certificate of need application, OHCA shall now take into consideration and make written findings concerning: (i) the application's impact on the provision of or any change in access to services for Medicaid recipients and indigent persons, and the impact upon the cost effectiveness of providing access to services provided under the Medicaid program; (ii) an applicant's past and proposed provision of health care services to Medicaid recipients and indigent persons; and (iii) whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

e. **Section 147: Non-Profit Hospitals to File IRS Form 990s and Community Needs Assessment Data with OHCA *(effective 10/1/2013)***. Along with the other financial data hospitals file with OHCA on an annual basis, each non-profit hospital shall also now include with such OHCA filings: (i) a complete copy of such hospital's most-recently completed IRS Form 990, including all parts and schedules; and (ii) in the form and manner prescribed by OHCA, data compiled to prepare such hospital's community health needs assessment as required pursuant to Section 501(r) of the Internal Revenue

Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time provided such copy and data shall not include: (a) individual patient information, including, but not limited to, patient-identifiable information; (b) information that is not owned or controlled by such hospital; (c) information that such hospital is contractually required to keep confidential or that is prohibited from disclosure by a data use agreement; or (d) information concerning research on human subjects.

S&G Note: *It will be interesting to see whether any of this information will be introduced or considered by OHCA in Certificate of Need determinations.*

f. **Section 148: Penalties for Providers Who Do Not Complete OHCA Inventory Questionnaires *(effective 10/1/2013)***. Pursuant to section 19a-634 of the Connecticut General Statutes, OHCA requires health care facilities and providers to fill out and submit a questionnaire biennially regarding the: (i) name and location of the facility; (ii) type of facility; (iii) hours of operation; (iv) type of services provided at that location; and (v) total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. Prior to the Act, health care facilities and providers were not subject to civil penalties under section 19a-653 of the Connecticut General Statutes for failing to complete the inventory questionnaire. The Act has eliminated this language and health care facilities and providers are now subject to penalties for failing to submit the questionnaire which can be up to $1,000 a day for each day such information is missing, incomplete or inaccurate.

g. **Section 149: Hospitals to Provide Detailed Patient Bills to DPH or Patients *(effective 10/1/2013)***. Pursuant to the Act and upon the request of DPH or a patient, a hospital shall provide to DPH or the patient a "detailed patient bill." For purposes of the Act, "detailed patient bill" means a patient billing statement that includes, in each line item, the hospital's current pricemaster[9] code and a description of the charge and the billed amount.

16. AN ACT AUTHORIZING AND ADJUSTING BONDS OF THE STATE FOR CAPITAL IMPROVEMENTS, TRANSPORTATION, ELIMINATION OF THE ACCUMULATED GAAP DEFICIT AND OTHER PURPOSES. **See Public Act 13-239.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00239-R00SB-00842-PA.htm

a. **Section 72: Bioscience Innovation Fund *(effective 7/1/2013)*.** Public Act 13-239 establishes a $200 million Bioscience Innovation Fund to be held and managed by Connecticut Innovations. Connecticut Innovations shall use the fund to: (i) provide financial assistance to eligible recipients; (ii) repay state bonds in as may be required by the State Bond Commission; and (iii) reimburse itself for administrative costs. Financial assistance shall be awarded to further the development of bioscience, biomedical engineering, health information management, medical care, medical devices, medical diagnostics, pharmaceuticals, personalized medicine and other related disciplines that are likely to lead to an improvement in or development of services, therapeutics, diagnostics or devices that are commercializable and designed to advance the coordination, quality or efficiency of health care and lower health care costs, and that promise, directly or indirectly, to lead to job growth in the state in these or related fields. Funds shall be disbursed annually between 2013 and 2022.

9 For purposes of this Act, *"pricemaster"* means a detailed schedule of hospital charges.

17. AN ACT CONCERNING NEWBORN SCREENING FOR ADRENOLEUKODYSTROPHY. **See Public Act No. 13-242.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00242-R00SB-00465-PA.htm

    a. **Section 1: Mandatory Screening of Newborns for Adrenoleukodystrophy *(effective 10/1/2013).*** Any facility or institution that cares for newborn infants shall cause all newborn infants in its care to be tested for adrenoleukodystrophy starting on and after the occurrence of the following: (i) the development and validation of a reliable methodology for screening newborns for adrenoleukodystrophy using dried blood spots and quality assurance testing methodology for such test or the approval of a test for adrenoleukodystrophy using dried blood spots by the FDA; and (ii) the availability of any necessary reagents for such test.

18. AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2015 CONCERNING GENERAL GOVERNMENT. **See Public Act No. 13-247.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00247-R00HB-06706-PA.htm

    a. **Section 74: DMHAS Pilot Program *(effective 10/1/2013).*** DMHAS will implement a pilot program to assist alcohol-dependent persons who are discharged from hospitals in the New Haven region (the "Pilot Program"). The Pilot Program will provide such persons with assistance in obtaining outpatient treatment services and community support services, including housing. DMHAS will be permitted to enter into a services agreement to assist with the administration of the Pilot Program.

19. AN ACT CONCERNING THE MAINTENANCE OF PROFESSIONAL LIABILITY INSURANCE BY NURSING HOMES, HOME HEALTH CARE AGENCIES AND HOMEMAKER-HOME HEALTH AIDE AGENCIES. **See Public Act No. 13-249.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00249-R00SB-01060-PA.htm

    a. **Sections 1-2: Mandatory Insurance Requirements for Nursing Homes, Home Health Care Agencies, and Homemaker-Home Health Agencies *(effective 1/1/2014).*** No person shall establish, conduct, operate or maintain a nursing home, home health care agency, or homemaker-home health agency without maintaining professional liability insurance or other indemnity against liability for professional malpractice. The amount of insurance which such person shall maintain as insurance or indemnity against claims for injury or death for professional malpractice shall be not less than one million dollars for one person, per occurrence, with an aggregate of not less than three million dollars. Residential care homes are not subject to this requirement.

20. AN ACT CONCERNING LICENSED ALCOHOL AND DRUG COUNSELORS. **See Public Act No. 13-283.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00283-R00SB-01065-PA.htm

    a. **Section 1: Licensure Requirements for Alcohol and Drug Counselors *(effective 7/12/2013)***. To be eligible for licensure as a licensed alcohol and drug counselor, one must now have attained a master's degree from an accredited institution of higher education in social work, marriage and family therapy, counseling, psychology or a related field approved by DPH.

       S&G Note: *While not expressly set forth in the Act, such a requirement only applies to individuals seeking initial licensure and not persons seeking to renew their licenses as alcohol and/or drug counselors.*

21. AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID PAYMENT INTEGRITY. **See Public Act No. 13-293.** http://www.cga.ct.gov/2013/ACT/PA/2013PA-00293-R00HB-06514-PA.htm

    a. **Section 1: Report Regarding State of Connecticut's Efforts to Prevent Medicaid Fraud, Abuse and Waste *(effective 7/12/2013)***. Public Act No. 13-293 (the "Act") requires that starting on January 1, 2015, and annually thereafter, DSS, in coordination with the Chief State's Attorney and the Attorney General, shall submit a joint report (the "Joint Report") on the State's efforts in the previous fiscal year to prevent and control Medicaid fraud, abuse and other payment errors and the recovery of Medicaid overpayments. The Joint Report shall include: (i) a final accounting of identified, ordered, collected and outstanding Medicaid recoveries from all sources; (ii) detailed and unit specific performance standards, benchmarks and metrics; (iii) projected cost savings for the following fiscal year; and (iv) new initiatives taken to prevent and detect overpayments. No personally identifying information or other information that is protected from disclosure under state or federal law or by court rule shall be included in the Joint Report. Each agency shall also post the Joint Report on its web site.

    b. **Section 1: Information to Be Provided *(effective 7/12/2013)***. As part of the Joint Report process, the Act requires DSS, the Chief State's Attorney, and the Attorney General to share the following information (at a minimum) with each other:

        - **DSS shall share the following information:**

            (1) Data related to Medicaid audits conducted by DSS including:

                (a) The number of such audits completed by provider type;
                (b) The amount of overpayments identified due to such audits;
                (c) The amount of avoided costs identified due to such audits;
                (d) The amount of overpayments recovered due to such audits; and
                (e) The number of such audits resulting in referral to the Chief State's Attorney.

                S&G Note: *The collection and availability of this information may affect how willing DSS will be to settle Medicaid audit claims.*

            (2) Data related to Medicaid program integrity investigations conducted by DSS including:

                (a) The number of complaints received by source type and reason;
                (b) The number of investigations opened by source type and provider type;
                (c) The number of investigations completed, with outcomes for each investigation by source type and provider type;
                (d) The amount of overpayments identified due to investigations;
                (e) The amount of overpayments collected due to investigations;
                (f) The number of investigations resulting in a referral to the Chief State's Attorney;
                (g) For each closed investigation, the length of time elapsed between case opening and closing;
                (h) For each investigation resulting in a referral to another agency, the length of time elapsed between case opening and referral;
                (i) The number of investigations resulting in suspension of Medicaid payments by provider type; and

(j) The number of investigations resulting in suspension of provider enrollment from the Medicaid program by provider type.

(3) The amount of overpayments collected by recovery contractors by type of contractor.

- **The Chief State's Attorney and the Attorney General shall each share the following information:**

(1) The number of investigations opened by source type;

(2) The general nature of the allegations by provider type;

(3) For each closed case, the length of time elapsed between case opening and closing;

(4) The final disposition category of closed cases by provider type;

(5) The monetary recovery sought and realized by action, including:

(a) civil monetary penalties;
(b) settlements; and
(c) judgments; and

(6) The number of referrals declined and reason.

c. **Section 1: Information in Joint Report Regarding Third-Party Liability Recovery *(effective 7/12/2013)*.** The Act requires the Joint Report to include third-party liability recovery information for the previous three-year period by fiscal year, including, but not limited to: (i) The total number of claims selected for billing by commercial health insurance and Medicare; (ii) the total amount billed for such claims; (iii) the number of claims where recovery occurred; (iv) the actual amount collected; (v) an explanation of any claim denials by category; (vi) the number of files updated with third-party insurance information; and (vii) the estimated cost avoidance in the future related to updated files.

d. **Section 2: Expansion of Medicaid Audit Program and Use of Contingency Fee-Based Audit Contractors *(effective 7/12/2013)*.** The Act also requires DSS to: (i) conduct an assessment of the feasibility of expanding its Medicaid audit program, including the possible use of contingency-based contractors; and (ii) produce a written analysis of the recovery of Medicaid dollars through its third-party liability contractors to determine if recovery procedures maximize collection efforts. DSS shall report its findings in writing to the Connecticut General Assembly no later than January 1, 2014.

S&G Note: *The Federal Government is currently using contingency-based contractors for auditing providers who receive Medicare reimbursement. If the Medicare audits conducted by such contractors are any indication of how the Medicaid audits will be conducted, providers will be severely and negatively burdened and impacted by such an audit program.*

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