SHIPMAN & GOODWIN LLP
COUNSELORS AT LAW

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This Legislative Update provides readers with a summary of relevant Connecticut legislation affecting healthcare providers and other healthcare or bioscience-related entities. The specific Public and Special Acts are summarized herein for your reference and convenience along with the link to the specific Public or Special Act. Page 1 lists the specific Public and Special Acts that are covered along with a reference to the page in this Alert where its corresponding summary is located.

Health Law Practice Group:

Joan W. Feldman
(860) 251-5104
jfeldman@goodwin.com

David M. Mack
(860) 251-5058
dmack@goodwin.com

John H. Lawrence, Jr.
(860) 251-5139
jlawrence@goodwin.com

Vincenzo Carannante
(860) 251-5096
vcarannante@goodwin.com

Lina Estrada McKinney
(860) 251-5660
lmckinney@goodwin.com

William J. Roberts
(860) 251-5051
wroberts@goodwin.com

1. **AN ACT CONCERNING THE PROVISION OF VOLUNTEER HEALTH CARE SERVICES ON A TEMPORARY BASIS**. See Public Act No. 10-23.

    - THE PROVISION OF VOLUNTEER HEALTH CARE SERVICES ON A TEMPORARY BASIS (effective 7/1/2010). Notwithstanding the requirements that health care practitioners require a Connecticut license to practice in Connecticut, Public Act No. 10-23 allows an out-of-state health care practitioner who holds a current unrestricted health care practitioner license or certificate issued in another state to provide uncompensated health care services in Connecticut in association with a free clinic or similar charitable medical event or the Special Olympics or other similar athletic competition held in the state.

2. **AN ACT CONCERNING ISSUANCE OF EMERGENCY CERTIFICATES AND THE SAFETY OF PATIENTS AND STAFF AT FACILITIES OPERATED BY THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.** See Public Act No. 10-60.

    - INTERMEDIATE CARE BED CERTIFICATIONS (effective 7/1/2010). The Department of Mental Health and Addiction Services ("DMHAS") is required to certify intermediate care beds in general hospitals to provide inpatient mental health services for adults with serious and persistent mental illness. DMHAS will adopt regulations to establish general hospital intermediate care bed certification requirements and procedures. DMHAS will implement the policies and procedures necessary to implement the certification requirements while adopting them as regulations.

    - BEHAVIORAL HEALTH RECOVERY PROGRAM (effective 5/18/2010). DMHAS is required to operate a behavioral health recovery program that will provide clinical substance abuse treatment, psychiatric treatment and non-clinical recovery support services to Medicaid-eligible individuals. Services provided under the program may include, but shall not be limited to, residential substance abuse treatment, recovery support services, peer supports, housing assistance, transportation, food, clothing and personal care items. DMHAS will be responsible for all services and payments related to the behavioral health recovery program.

3. **AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS.** See Public Act 10-63.

    - INSURANCE COVERAGE FOR ORAL CHEMOTHERAPY TREATMENTS (effective 1/1/2011). Certain types of health insurance policies providing coverage for intravenously and orally administered anti-cancer medications used to kill or slow the growth of cancerous cells must now provide coverage for orally administered anti-cancer medications on a basis that is no less favorable than intravenously administered anti-cancer medications. Insurers, HMOs, medical and hospital service corporations, and fraternal benefit societies are prohibited from reclassifying anti-cancer medications or increasing the patient's out-of-pocket costs for the medications as a way to comply. The types of health insurance policies that are subject to this requirement are: (1) basic hospital expense coverage; (2) basic medical-surgical expense coverage; (3) major medical expense coverage; (4) limited benefit health coverage; (5) hospital or medical service plan contract; and (6) hospital and medical coverage provided to subscribers of a health care center.

4. **AN ACT CONCERNING THE ADMINISTRATION OF VACCINES BY LICENSED PHARMACISTS.** See Public Act No. 10-82.

    - THE ADMINISTRATION OF VACCINES BY LICENSED PHARMACISTS (effective 10/1/2010). In addition to vaccines for the prevention and control of influenza, Public Act No. 10-82 now authorizes a licensed pharmacist to administer an FDA-approved vaccine

to an adult to prevent invasive pneumococcal disease and herpes zoster and its sequelae, provided that the vaccine is administered pursuant to the order of a licensed health care provider.

5. **AN ACT ESTABLISHING THE UNIVERSITY OF CONNECTICUT HEALTH NETWORK AND CONNECTICUT BIOSCIENCE INITIATIVE.** See Public Act 10-104.

   - ESTABLISHMENT OF THE UCONN HEALTH NETWORK AND CONNECTICUT BIOSCIENCE INITIATIVE (effective 06/03/2010). Public Act No. 10-104 (the "Act") provides for, among other things, the construction of a new bed tower at John Dempsey Hospital and the renovation of academic, clinical and research space at the University of Connecticut Health Center. Additionally, the Act provides for the development of the UConn Health Network Initiative to develop, among other things: a simulation and conference center at Hartford Hospital for use in educating and training health care professionals utilizing new technologies, a primary care institute on the Saint Francis Hospital and Medical Center campus and a cancer treatment center in New Britain. The Act also extends the same benefits offered to businesses located in an enterprise zone to bioscience businesses located in Hartford and certain surrounding cities and towns. These projects will be funded in part from state bonds and from federal, private, and other non-state money as further delineated in the Act. Additionally, the Act describes the scope of operations of the Connecticut Institute for Primary Care Innovation and the Connecticut Institute for Nursing Excellence, both initiatives under the UConn Health Network Initiative.

6. **AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES.** See Public Act 10-116.

   - AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES (effective 7/1/2010). Public Act 10-116 (the "Act") makes changes to the law governing audits of providers that bill the Department of Social Services ("DSS") for services rendered to clients enrolled in DSS programs. Any provider aggrieved by a decision contained in a final written report issued by DSS, may, not later than 30 days after the receipt of the final report, request, in writing, a review on all items of aggrievement. Following review on all items of aggrievement, DSS shall issue a final decision. The provider now has the express right to appeal a final decision to a Superior Court of Connecticut. Furthermore, DSS will adopt auditing regulations to ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process. See Public Act 10-116.

7. **AN ACT CONCERNING REVISIONS TO PUBLIC HEALTH RELATED STATUTES AND THE ESTABLISHMENT OF THE HEALTH INFORMATION TECHNOLOGY EXCHANGE OF CONNECTICUT.** See Public Act 10-117.

   - RELINQUISHMENT OF HEALTH CARE INSTITUTION LICENSE; REQUIRED CERTIFIED DOCUMENTATION (effective 10/1/2010). Each licensed institution[1] that ceases to operate is required at the time it relinquishes its license to the Department of Public Health ("DPH"), to provide to DPH a certified document specifying: (1) the location where patient records will be stored; (2) the procedure for patients and their authorized representatives

1 Pursuant to Connecticut General Statutes § 19a-490 "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 section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded."

to gain access to such health records; (3) provisions for storage, should the storage location cease to operate or change ownership; and (4) that DPH is authorized to enforce the certified documents should the storage location cease to operate or change ownership. Institutions that fail to provide the required certified documentation will be assessed a civil penalty not to exceed $150 for each day of non-compliance.

- REQUEST FOR PATIENT RECORDS BY PATIENT (effective 10/1/2010). No health care provider can refuse to return to a patient original records or copies of records that the patient has brought to the provider from another provider. A provider may retain copies of such records for the provider's file at its own cost prior to returning the records. Additionally, no health care provider, who has purchased or assumed the practice of a provider who is retiring or deceased, may refuse to return original records or copied records to a patient who decides not to seek care from the successor provider. No copying costs shall be charged to the patient when returning records to a patient who does not seek care from the successor provider. In the event a provider abandons his/her practice, DPH may appoint a licensed health care provider to be the keeper of the records, who shall be responsible for disbursing the original records to the provider's patients, upon the request of any such patient.

- BIENNIAL LICENSURE INSPECTION BY DEPARTMENT OF PUBLIC HEALTH (effective 10/1/2010). DPH shall continue to make biennial licensure inspections and investigations and examinations of all institutions and their records as DPH deems necessary. In addition to having the right to inspect the premises of an institution or administer oaths and take testimony under oath during an inquiry, investigation or hearing to carry out any biennial licensure inspection and investigation and/or examination, DPH may now also issue subpoenas and order the production of books, records or documents.

- AUDITS OF NURSING HOME FACILITIES BY THE DEPARTMENT OF SOCIAL SERVICES (effective 10/1/2010). DSS, when necessary, may examine and audit the financial records of any nursing home facility or any nursing facility management services certificate holder. Each nursing home facility and nursing facility management services certificate holder is required to retain all financial records and information relating to the operation of the nursing home facility for no less than ten years and all financial records and information relating to real estate transactions affecting the operation of the nursing home for no less than 25 years. These records must be made available to DSS upon request. In connection with such examination, DSS can issue subpoenas, order the production of books, records and documents, administer oaths and take testimony under oath.

- APPLICATION OF LICENSURE FOR NURSING HOME ACQUISITION (effective 10/1/2010). Any person applying for a license to purchase a nursing home must submit a change in ownership application with respect to the facility being acquired. The application must include whether the potential nursing home licensee has had: (1) three or more civil penalties imposed through final order or civil penalties imposed pursuant to the laws of another state; (2) sanctions in any state, other than civil penalties of less than $20, imposed through final adjudication under the Medicare or Medicaid program; and (3) his/her/its Medicare or Medicaid provider agreement terminated or not renewed. If it is determined that the licensee's application contains information concerning civil penalties, sanctions, termination or nonrenewals, the application will not be approved for a period of five years from the date of final order on such civil penalties, sanctions, or termination of nonrenewal.

- APPLICATION REQUIREMENTS FOR CERTIFICATE TO PROVIDE NURSING FACILITY MANAGEMENT SERVICES (effective 10/1/2010). Any person or entity seeking a certificate to provide nursing facility management services shall submit an application to DPH with the following: (1) the name and business address of the applicant and whether the applicant is an individual, partnership, corporation or other legal entity; (2) if applicable, the names of the officers, directors, trustees, managing and general partners of the applicant, the names of the persons who have a 10% or greater beneficial ownership interest in the partnership, corporation or other legal entity, and a description of such person's relationship to the applicant; (3) if the applicant is a corporation incorporated in another state, a certificate of good standing from the other state agency with jurisdiction over corporations in such state; and (4) if the applicant currently provides nursing facility management services in another state, a certificate of good standing from the applicable licensing agency in the other state. DPH is authorized to conduct any inquiry or investigation regarding an applicant or certificate holder as it deems necessary. Any person or entity found to be providing nursing facility management services without a certificate will be subject to a civil penalty of not more than $1,000 for each day that the services are provided without such certificate.

- CONSENT ORDER FOR OWNERS OF PROPERTY WHERE HEALTH INSTITUTIONS ARE LOCATED (effective 10/1/2010). If any person owns real property (the "Lessor") within which a health care institution is located and the Lessor is not the licensee of such institution, the Lessor must submit a copy of the lease agreement to DPH at the time of: (1) any change of ownership and (ii) with each license renewal application. The lease agreement must identify the party responsible for the maintenance and repair of all buildings and structures within which the institution is established, conducted or operated. If a violation is found as a result of an inspection, the Lessor may be required to sign a consent order providing assurances that repairs or improvements necessary for compliance with the provisions of the Public Health Code will be completed within a specified period of time or be assessed a civil penalty of not more than $100 for each day the Lessor is in violation of the Public Health Code or consent order. A consent order may designate a temporary manager of such real property, who will have the authority to complete any repairs or improvements required by such order. At DPH's request, the Attorney General may petition the Superior Court for equitable and injunctive relief as such court deems appropriate to ensure compliance with the provisions of a consent order.

- DISCIPLINARY ACTION BY DENTAL COMMISSION (effective 10/1/2010). The Dental Commission may now also take disciplinary action against a practitioner for failure to maintain professional liability insurance or other indemnity against liability for professional malpractice. A violation of this provision by an unlicensed employee in the practice of dentistry or dental hygiene, with the knowledge of the employer, will be deemed a violation by the employer.

- DISCIPLINARY ACTION BY BOARD OF CHIROPRACTIC EXAMINERS (effective 10/1/2010). The Board of Chiropractic Examiners may now take disciplinary action against licensed chiropractors for failure to comply with DPH's continuing education requirements. DPH will adopt regulations to: (1) define the basic requirements for continuing education programs; (2) delineate qualifying programs; (3) establish a system of control and reporting; and (4) provide for the waiver of the continuing education requirement for good cause.

- ISSUANCE OF LICENSE TO CHIROPRACTOR WITHOUT EXAMINATION (effective 10/1/2010). DPH may now grant a license without any written or practical examination

to a chiropractor who (i) holds a current valid license in good standing issued after examination by another state or territory that maintains licensing standards that, except for examination, are commensurate with Connecticut's standards, and (ii) has worked continuously as a licensed chiropractor in an academic or clinical setting for at least five years immediately preceding the date of application for licensure without examination.

- LICENSURE BY ENDORSEMENT FOR NURSING HOME ADMINISTRATORS (effective 10/1/2010). Any person seeking licensure by endorsement as a nursing home administrator must meet the following new requirements: (i) hold a current license in good standing as a nursing home administrator in another state that was issued on the basis of holding, at a minimum, a baccalaureate degree and having passed the examination required for licensure in such state; and (ii) has practiced as a licensed nursing home administrator for not less than 12 months within the 24 month period preceding the date of the application.

- EXECUTION OF ORDERS BY REGISTERED NURSES (effective 10/1/2010). A registered nurse may now execute orders issued by licensed physician assistants, podiatrists and optometrists, provided such orders do not exceed the nurse's or the ordering practitioner's scope of practice.

- NO LICENSE ISSUED TO APPLICANT FACING DISCIPLINARY ACTION (effective 10/1/2010). DPH will not issue a license to any applicant regulated by DPH against whom professional disciplinary action is pending or who is the subject of an unresolved complaint with the professional licensing authority in another jurisdiction.

- POWERS OF DEPARTMENT OF PUBLIC HEALTH CONCERNING REGULATED PROFESSIONS (effective 10/1/2010). With respect to any investigation of a person subject to regulation, licensing or certification by DPH and in any disciplinary proceeding regarding such person, except as required by federal law, DPH will not: (i) be denied access to or use of copies of patient medical records on the grounds that privilege or confidentiality applies to such records; and (ii) further disclose patient medical records it receives in connection with any such investigation.

- UNLICENSED ASSISTIVE PERSONNEL; NO PROHIBITION ON CERTAIN DUTIES (effective 10/1/2010). Trained unlicensed assistive personnel may administer jejunostomy and gastrojejunal tube feedings to persons who: (1) attend day programs or respite centers under the jurisdiction of the Department of Developmental Services ("DDS"); (2) reside in residential facilities under the jurisdiction of DDS; or (3) receive support under the jurisdiction of DDS, when such feedings are performed pursuant to the written order of a physician, advanced practice registered nurse ("APRN") licensed to prescribe or a physician assistant licensed to prescribe such services.

- TRANSFERS OF FUNDS FROM THE TOBACCO AND HEALTH TRUST FUND (effective 7/1/2010). If any funds are available from the Tobacco and Health Trust Fund for regional emergency medical services councils, it shall be transferred to DPH to fund unclassified durational positions for regional emergency medical services coordinators or assistant regional emergency medical service coordinators.

- LICENSURE REQUIREMENTS TO PRACTICE MEDICINE OR SURGERY NOT APPLICABLE TO FOREIGN PHYSICIANS OR SURGEONS (effective 6/8/2010). In Connecticut, no person may practice medicine or surgery without the appropriate license. This prohibition does not apply to any foreign physician or surgeon (a) participating in a supervised clinical training under the direct supervision and control of a licensed physician

or surgeon, and (b) whose professional activities are confined to a licensed hospital that has an accredited residency program or that is an accredited primary affiliated teaching hospital of a medical school. Such hospital is required to verify that the foreign physician or surgeon holds a current valid license in another country.

- CHRONIC AND CONVALESCENT NURSING HOME ROOM TEMPERATURES (effective 7/1/2010). A chronic and convalescent nursing home or a rest home with nursing supervision may maintain temperatures in resident rooms and other areas used by residents at levels that are lower than the minimum temperature standards prescribed in the Public Health Code provided that temperature levels at such facilities comply with the comfortable and safe temperature standards prescribed under federal law.

- CHRONIC AND CONVALESCENT NURSING HOMES; PRESERVATION OF PATIENT RECORDS (effective 7/1/2010). Chronic and convalescent nursing homes and rest homes with nursing supervision are now required to preserve all patient medical records for not less than seven years following the date of the patient's discharge from such facility and not less than seven years following the death of a patient at the facility. Such records can be maintained in an electronic format so long as such preservation complies with accepted professional standards for preserving medical records.

- TRAINING FOR EMPLOYEES OF CONVALESCENT NURSING HOMES (effective 7/1/2010). Administrators of convalescent nursing homes or rest homes with nursing supervision must ensure that all staff members receive annual training in areas specific to the needs of the facility's patient population. The administrator must ensure that any person conducting the annual training is familiar with the needs of the patient population at the facility.

- CHRONIC AND CONVALESCENT NURSING HOMES AND TIMING OF MEALS (effective 7/1/2010). If the federal requirements listed in 42 CFR § 483.35(f)(4)[2] are satisfied, a chronic and convalescent nursing home or rest home with nursing supervision may extend the maximum time span between the patient's evening meal and breakfast from 14 hours to 16 hours. When providing bed time nourishment to patients, these facilities must verbally offer such nourishment to patients but are not required to serve patients who decline such nourishment.

- STRETCHERS AT CHRONIC AND CONVALESCENT NURSING HOMES (effective 7/1/2010). A chronic and convalescent nursing home or rest home with nursing supervision may provide one stretcher per floor irrespective of whether such floor contains multiple nursing units.

- LICENSURE OF PRACTICAL NURSE WITHOUT EXAMINATION (effective 10/1/2010). Any person who is licensed at the time of application as a licensed practical nurse in another state whose requirements are equivalent to or higher than those of Connecticut shall be entitled to a Connecticut license without examination upon payment of a fee of $150. An applicant may now also substitute clinical work experience acquired in another state if the applicant does not meet Connecticut's licensure requirements. If the other state issues licenses based on completion of a practical nursing education program that is shorter in length than the minimum length for Connecticut's practical nursing education programs or based on partial completion of a registered nursing education program, an applicant may substitute licensed clinical work experience that: (1) is performed under the supervision of a licensed registered nurse; (2) occurs following the completion of

2 42 CFR § 483.35(f)(4) states: "When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served."

a nursing education program; and (3) when combined with the applicant's educational program, equals or exceeds the minimum program length for licensed practical nursing education programs approved in Connecticut.

- CIRCULATING NURSE PRESENT IN OPERATING ROOM OR OUTPATIENT SURGICAL FACILITY (effective 10/1/2010). Hospitals and outpatient surgical facilities must ensure that a circulating nurse is present for the duration of each surgical procedure performed in an operating room. The facility must ensure that the assigned circulating nurse is not assigned to another procedure that is scheduled concurrently or that may overlap in time with the originally assigned surgical procedure. A "circulating nurse" is a registered nurse who is educated, trained, and/or experienced in perioperative nursing and who is responsible for coordinating the nursing care and safety needs of a patient in the operating room.

- OXYGEN RELATED PATIENT CARE ACTIVITIES IN A HOSPITAL (effective 10/1/2010). A hospital may designate any licensed health care provider and any certified ultrasound or nuclear medicine technician to perform the following oxygen related patient care activities in a hospital: (1) connecting or disconnecting oxygen supply; (2) transporting a portable oxygen source; (3) connecting, disconnecting or adjusting the mask, tubes and other patient oxygen deliver apparatus; and (4) adjusting the range or flow of oxygen consistent with a medical order. A hospital must document that each person designated to perform oxygen-related patient care activities has been properly trained and provide annual competency testing.

- ESTABLISHMENT OF HEALTH INFORMATION TECHNOLOGY EXCHANGE OF CONNECTICUT (effective 6/8/2010). There will be established the Health Information Technology Exchange of Connecticut (the "Exchange"), to promote, plan, design, develop and improve health care information technology, including, but not limited to, providing grants for the advancement of health information technology and exchange in Connecticut. The Exchange may establish or designate one or more subsidiaries to carry out its purpose or any other purpose prescribed by its board of directors. The Exchange may enter into contracts with the understanding that the state will not limit or alter the rights vested in the Exchange until such contract and the obligations thereunder are fully met and performed on the part of the Exchange, unless such limitation is made for the protection of such persons entering into contracts with the Exchange. The Exchange will be exempt from all state and federal franchise, corporate business, property and income taxes. The Exchange will seek private and federal funds for its on-going operation and for the funding of any grants it awards.

- ADOPTION OF CODE BY PHARMACEUTICAL OR MEDICAL DEVICE MANUFACTURING COMPANIES (effective 10/1/2010). On or before January 1, 2011, pharmaceutical or medical device manufacturing companies must adopt and implement a code that is consistent with and contains all the minimum requirements prescribed in, the Pharmaceutical Research and Manufacturers of America's "Code on Interaction with Healthcare Professionals" or AdvaMed's "Code of Ethics on Interactions with Health Care Professionals" (the "Industry Codes") as such Industry Codes were in effect on January 1, 2010. In addition, each pharmaceutical or medical device company must adopt a comprehensive compliance program in accordance with the guidelines provided in the "Compliance Program Guidance for Pharmaceutical Manufacturers" dated April, 2003 and issued by the United States Department of Health and Human Services Offices of Inspector General. The Commissioner of Consumer Protection may impose a civil penalty of not more than $5,000 for non-compliance. In general, the Industry Codes provide specific guidelines applicable to interactions between health care providers and medical

product or pharmaceutical companies (the "Companies") and which address, among other things, what Companies may and may not offer or provide to healthcare providers.

8. **AN ACT CONCERNING INSURANCE REIMBURSEMENT PAYMENTS TO SCHOOL-BASED HEALTH CENTERS.** See Public Act 10-118.

   - INSURANCE REIMBURSEMENT PAYMENTS FOR SCHOOL-BASED HEALTH CENTERS (effective 6/7/2010). School-based health centers ("SBHCs") are free-standing medical clinics located within or on school grounds. Public Act 10-118 now requires each Connecticut licensed health insurer, at the request of a SBHC, to offer to contract with a SBHC to reimburse enrollees for covered health services. This offer must be made on terms and conditions similar to contracts offered to other health care service providers.

9. **AN ACT CONCERNING THE REPORTING OF ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES AND ACCESS TO INFORMATION RELATED TO PENDING COMPLAINTS FILED WITH THE DEPARTMENT OF PUBLIC HEALTH.** See Public Act 10-122.

   - REPORTING OF ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES (effective 7/1/2010). Annual adverse event reports submitted by the Commissioner of Public Health ("Commissioner") after July 1, 2011 to the General Assembly shall include hospital and outpatient surgical facility adverse event information identified: (1) by the National Quality Forum's List of Serious Reportable Events category, and (2) in accordance with any list compiled by the Commissioner and adopted as regulations. The adverse event reports shall be in a format that uses "Contextual Information." Contextual Information includes, but is not limited to, (A) the relationship between the number of adverse events and a hospital's total number of patient days or an outpatient surgical facility's total number of surgical encounters; and (B) information concerning the patient population served by the hospital or outpatient surgical facility, including such hospital's or outpatient surgical facility's payor or case mix. Any report submitted by the Commissioner after July 1, 2011 shall include comments received by the Commissioner from hospitals or outpatient surgical facilities.

   - FILING OF COMPLAINTS WITH THE DEPARTMENT OF PUBLIC HEALTH (effective 7/1/2010). Individuals filing complaints with DPH alleging incompetence, negligence, fraud or deceit by a person subject to DPH regulation or licensing, shall have access to certain information. Upon request of the person who filed the complaint (the "Complainant"), DPH shall: (1) provide the Complainant with information on the status of the complaint; (2) provide the Complainant with access to records compiled as of the date of the request pursuant to any investigation of the complaint, provided that the Complainant shall not have access to confidential information such as personnel or medical records unless such records solely relate to the Complainant, or information that is otherwise confidential pursuant to federal and/or state law; (3) provide the Complainant an opportunity to submit a written statement as to whether the Complainant objects to resolving the complaint with a consent order before DPH takes such steps to resolve the complaint with a consent order; (4) if a hearing is held with respect to such complaint after a finding of probable cause, provide the Complainant with a copy of the notice of hearing, which describes the process for the Complainant to have the opportunity to present oral or written statements at such hearing; and (5) notify the Complainant of the final disposition of such complaint no later than seven days after such final disposition.

   - MANDATORY MEDIATION FOR CIVIL ACTIONS; NEGLIGENCE OF HEALTH CARE PROVIDERS (effective 7/1/2010). There will be mandatory mediation for all civil actions brought to recover damages resulting from personal injury or wrongful death, in which it is

alleged that such injury or death is the result of negligence of a health care provider. Prior to the close of pleadings in such civil action, the presiding judge will refer the action to mandatory mediation or any other alternative dispute resolution program agreed to by the parties while staying all further court actions relating to the civil action for no more than 120 days. The first mediation session will be conducted by the presiding judge or such other judge of the Superior Court as the presiding judge may select. At the first mediation session, the judge will determine whether the action can be resolved at such mediation, or if the action cannot be resolved at such mediation, whether the parties agree to participate in further mediation. If the action cannot be resolved at the first mediation session and the parties do not agree to further mediation, then mandatory mediation will end. If the action cannot be resolved at the first mediation session and the parties agree to further mediation, the presiding judge of the civil action will refer the action for mediation to an attorney. The cost of the mediation will be borne equally by the plaintiffs and the defendants. If the mediation does not settle or conclude the civil action, and if all parties agree, the mediator and the parties may file a stipulation with the court regarding any matter or conclusion that would narrow the issues, expedite discovery or assist the parties in preparing for trial.

10. AN ACT CONCERNING ANATOMICAL GIFTS. See Public Act 10-123.

- CHANGES TO ANATOMICAL GIFT RULES (effective 10/1/2010). Public Act 10-123 (the "Act") replaces the 1987 Uniform Anatomical Gift Act in its entirety. The Act, however, retains many provisions of the existing anatomical gift rules, repeals and updates others and provides entirely new provisions affecting anatomical gifts. We have summarized some of the more relevant changes and included the link to the Act above.

  I. What's New: Definitions (Section 2 of the Act). Some of the changes in the Act are introduced via new definitions. For example, the following new terms are defined or updated by the Act:

     A. Agent: "Agent means an individual: (A) Authorized to make health-care decisions on the principal's behalf by a power of attorney for health care; or (B) Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal."

     B. Disinterested witness: "Disinterested witness (A) means a witness other than the spouse, child, parent, sibling, grandchild, grandparent or guardian of the individual who makes, amends, revokes or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual, and (B) does not include a person to whom an anatomical gift could pass under section 11 of this Act."

     C. Eye bank: "Eye bank means a person that is licensed, accredited or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of human eyes or portions of human eyes."

     D. Procurement organization: "Procurement organization means a person licensed, accredited or approved under federal laws or the laws of any state, as a nonprofit organ procurement organization, eye or tissue bank."

     E. Reasonably available: "Reasonably available means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift."

F. Refusal: "Refusal means a record ... that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part."

G. Tissue bank: "Tissue bank means a person that is licensed, accredited or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of tissue."

II. What's New: Who Can Make an Anatomical Gift While the Donor Is Alive? (Section 4 of the Act). An anatomical gift may be made by (1) an adult donor; (2) a minor donor who is emancipated or is authorized under state law to apply for an identification card or operator's license; (3) the donor's Agent; (4) a parent of the unemancipated minor donor; or (5) the donor's guardian.

III. What's New: How Can Donors Make Anatomical Gifts? (Section 5 of the Act).

A. A donor may now make an anatomical gift during a donor's terminal illness or injury by any form of communication addressed to at least two adults (one of whom is a disinterested witness).

B. Donors can make and sign records for an anatomical gift. The record can be signed by another person and two witnesses. The Act now requires that one of the witnesses be a "disinterested witness."

IV. What's New: Revocation or Amendment Rules (Sections 6 and 8 of the Act).

A. As before, an anatomical gift may be revoked or amended through a record that is signed by another person at the donor's direction because he/she is unable to sign. Now, however, it will also require two witnesses (one of which must be disinterested).

B. An anatomical gift may now be revoked or amended by a subsequently executed document of gift that amends or revokes a previous anatomical gift.

C. An anatomical gift may now be revoked or amended by the destruction or cancellation of the document of gift.

D. In the absence of an express, contrary indication by the donor, another person is barred from making, amending or revoking an anatomical gift made by the donor or other authorized person. The only exception is that a parent of an unemancipated minor may amend or revoke an anatomical gift.

E. A donor's revocation of an anatomical gift is not a refusal and does not bar other authorized persons from making an anatomical gift.

F. If an authorized person (other than the donor) makes an unrevoked anatomical gift or amendment to the anatomical gift, another person may not make, amend or revoke an anatomical gift.

G. A revocation of an anatomical gift (by someone other than the donor) will not preclude another person from making an anatomical gift.

V. What's New: Anatomical Gift Refusal Rules (Section 7 of the Act).

A. An individual may refuse to make an anatomical gift through any form of communication made during the individual's terminal illness or injury addressed to at least two adults, one of whom is a disinterested witness. Previously, the individual needed only to communicate the refusal to a physician.

B. An individual who has made a refusal may now amend or revoke a refusal by: (1) subsequently making an anatomical gift inconsistent with the refusal; or (2) destroying or cancelling a record evidencing the refusal.

C. In the absence of an express, contrary indication by the individual, an individual's unrevoked refusal to make an anatomical gift bars all other persons from making an anatomical gift. The only exception to this rule now is for an unemancipated minor's refusal. In such a case, a parent may revoke such minor's refusal.

VI. What's New: Others Who Can Make Anatomical Gifts (Sections 9 and 10 of the Act).

A. Previously, there was a list (in order of priority) of nine classes of persons who could make an anatomical gift of all or part of a decedent's body. The Act adds the following individuals to the list: (1) the Agent; (2) adult grandchildren of the decedent; (3) an adult who exhibited special care and concern for the decedent; and (4) any other person having the authority to dispose of the decedent's body. Moreover, the list has been re-prioritized and the Agent now has top priority over all others.

B. If there is more than one member in a class, an anatomical gift may be made by any member of a class unless an objection by another class member is known. If an objection is known, an anatomical gift can be made only by a majority of the members of the class who are reasonably available.

C. A person may not make an anatomical gift if, at the time of the decedent's death, a person in a higher priority class is reasonably available.

D. An anatomical gift may be amended or revoked (orally or in writing) by any member of a higher class who is reasonably available. If more than one member of a higher class is reasonably available, the anatomical gift may be (1) amended only if a majority of the reasonably available class members agree to amend or (2) revoked only if an equal number or a majority of the reasonably available class members agree to revoke the gift.

E. A revocation will be effective only if the procurement organization, transplant hospital, physician, or technician knows of the revocation before an incision has been made to remove a body part or before invasive procedures have begun to prepare the recipient.

VII. What's New: Anatomical Gift Donees (Section 11 of the Act):

A. The Act now expressly provides that eye and tissue banks may be recipients of anatomical gifts.

B. If an anatomical gift is designated for a particular individual and it turns out that the anatomical gift cannot be transplanted into the individual (unless the person

making the gift indicates otherwise) the gift will now pass to: an eye bank (if it's an eye); a tissue bank (if it's tissue) and an organ procurement organization (if it's an organ).

C. If an anatomical gift is made that does not name a person but identifies the purpose for which an anatomical gift may be used, the following rules will now apply: (1) If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank; (2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank; (3) if the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and (4) if the part is an organ, an eye or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

D. If more than one purpose is listed for an anatomical gift without any designated priority, the gift shall first be used for implantation or therapy and then for research and education.

E. Anatomical gifts of organs pass to an organ procurement organization as the organ's custodian.

VIII. What's New: Hospital's and Procurement Organization's Duties Concerning Anatomical Gifts (Section 14 of the Act).

A. When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the Department of Motor Vehicles ("DMV") and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

B. A procurement organization shall be allowed reasonable access to information contained in records maintained by the DMV to ascertain whether an individual at or near death is a donor.

C. When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to assess the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research or education from a donor or a prospective donor. During such examination period, measures necessary to maintain the potential medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

D. Unless otherwise prohibited by law, at any time after a donor's death, the person to which a part passes may conduct any reasonable examination necessary to assess the medical suitability of the body or part for its intended purpose.

E. Unless otherwise prohibited by law, an examination may include an examination of all medical and dental records of the donor or prospective donor.

F. Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement

organization shall conduct a reasonable search for the parents of the minor and provide the parents with the opportunity to revoke or amend the anatomical gift or revoke the refusal.

G. Upon referral by a hospital, a procurement organization shall make a reasonable search for any person listed in Section 9 of the Act having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended or revoked, the procurement organization shall promptly advise the other person of all relevant information.

H. Prior to enactment of the Act, the time and determination of death is to be determined by two physicians and neither of the physicians who attend the donor at death nor the physicians who determine the time of death may participate in the removal or transplantation procedures unless a specific exception applies. Effective October 1, 2010, the new Act requires only one physician to make time and determination of death decisions. Please note that while the Act will only require one physician to do so, health care providers still have the option to decide to require that two physicians make time and determination of death decisions.

IX. What's New: Liability (Sections 17 and 18 of the Act).

A. A person that, in order to obtain financial gain, intentionally falsifies, forges, conceals, defaces or obliterates a document of gift, an amendment or revocation of a document or gift, or a refusal shall be guilty of a class A misdemeanor.

B. In determining whether an anatomical gift has been made, amended or revoked, a person may rely upon representations of certain individuals listed in subdivisions (a) (2) to (8) of Section 9 of the Act, relating to such individual's relationship to the prospective donor unless the person knows that the individual's representation is untrue.

11. AN ACT CONCERNING BIOMEDICAL RESEARCH TRUST FUND RESEARCH GRANTS. See Public Act 10-136.

- BIOMEDICAL RESEARCH TRUST FUND RESEARCH GRANTS (effective 7/1/2010). DPH may now also make grants-in-aid from the Biomedical Research Trust Fund to eligible institutions to fund biomedical research in the fields of Alzheimer's disease and diabetes in addition to heart disease, cancer and other tobacco-related diseases. DPH may award the grants to: (1) nonprofit, tax-exempt colleges or universities or (2) hospitals that conduct biomedical research. The total amount of grants made during a fiscal year cannot exceed 50% of the total amount held in the fund on the date the grants are approved.

12. AN ACT CONCERNING THE ISSUANCE OF EMERGENCY CERTIFICATES BY CERTAIN STAFF OF THE EMERGENCY MOBILE PSYCHIATRIC SERVICES PROGRAM. See Public Act 10-170.

- THE ISSUANCE OF EMERGENCY CERTIFICATES BY CERTAIN STAFF OF THE EMERGENCY MOBILE PSYCHIATRIC SERVICES PROGRAM (effective 10/1/2010). Any licensed clinical social worker, APRN, or professional counselor who is a member of a mobile psychiatric services team and has (1) received a minimum of eight hours of specialized training in the conduct of evaluations, and (2) has reason to believe based

on a direct evaluation of a child, that such child (i) has psychiatric disabilities, (ii) is dangerous to himself or others, and (iii) is in need of immediate care and treatment, may issue an emergency certificate that requires the hospitalization of such child for psychiatric and medical evaluation. A child committed under this emergency certificate shall be evaluated no later than 24 hours after the issuance of the emergency certificate and shall not be held for more than 72 hours unless committed for a longer period in accordance with state law. Under prior law, only physicians could issue such certificates. Children hospitalized by social workers, counselors, and APRNs now have the same rights as existing law gives those hospitalized by physicians. These rights include the right to consult with and be represented by an attorney and the right to a hearing.

13. AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES FOR THE FISCAL YEAR ENDING JUNE 30, 2011. See Public Act 10-179.

- CHANGES TO CERTIFICATE OF NEED RULES (effective 10/01/2010). Public Act 10-179 makes many substantive changes to the Office of Health Care Access's ("OHCA's") Certificate of Need ("CON") rules and processes including, (1) bright line rules for when a CON is and is not required; (2) the criteria OHCA must consider when reviewing and issuing a decision on a CON application; and (3) simplifying the CON application process. The following provides a summary of OHCA's CON rules and processes:

  I. CON Required: The following activities require a CON:

     A. Establishment of a new health care facility[3];
     B. Transfer of ownership[4] of a health care facility;
     C. Establishment of a free-standing emergency department;
     D. Termination of an emergency department;
     E. Termination of hospital inpatient and outpatient mental health and substance abuse services;
     F. Establishment of inpatient or outpatient cardiac services;
     G. Acquisition of CT, MRI, PET, and PET/CT scanners;
     H. Acquisition of nonhospital-based linear accelerators;
     I. Increase in the licensed bed capacity[5] of a health care facility;
     J. Acquisition of equipment utilizing technology that has not previously been utilized in the state;
     K. Establishment of an Ambulatory Surgery Center (hospital or physician owned); and
     L. Increase in number of Ambulatory Surgery Center operating rooms (two or more within three years).

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3 "Health care facility" means (A) hospitals licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C) freestanding emergency departments; (D) outpatient surgical facilities, as defined in section 19a-493b, as amended by the Act, and licensed under chapter 368v; (E) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; (F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638, as amended by the Act. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

4 "Transfer of ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility or institution, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a health care facility.

5 "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive, as amended by the Act.

II. CON Not Required: The following activities do not require a CON[6]:

A. Health care facilities owned and operated by the federal government;
B. Private practice facilities;
C. Health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;
D. Residential care, nursing, and rest homes;
E. Assisted living services agency;
F. Home health agencies;
G. Hospice services;*
H. Outpatient rehabilitation facilities;*
I. Outpatient chronic dialysis services;
J. Transplant services; *
K. Free clinics[7];
L. School-based health centers, community health centers, and federally qualified health centers;
M. Program licensed or funded by DCF (unless program is a psychiatric residential treatment facility);
N. Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for a state agency, excluding hospitals;
O. Health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;
P. Outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district;
Q. Residential facility for the mentally retarded that is certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded;*
R. Replacement of existing imaging equipment if such equipment was acquired through prior CON approval or determination, provided OHCA is notified of the date on which the equipment is replaced and the disposition of the replaced equipment;
S. Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist;*
T. Partial or total elimination of services provided by an Ambulatory Surgery Center;*
U. Termination of services for which DPH has requested the facility to relinquish its license;*
V. Termination of inpatient or outpatient hospital services excluding, mental health and substance abuse;* or
W. Establishment or expansion of a hospital inpatient or outpatient service other than cardiac services.*

III. Determination Letter: A health care facility who wishes to relocate or is unsure whether a CON is required, must submit a letter to OHCA that describes the project and requests that OHCA make a determination as to whether a CON is required. If proposing relocation, the facility, in the letter, must demonstrate to OHCA's satisfaction that the population the facility serves and the payer mix will not change as a result of the relocation.

6 The activities marked with an asterisk signify that this is a new or changed requirement.
7 "Free clinic" means a private, nonprofit community-based organization that provides medical, dental, pharmaceutical or mental health services at reduced cost or no cost to low-income, uninsured and underinsured individuals.

IV. CON Application Process and Timeline: Previously, after an applicant filed a letter of intent, the applicant would receive a customized application from OHCA and would have to wait 60 days (but no more than 120 days) before filing it. Once filed, OHCA would have ten business days to require more information through completeness questions which the applicant had no time limit to respond to. Once OCHA received all the additional and requested information, it would deem the application complete and from that date, OHCA would have 90 days to make a decision on the application. OHCA has now changed and streamlined the process as summarized below:

A. *Letter of Intent*: The Letter of Intent requirement has been eliminated.

B. *Notice Requirements*: The applicant must publish notice of its proposal in a newspaper with substantial circulation in the project's service area for three consecutive days, no more than 20 days before the applicant submits the application to OHCA. The notice must include a brief description of the project and the street address of its location.

C. *Application*: OHCA will develop and post an application form on its website prior to 10/01/2010. The new application form will require applicants to address[8]:

- The relationship of the proposed project to the state-wide health care facilities and services plan;*
- Whether there is a clear public need for the health care facility or services proposed by the applicant;
- Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state;*
- Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region;
- The applicant's past and proposed provision of health care services to relevant patient populations and payer mix;*
- Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;*
- The utilization of existing health care facilities and health care services in the service area of the applicant;* and
- Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities. *

D. *Application Fee*: The applicant must pay a flat $500 nonrefundable application fee.

E. *Additional Information Requests*: Within 30 days after the application is filed, OHCA may request additional information as may be necessary to complete the application. The applicant then has 60 days from the date of the request to submit the additional information.

F. *Application Deemed Complete*: Once it determines the application is complete, OHCA must notify the applicant and the public. It must also post the notice on its

8 The activities marked with an asterisk signify that this is a new or changed requirement.

website, which is considered the date that begins the review process. The review period for a complete application is 90 days from the posting on the website and OHCA must issue a CON decision before the end of the 90 day period. If OHCA holds a public hearing on the application, it must issue a decision within 60 days after the public hearing.

G. *Public Hearings*: OHCA must hold a public hearing if three or more individuals, or an individual, on behalf of an entity with five or more individuals, makes a written request for a hearing within 30 days following OHCA's determination that the application is complete. The Act authorizes OHCA to hold a public hearing on any CON application. OHCA must provide at least two weeks advance written notice to (1) the applicant and (2) the public through a newspaper with substantial circulation in area served by the facility or provider.

V. CON Validity Period and Extensions: A CON is valid only for the project described in the application and only for two years from the "date of issuance" by OHCA. OHCA may withdraw, revoke, or rescind the CON if it determines that (1) commencement, construction, or other preparation has not been substantially undertaken during a valid CON period or (2) the CON holder has not made a good-faith effort to complete the project as approved.

VI. Notices and Hearings For Termination of Services:

A. Terminating a service authorized by a prior CON: Any health care facility proposing to terminate a service that was authorized by a CON must file a modification request with OHCA no later than 60 days prior to the proposed termination date. OHCA must hold a public hearing on any request if three or more individuals or an individual, on behalf on entity with five or more individuals, submits a written request for a public hearing.

B. Terminating all services authorized by a prior CON(s): A facility proposing to terminate all services it offers that were previously authorized by one or more CONs must notify OHCA no later than 60 days before terminating the services. The facility must surrender its CON no later than 30 days before terminating the services.

C. No Prior CON: A facility proposing to terminate the operation of a facility or service for which no CON was obtained must notify OHCA no later than 60 days prior to termination.

VII. OHCA Inventory Questionnaire: To allow OHCA to conduct a state-wide health care facility utilization study and prepare the state-wide health care facilities and services plan, OHCA must develop an inventory questionnaire to obtain the following information: (1) the name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed biennially by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data. See Public Act 10-179.

- PAYMENTS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (effective 5/7/2010). Any payment made under the Patient Protection and Affordable Care Act ("PPACA") to an individual will not be counted as income to such individual when applying for or receiving need-based benefits and/or services from any state or state-

funded local program. Additionally, such payment will not be counted as resources for the month in which the payment was received or the following two months, for the purposes of determining the individual's eligibility to receive such benefits and/or services. Any payment under PPACA will not be counted as income for purposes of determining the eligibility for, or the benefit level of, such individual under any property tax exemption, property tax credit or rental rebate program financed in whole or in part with state funds, nor will such payment be counted as income for purpose of any property tax relief program that a municipality may, at its option, offer.

- LIMITATION ON PAYMENTS BY THE DEPARTMENT OF SOCIAL SERVICES FOR OVER-THE-COUNTER DRUGS (effective 5/7/2010). Starting June 1, 2010, medical assistance programs administered by DSS will not cover the costs of over-the-counter medications, except for over-the-counter medications administered under the Connecticut AIDS Drug Assistance Program, insulin and insulin syringes or as may be required by federal law.

- DETERMINATION LETTER FOR SALE OF A NONPROFIT HOSPITAL (effective 10/1/2010). When the sale of a nonprofit hospital to a for-profit entity is contemplated, the agreement governing the sale must be approved by the Attorney General (the "AG") and the Commissioner of Public Health (the "Commissioner"). Concurrently, the nonprofit hospital and the purchaser must submit a certificate of need determination letter (instead of a letter of intent as formerly required) to the AG and the Commissioner. The AG and the Commissioner will review the certificate of need determination letter. The AG will determine whether the agreement governing the sale requires approval. If approval of the agreement is required, the AG and the Commissioner shall send to the nonprofit hospital and the purchaser an application form for approval. The application form will require certain information, including but not limited to: (1) a description of the terms of the proposed agreement; (2) copies of all contracts, agreements and memoranda of understanding relating to the proposed agreement; and (3) a fairness evaluation by an independent person who is an expert in such agreements.

14. AN ACT ESTABLISHING A COMMISSION OF NONPROFIT HEALTH AND HUMAN SERVICES. See Special Act 10-5.

- COMMISSION ON NONPROFIT HEALTH AND HUMAN SERVICES (effective 6/8/2010). A Commission on Nonprofit Health and Human Services (the "Commission") will be established and will examine the funding provided to nonprofit providers of health and human services under purchase of service contracts. No later than January 1, 2011, the Commission will submit a preliminary report to the Governor and the General Assembly detailing recommendations for budget, policy and statutory changes to improve funding for nonprofit providers of health and human services under purchase of service contracts. "Purchase of service contract" means a contract between a state agency and a private provider organization or a municipality for the purpose of obtaining direct health and human services for agency clients and generally not for administrative or clerical services, material goods, training or consulting services, and does not include a contract with an individual. A final report is due from the Commission no later than April 1, 2011. The Commission shall terminate on the date it submits its final report or April 1, 2011, whichever is later.

Questions or Assistance? If you have any further questions regarding Connecticut legislation, please feel free to contact one of the following attorneys:

Joan W. Feldman
(860) 251-5104
jfeldman@goodwin.com

David M. Mack
(860) 251-5058
dmack@goodwin.com

John H. Lawrence, Jr.
(860) 251-5139
jlawrence@goodwin.com

Vincenzo Carannante
(860) 251-5096
vcarannante@goodwin.com

Lina Estrada McKinney
(860) 251-5660
lmckinney@goodwin.com

William J. Roberts
(860) 251-5051
wroberts@goodwin.com

One Constitution Plaza
Hartford, CT 06103-1919
860-251-5000

300 Atlantic Street
Stamford, CT 06901-3522
203-324-8100

1133 Connecticut Avenue NW
Washington, DC 20036-4305
202-469-7750

289 Greenwich Avenue
Greenwich, CT 06830-6595
203-869-5600

12 Porter Street
Lakeville, CT 06039-1809
860-435-2539

www.shipmangoodwin.com

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW