

July 2014



Connecticut General Assembly Health Law Legislative Update

This Legislative Update provides readers with a summary of Connecticut legislation affecting healthcare providers and other healthcare related entities or agencies enacted during the 2014 legislative session. Please note that this Legislative Update is a summary of the legislative highlights or what we view as the most significant new laws from the General Assembly. Thus, you should refer to the full Public Act 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 Public Act. The Table of Contents below lists the Public Acts that are covered along with a reference to the page in this Legislative Update where its corresponding summary is located.

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SUMMARIES

1. AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE. **See Public Act No. 14-12.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00012-R00SB-00036-PA.htm>

a. **Section 1: APRN's to Practice Independently (effective July 1, 2014).**

Advanced Practice Registered Nurses ("APRNs") who have maintained licensure in Connecticut and who have practiced in collaboration with a Connecticut licensed physician for at least three years, may practice alone or in collaboration with a physician or another health care provider licensed to practice in Connecticut. APRNs must keep documentation of their three years of collaboration (i.e. at least 2000 hours) and submit such documentation to the Department of Public Health ("DPH") within 45 days of DPH's request. If an APRN who has satisfied these supervision requirements plans to practice without collaboration, he or she must notify DPH in advance.

S&G Note: *Notably, APRNs and not Physician Assistants can practice independent of a physician after having practiced for three years in collaboration with a Connecticut licensed physician. We can expect to see more APRNs practicing independently in the community and in health care facilities. However, this change does not mean that payers will not continue to expect collaboration between an APRN and a physician.*

b. **Section 5: Expanded Transparency Reporting Obligations (effective October 1, 2014).**

The Act requires manufacturers of drugs, devices, biological products or medical supplies that are reimbursable under Medicare, Medicaid or the Children's Health Insurance Program to report on a quarterly basis payments or other transfers of value to APRNs practicing in Connecticut. The Act requires these manufacturers to report, with respect to APRNs, the same information as required with respect to physicians by the federal Physician Payment Sunshine Act. Manufacturers must submit their first report no later than July 1, 2015 to the Department of Consumer Protection ("DCP").

S&G Note: *The Act leaves many questions regarding how manufacturers will comply with the reporting obligations and we hope and anticipate that DCP will provide guidance in the future. For example, the Act does not incorporate the numerous exceptions to reporting present in the Physician Payment Sunshine Act, and thus manufacturers may be required to report payments made to APRNs but not similar payments made to physicians. Further, the Act does not incorporate the Physician Payment Sunshine Act's 10% revenue threshold for the law to apply, meaning certain manufacturers will need to report payments to APRNs practicing in Connecticut but not report payments to physicians. In addition, the Act does not include an exception for hospitals or hospital-based pharmacies that manufacture products solely for their own use, nor does it include an exception for payments made to APRNs who may be employed by the manufacturer. These are only a few of dozens of inconsistencies between the Act and the Physician Payment Sunshine Act that manufacturers will need to address. Given these discrepancies between the reporting requirements under Connecticut law and the reporting requirements under the Physician Payment Sunshine Act, manufacturers may consider implementing a policy that prohibits any remuneration to APRNs in Connecticut.*

2. AN ACT PROVIDING IMMUNITY TO A PERSON WHO ADMINISTERS AN OPIOID ANTAGONIST TO ANOTHER PERSON EXPERIENCING AN OPIOID-RELATED DRUG OVERDOSE. **See Public Act No. 14-61.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00061-R00HB-05487-PA.htm>
 - a. **Section 1: Grant of Immunity (effective October 21, 2014).** Public Act 14-61 grants immunity from civil action or criminal prosecution to any person who, in good faith and while exercising reasonable care, believes that another person is experiencing an opioid-related drug overdose and administers an opioid antagonist¹ to such person. Note that this grant of immunity does not apply to licensed health care professionals acting in the ordinary course of one's employment.

3. AN ACT CONCERNING PROBATE COURT OPERATIONS. **See Public Act No. 14-103.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00103-R00SB-00154-PA.htm>
 - a. **Section 10: Appointment of Successor Conservators (effective July 1, 2014).** Pursuant to Public Act 14-103, whenever a Probate Court appoints a conservator, the Probate Court may also appoint a successor conservator. The successor conservator shall step in and serve in the event that a conservator resigns, is removed, dies, or is found to be incapable of performing his/her conservatorship duties.

***S&G Note:** Individuals may also designate who they wish to serve as their successor conservators via their Health Care Instructions.*

4. AN ACT CONNECTING THE PUBLIC TO BEHAVIORAL HEALTH CARE SERVICES. **See Public Act No. 14-115.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00115-R00SB-00322-PA.htm>
 - a. **Section 1: Information and Referral Service (effective July 1, 2014).** Public Act 14-115 requires the Office of Healthcare Advocate to establish an information and referral service to help residents and health care providers receive behavioral health care information, referrals and access to behavioral health care providers.

5. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS CONCERNING MEDICAL SPAS. **See Public Act No. 14-119.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00119-R00SB-00418-PA.htm>
 - a. **Section 1: Staffing at Medical Spas (effective October 1, 2014).** Public Act 14-119 (the "Act") requires each medical spa² to employ or contract with a physician, physician assistant or APRN who: (i) is actively practicing in Connecticut; (ii) has received education or training on performing cosmetic medical procedures; and (iii) has experience performing cosmetic medical procedures.
 - b. **Section 1: Performance of Cosmetic Procedures (effective October 1, 2014).** The Act requires medical spas to perform all cosmetic medical procedures in

1 For purposes of this Act, an "opioid antagonist" means naloxone hydrochloride (i.e. Narcan) or any other similarly acting and equally safe drug approved by the Food and Drug Administration for the treatment of drug overdose.

2 For purposes of the Act, a medical spa is an establishment in which "cosmetic medical procedures" are performed. "Cosmetic medical procedure" means any procedure performed on a person that is directed at improving the person's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease and may include, but is not limited to, cosmetic surgery, hair transplants, cosmetic injections, cosmetic soft tissue fillers, dermaplaning, dermastamping, dermarolling, dermabrasion that removes cells beyond the stratum corneum, chemical peels using modification solutions that exceed 30% concentration with a pH value of lower than 3.0, laser hair removal, laser skin resurfacing, laser treatment of leg veins, sclerotherapy and other laser procedures, intense pulsed light, injection of cosmetic filling agents and neurotoxins and the use of class II medical devices designed to induce deep skin tissue alteration.

accordance with existing Connecticut public health statutes. The Act permits such procedures to be performed by only licensed physicians, physician assistants, APRNs or registered nurses.

- c. **Section 1: Initial Assessment (effective October 1, 2014).** The Act requires medical spas to perform an initial physical assessment of each person undergoing a cosmetic medical procedure prior to performance of the procedure. The assessment must be performed by a physician, physician assistant or APRN employed by, or under contract with, the medical spa.
 - d. **Section 1: Notices (effective October 1, 2014).** The Act requires medical spas to post information, including the names and any specialty areas of any physician, physician assistant, APRN or registered nurse performing cosmetic medical procedures, in a conspicuous place that is accessible to customers at the medical spa and on any Internet web site maintained by the medical spa. Such information shall also be contained in: (i) any advertisement by the medical spa, or be included on the identified Internet web site; and (ii) any written notice that is provided to each person before undergoing any cosmetic medical procedure at the medical spa.
6. AN ACT CONCERNING THE APPOINTMENT OF A CONSERVATOR FOR A PERSON WITH INTELLECTUAL DISABILITY. **See Public Act No. 14-121.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00121-R00SB-00463-PA.htm>
- a. **Section 1: Appointment of Conservators for Persons with Intellectual Disabilities (effective October 1, 2014).** Before a Probate Court determines that a person requires a conservator, the Probate Court must receive specific information and evidence from one or more physicians regarding a person's mental condition and the effect this condition has on a person's ability to care for himself or herself or to manage his or her affairs. For persons with an intellectual disability,³ Public Act 14-121 now permits psychological evidence from a licensed psychologist to be introduced in lieu of such medical evidence.
7. AN ACT CONCERNING VARIOUS REVISIONS TO THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES' STATUTES. **See Public Act No. 14-138.** <http://www.cga.ct.gov/2014/ACT/pa/pdf/2014PA-00138-R00HB-05145-PA.pdf>
- a. **Section 1: Requirement to Keep Statistical Data (effective October 1, 2014).** The Connecticut Department of Mental Health and Addiction Services ("DMHAS") must specify uniform methods of how/what type of statistical data providers must maintain regarding their patients, including a client/patient identifier system, the number of persons treated, demographic and clinical information about such persons, frequency of admission and readmission, frequency and duration of treatment, level(s) of care provided and discharge and referral information. Public Act 14-138 clarifies that DMHAS shall require

³ Connecticut General Statutes Section 1-1g states that intellectual disability "means a significant limitation in intellectual functioning and deficits in adaptive behavior that originated during the developmental period before eighteen years of age."

all public and private agencies, including agencies that operate institutions⁴ to maintain this information and provide it to DMHAS upon request as specified by DMHAS.

8. AN ACT CONCERNING THE ADMISSION OF VETERANS TO HOSPITALS AND THE APPLICATION OF MILITARY OCCUPATIONAL TRAINING TO STATE LICENSURE REQUIREMENTS. **See Public Act No. 14-141.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00141-R00HB-05294-PA.htm>
 - a. **Section 1: Hospital Billing Requirements for Veterans (effective October 1, 2014).** Public Act 14-141 requires that whenever a person is admitted to a hospital, such person shall be asked if he or she is a veteran. If the patient is a veteran, the hospital shall take sufficient steps to determine that no other funds or means of payment are available to cover the cost of services rendered to the veteran. The Department of Veterans' Affairs shall make available to hospitals a list of payment options and benefits available to cover a veteran's hospital costs.

9. AN ACT ELIMINATING THE HOME-CARE COST CAP. **See Public Act No. 14-142.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00142-R00HB-05325-PA.htm>
 - a. **Section 1: Eliminating the Home-Care Cost Cap (effective July 1, 2014).** The Connecticut Home Care Program for Elders provides home health and community-based services to seniors as an alternative to nursing home care. The program has state and Medicaid waiver-funded components. Public Act 14-142 eliminates the program's statutory cost cap on community-based, waiver-funded services, which is currently 60% of the weighted average cost of care in skilled nursing and intermediate care facilities.

10. AN ACT CONCERNING FEES CHARGED FOR SERVICES PROVIDED AT HOSPITAL-BASED FACILITIES. **See Public Act No. 14-145.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00145-R00HB-05337-PA.htm>
 - a. **Section 2: Hospital Facility Fee Notification Requirements (effective October 1, 2014).**
 - **Notification Requirements When CPT E/M Codes are Utilized:** Pursuant to Public Act 14-145 (the "Act"), if a hospital or health system⁵ charges a facility

4 Connecticut General Statutes Section 19a-490 states that institution "means a hospital, short-term hospital, special hospice, hospice inpatient facility, 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, outpatient clinic, 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 persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability."

5 The Act states that: "Health system" means: (A) a parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means. "Hospital" has the same meaning as provided in section 19a-490 of the Connecticut General Statutes. Connecticut General Statutes § 19a-490 states that "Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals.

fee⁶ utilizing a current procedural terminology evaluation and management (“CPT E/M”) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information: (1) that the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider; (2) (A) the amount of the patient’s potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient’s health insurance coverage are not known with reasonable certainty, an estimate of the patient’s financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient’s actual financial liability will depend on the professional medical services actually provided to the patient, and (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and (3) that a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital’s or health system’s charges and fees, including the patient’s potential financial liability, if any, for such charges and fees.

- **Notification Requirements When CPT E/M Codes are Not Utilized:** If a hospital or health system charges a facility fee without utilizing a CPT E/M code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information: (1) that the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider; (2) (A) a statement that the patient’s actual financial liability will depend on the professional medical services actually provided to the patient, and (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based; and (3) that a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital’s or health system’s charges and fees, including the patient’s potential financial liability, if any, for such charges and fees.
- **Written Notice Requirements:** The written notices described above must be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges.
- **Non-Emergency v. Emergency Care:** For non-emergency care, if a patient’s appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the

⁶ The Act states that: a “Facility fee” means any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is: (A) intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee. “Hospital-based facility” means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided.

hospital-based facility. For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with EMTALA or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's legally authorized representative as soon as practicable.

- **Public Notice:** A hospital-based facility shall prominently display a written notice in locations that are readily accessible to and visible by patients, including patient waiting areas, stating that: (1) the hospital-based facility is part of a hospital or health system; and (2) if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based. A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet websites and stationery.
- **Non-Applicability:** The notification requirements of this Act do not apply to Medicare or Medicaid patients or patients receiving services pursuant to a workers' compensation plan.

S&G Note: Such notification requirements are already required for "provider based facilities" receiving Medicare reimbursement. Please be sure to also see Section 77 of Public Act 14-217 for additional new laws relating to the aforementioned hospital-based facility fees.

11. AN ACT CONCERNING COVERAGE UNDER STATE MEDICAL ASSISTANCE PROGRAMS FOR CERTAIN OVER-THE-COUNTER DRUGS. **See Public Act No. 14-157.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00157-R00HB-05443-PA.htm>
 - a. **Section 1: Coverage of Over-the-Counter Drugs (effective June 11, 2014).** Public Act 14-157 expands the types of over-the-counter drugs the Department of Social Services ("DSS") may pay for through its medical assistance programs to include those that must be covered as essential health benefits under the federal Patient Protection and Affordable Care Act, including drugs rated "A" or "B" in the current U. S. Preventive Services Task Force recommendations for people with specific diagnoses.
12. AN ACT CONCERNING BRAND NAME DRUG PRESCRIPTIONS FOR STATE MEDICAL ASSISTANCE RECIPIENTS. **See Public Act No. 14-158.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00158-R00HB-05439-PA.htm>
 - a. **Section 1: Specifying a Brand Name Drug (effective July 1, 2014).** Current Connecticut law permits a health care provider to specify on a prescription for a medical assistance patient that there shall be no substitution for the brand name drug product specified. To do so, the phrase "brand medical necessary" must appear on the prescription. Public Act 14-158 (the "Act") eliminates the requirement that the health care provider submit a hand-written prescription to a pharmacist stating "brand medically necessary" when the health care provider electronically submits a prescription for a medical assistance recipient specifying that there can be no substitution for the brand-name drug prescribed. The Act instead requires the prescriber to select the code on the certified electronic prescription that indicates a substitution is not allowed.

13. AN ACT CONCERNING EMPLOYERS AND HOME-CARE WORKERS. **See Public Act No. 14-159.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00159-R00HB-05453-PA.htm>

- a. **Section 1: Sleep Time Requirements for Overtime Pay (effective January 1, 2015).** Public Act 14-159 (the “Act”) permits a “sleep-time” exclusion from overtime pay requirements for certain employees employed by third-party providers (e.g., home-care agencies) to provide “companionship service.”⁷ Specifically, the Act permits an employee and third-party provider to agree to exclude a regularly scheduled sleep period of up to eight hours from the work hours used to determine the employee’s overtime pay if: (i) the employee is required to be present at a worksite for at least 24 consecutive hours; (ii) adequate on-site sleeping facilities are provided to the employee; and (iii) the employee receives at least five hours of sleep-time.

S&G Note: *The Act’s sleep-time exclusion aligns Connecticut law with changes in federal regulations effective January 1, 2015.*

14. AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS. **See Public Act No. 14-160.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00160-R00HB-05440-PA.htm>

- a. **Section 1: Separate Medicaid Reimbursement for ED Physicians (effective July 1, 2014).** Pursuant to Connecticut General Statutes Section 17b-239(b), DSS established Medicaid rates to be paid to acute care and children’s hospitals based on diagnosis-related groups (“DRGs”). Pursuant to Public Act 14-160, on and after January 1, 2015⁸, and concurrent with the implementation of the DRG payment methodology for hospitals, an emergency department physician may enroll separately as a Medicaid provider and qualify for direct reimbursement for professional services provided in a hospital’s emergency department to a Medicaid patient, including services provided on the same day the Medicaid patient is admitted to the hospital. DSS shall pay such emergency department physician in accordance with the physician fee schedule in effect at that time. If DSS, however, determines that payment to an emergency department physician results in an additional cost to the State of Connecticut, DSS shall adjust such rate in consultation with the Connecticut Hospital Association and the Connecticut College of Emergency Physicians to ensure budget neutrality.

15. AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM. **See Public Act No. 14-162.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00162-R00HB-05500-PA.htm>

- a. **Sections 1 and 2: Extrapolation (effective July 1, 2014).** Public Act 14-162 (the “Act”) includes a new definition of “extrapolation.” Specifically, the Act defines extrapolation to mean “the determination of an unknown value by projecting the

⁷ For purposes of the Act, “companionship services” is defined under federal law and generally means fellowship, protection, and limited care for an elderly person or person with an illness, injury, or disability.

⁸ The Act also provides that “[i]n the event the commissioner is unable to implement the provisions of subsection (e) of this section by January 1, 2015, the commissioner shall submit written notice, not later than thirty-five days prior to January 1, 2015, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies indicating that the department will not be able to implement such provisions on or before such date. The commissioner shall include in such notice (1) the reasons why the department will not be able to implement such provisions by such date, and (2) the date by which the department will be able to implement such provisions.”

results of the review of a sample to the universe from which the sample was drawn.” For purpose of this definition, “universe” means “a defined population of claims submitted by a provider during a specific time period.”

- b. **Sections 1 and 2: Training Materials (effective July 1, 2014).** The Act requires DSS to provide free training to health care providers and facilities on how to avoid clerical errors when entering claims. DSS shall also provide information on how to avoid clerical errors on its website.
- c. **Sections 1 and 2: Audit Protocols (effective July 1, 2014).** The Act requires DSS to publish audit protocols to assist Medicaid-participating health care providers and facilities in developing programs to improve compliance with Medicaid laws and regulations.⁹ DSS shall establish audit protocols for specific provider categories, including (i) home health agencies; (ii) drug and alcohol treatment centers; (iii) hospital outpatient services; (iv) physician and nursing services; (v) dental services; (vi) behavioral health services; (vii) pharmaceutical services; (viii) medical transportation services; and (ix) durable medical equipment. DSS shall also establish audit protocols for specific facility categories including: (i) chronic and convalescent nursing homes; (ii) chronic disease hospitals associated with chronic and convalescent nursing homes; (iii) rest homes with nursing supervision; (iv) residential care homes; and (v) residential facilities for persons with intellectual disabilities.
- d. **Section 2: Selection of a Facility for Auditing (effective July 1, 2014).** The Act permits DSS to use a facility’s compliance history when selecting a facility to audit.

S&G Note: *This revision suggests that DSS may target facilities with past compliance issues for audits more than facilities without a history of compliance issues.*

- e. **Section 2: Exit Conference (effective July 1, 2014).** After conducting an audit, DSS provides to the health care facility a preliminary report of DSS’s findings and an exit conference is scheduled with the facility to discuss the preliminary report. The Act grants providers a right to present evidence at the exit conference to refute the findings of the preliminary report.

S&G Note: *While providers have long brought evidence to the exit conference to refute the findings of the preliminary report, the Act now explicitly permits such evidence to be presented.*

16. AN ACT CONCERNING MANDATORY REPORTING OF ABUSE AND NEGLECT OF INDIVIDUALS WITH AUTISM SPECTRUM DISORDER, THE DEFINITION OF ABUSE, AND THE DEPARTMENT OF DEVELOPMENTAL SERVICES ABUSE AND NEGLECT REGISTRY. **See Public Act No. 14-165.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00165-R00HB-05456-PA.htm>

- a. **Section 6: Mandated Reporting (effective October 1, 2014).** Pursuant to

⁹ DSS must publish audit protocols for health care providers by February 1, 2015 and for health care facilities by April 1, 2015.

Connecticut law, certain health care providers¹⁰ must notify the Office of Protection and Advocacy for Persons with Disabilities (“OPAPD”) of any instance in which the provider has reasonable cause to suspect or believe that any person with an intellectual disability has been abused or neglected. Such health care providers must make an oral report to OPAPD as soon as possible within 72 hours (in cases where the allegation results in death an oral report must be made within 24 hours). The provider must also submit a written report to OPAPD within five days of the oral report. Public Act 14-165 expands these current requirements to require certain health care providers to also notify OPAPD in the event the provider has reasonable cause to suspect or believe that any person who receives services from the DSS Division of Autism Spectrum Disorder Services has been abused or neglected.

17. AN ACT CONCERNING NOTICE OF ACQUISITIONS, JOINT VENTURES, AFFILIATIONS OF GROUP MEDICAL PRACTICES AND HOSPITAL ADMISSIONS, MEDICAL FOUNDATIONS AND CERTIFICATES OF NEED. **See Public Act No. 14-168.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00168-R00SB-00035-PA.htm>

- a. **Section 1: Notice to the Attorney General (effective October 1, 2014).** Public Act 14-168 (the “Act”) requires that the Attorney General (“AG”) be noticed 30 days prior to the effective date of any transaction that results in a material change to the business or corporate structure of a group practice. A group practice is defined as two or more physicians in which each physician provides substantially the full range of services that the physician members routinely provide. A material change includes: (1) mergers, consolidations or other affiliation with (a) another group practice that results in a group practice of more than eight physicians; (b) hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (2) the acquisition of all or substantially all of (a) the properties and assets of a group practice, or (b) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (3) the employment of all or substantially all of the physicians of a group practice by (a) another group practice that results in a group practice comprised of eight or more physicians; or (b) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; and (4) the acquisition of one or more insolvent group practices by (a) another group practice that results in a group practice comprised of eight or more physicians; or (b) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system.

The notice to the AG shall indicate the parties to the transaction, a description of the proposed transaction, the names and specialties of the physicians subject to the transaction, the names of the entities to provide services post proposed transaction, address for each location, service area to be served and services to be provided at each location.

No later than December 31, 2014 and annually thereafter, each hospital and hospital system and each group practice comprised of more than 30 physicians

10 The reporting obligation applies to the following health care providers: physicians and surgeons; resident physicians or interns in any hospital in Connecticut; registered nurses; persons paid for caring for persons in any facility; licensed practical nurses; medical examiners; dental hygienists; dentists; occupational therapists; optometrists; chiropractors; psychologists; podiatrists; social workers; mental health professionals; physician assistants; licensed or certified substance abuse counselors; licensed marital and family therapists; speech and language pathologists; pharmacists; physical therapists; and licensed professional counselor or sexual assault counselors.

shall file with the AG and DPH a written report for each group practice that includes: (a) the names and specialties of each physician practicing medicine with the group practice; (b) the names of the business entities that provide services to the group practice; and (c) the primary service area served by each location.

S&G Note: *This legislative change is clearly intended to control the entry of for-profit hospital and hospital systems into the Connecticut market by virtue of the establishment or ownership of medical foundations or other physician groups. It is yet to be seen as to how active either the AG or the DPH will be in monitoring these acquisitions. Given that most physician practices have historically been for-profit and independent, this is a bit of a sea change in terms of the State's efforts to control access to physician services and cost issues.*

- b. **Section 3: Amendments to the Medical Foundation Statute (effective June 3, 2014).** Pursuant to the Act, Connecticut General Statutes Section 33-182bb (a) (1) is amended to provide that, "The authority to appoint or elect board members shall not be granted to any person or entity that is not a member of the medical foundation."

In addition, (1) no employee or representative of a for-profit hospital, for-profit health system, for-profit medical school or any entity that owns or controls a for-profit hospital, for-profit health system or for-profit medical school may serve on the board of directors of a medical foundation organized by a nonprofit hospital, nonprofit health system or nonprofit medical school; (2) no employee or representative of a nonprofit hospital, nonprofit health system, nonprofit medical school or any entity that owns or controls a nonprofit hospital, health system or medical school may serve on the board of a medical foundation organized by a for-profit hospital, health system or medical school; and (3) no person shall serve on the board of directors of a medical foundation organized by a for-profit hospital, or for-profit health system, for-profit medical school and, at the same time serve on the board of directors of a medical foundation organized by a nonprofit hospital, health system or medical school.

Medical foundations must file annual information with the Office of Health Care Access ("OHCA") and if they are not tax-exempt, they must file information that is comparable to that which a tax-exempt medical foundation must file. A hospital, health system or medical school may organize and be a member of no more than one medical foundation.

S&G Note: *For-profit hospitals, health systems or medical schools can now own a medical foundation. However, for-profit hospitals, health systems or medical schools cannot hold a seat on a nonprofit medical foundation board and vice versa. This restriction appears to limit the ability of for-profits from having influence over nonprofit tax-exempt medical foundations. With respect to the mandate that a hospital, health system or medical school cannot be a member of more than one medical foundation, we presume that the Legislature was attempting to limit the number of medical foundations a health system could own without creating hospital-specific relationships within the State of Connecticut.*

- c. **Section 5: Amendments to the Certificate of Need Statute (effective July 1, 2014).** Connecticut General Statutes Section 19a-638 was amended to require a certificate of need ("CON") when there is a transfer of ownership of a group practice to any entity other than a physician or group of physicians, except if the transfer of ownership occurs before September 1, 2014. The definition of

Group Practice can be found at Connecticut General Statutes Section 19a-630(10). OHCA will consider the proposed transaction to determine: (1) whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; (2) whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposed transaction will not adversely affect health care costs or accessibility to care; and (3) there is a presumption in favor of the transaction when there was an offer made in response to a request for proposal or similar voluntary offer for sale. The review period by OHCA for such a transaction shall be 60 days from the date that OHCA posts notice on its website and a public hearing shall be held if 25 or more individuals request a hearing.

S&G Note: *OHCA now has jurisdiction to review acquisitions of physician group practices by other physician group practices. This jurisdictional authority for OHCA allows OHCA to impose requirements on the acquiring entity with respect to access, costs, and service to Medicaid and other vulnerable populations.*

- d. **Section 9: Amendments to Sale of Nonprofit Hospitals (effective June 3, 2014).** Section 19a-486a is amended to provide that no later than 30 days after receipt of the CON letter from the DPH Commissioner and the AG, the purchaser and the nonprofit hospital shall hold a hearing on the contents of the CON in the municipality in which the new hospital is proposed to be located. The AG and the DPH Commissioner may impose any conditions it desires on the proposed sale. In addition, the Commissioner may deny the sale if he or she is not satisfied that the sale will result in “high quality and affordable health care after accounting for any proposed change impacting hospital staffing”.

S&G Note: *This change seems to be one area which will provide representatives from labor with the opportunity to voice their concerns regarding staffing, access and quality of care.*

18. AN ACT CONCERNING NOTICE OF A PATIENT’S OBSERVATION STATUS. **See Public Act No. 14-180.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00180-R00HB-05535-PA.htm>

- a. **Section 1: Hospital Observation Status Requirements (effective October 1, 2014).** Public Act 14-180 (the “Act”) requires all hospitals¹¹ to provide oral and written notice to each patient that the hospital places in observation status of such placement not later than 24 hours after such placement, unless such patient has been discharged or has left the hospital prior to the expiration of the 24-hour period. Such oral and written notices shall include: (1) a statement that the patient is not admitted to the hospital but is under observation status; (2) a statement that observation status may affect the patient’s Medicare, Medicaid or private insurance coverage for (A) hospital services, including medications and pharmaceutical supplies, or (B) home or community-based care or care at a skilled nursing facility upon the patient’s discharge; and (3) a recommendation that the patient contact his or her health insurance provider or the Office of the Healthcare Advocate to better understand the implications of placement in observation status. The written notice must be signed and dated by the patient receiving the notice or such patient’s legal guardian, conservator or other legally authorized representative.

¹¹ The Act refers to all hospitals defined in section Connecticut General Statutes Section 19a-490. Connecticut General Statutes Section 19a-490 defines hospital as “an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals.”

19. AN ACT CONCERNING THE ALZHEIMER'S DISEASE AND DEMENTIA TASK FORCE'S RECOMMENDATIONS ON TRAINING. **See Public Act No. 14-194.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00194-R00SB-00179-PA.htm>
- a. **Section 1: Nursing Home and Rest Home Requirements (effective October 1, 2014).** Pursuant to Public Act 14-194 (the "Act"), a nursing home administrator of a chronic and convalescent nursing home or a rest home with nursing supervision shall designate one staff person in each such home to review and make recommendations to the administrator concerning residents with dementia, including, but not limited to: (1) factors that affect person-centered care; (2) wellness indicators; and (3) staff training programs for dementia care capability. The designated staff person shall monitor implementation of the approved recommendations. The administrator shall also ensure that all facility staff receive training upon employment and annually thereafter in Alzheimer's disease and dementia symptoms and care.
 - b. **Section 2: Home Health Agency, Residential Care Home, Assisted Living Services Agency, and Hospice Requirements (effective October 1, 2014).** The Act requires each home health agency, residential care home and assisted living services agency, and each licensed hospice care organization to provide training and education on Alzheimer's disease and dementia symptoms and care to all staff providing direct care upon employment and annually thereafter.
 - c. **Section 3: Residential Facilities for Persons with Intellectual Disability Requirements (effective October 1, 2014).** For residential facilities for persons with intellectual disability licensed pursuant to Connecticut General Statutes Section 17a-227, the Act now requires all residential facilities serving persons with Down's syndrome 50 years of age or older to have at least one staff member trained in Alzheimer's disease and dementia symptoms and care.
20. AN ACT CONCERNING PHARMACY REWARDS PROGRAMS AND PROTECTED HEALTH INFORMATION. **See Public Act No. 14-197.** <http://www.cga.ct.gov/2014/ACT/PA/2014PA-00197-R00SB-00208-PA.htm>
- a. **Section 1: Pharmacy Rewards Program Terms and Conditions (effective July 1, 2014).** Public Act 14-197 (the "Act") requires a retailer to provide a consumer enrolling in a pharmacy rewards program with a written plain language summary of the terms and conditions of the program. The summary must be provided to the consumer prior to the retailer enrolling the consumer in the program.
 - b. **Section 1: HIPAA Authorization Requirements (effective July 1, 2014).** In the event a consumer is required to sign a HIPAA authorization form to participate in a pharmacy rewards program, the Act requires the retailer to include the following information on the form adjacent to the point where the form is to be signed: (i) the specific uses of health information that the authorization allows; (ii) whether health information will be disclosed to third parties and, if so disclosed, that such information will not be protected by federal or state privacy laws; (iii) which, if any, third parties will have access to the consumer's health information; (iv) how the consumer may revoke the HIPAA authorization; and (v) that the consumer is entitled to a copy of the HIPAA authorization form once signed.

21. AN ACT CONCERNING HEPATITIS C TESTING. **See Public Act No. 14-203.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00203-R00SB-00257-PA.htm>

- a. **Section 1: Testing (effective October 1, 2014).** Public Act 14-203 (the “Act”) requires physicians, APRNs and physician assistants who provide primary care¹² services to offer to provide or order a hepatitis C screening or diagnostic test¹³ for patients born between 1945 and 1965, when providing services to these patients. This requirement does not apply when the provider reasonably believes that the patient: (i) is being treated for a life-threatening emergency; (ii) has previously been offered or received a hepatitis C screening test; or (iii) lacks the capacity to consent.

22. AN ACT CONCERNING THE DUTIES OF A CONSERVATOR AND OTHER PERSONS AUTHORIZED TO MAKE DECISIONS RELATING TO THE CARE AND DISPOSITION OF A DECEASED PERSON’S BODY. **See Public Act No. 14-204.**
<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00204-R00SB-00260-PA.htm>

- a. **Sections 1-2: Who Can Make Decisions Regarding the Disposition of One’s Body Upon Death (effective October 1, 2014).** Pursuant to Public Act 14-204 (the “Act”), conservators and/or individuals given such authority through properly executed “power of attorney” documents, may execute in advance of such conserved person’s or principal’s death a written document, signed by such conservator or agent and attested by two witnesses, either: (A) directing the disposition of such conserved person’s or principal’s body upon the death of such conserved person or principal, which document may also designate an individual to have custody and control of such conserved person’s or principal’s body and to act as agent to carry out such directions; or (B) if there are no directions for disposition, designating an individual to have custody and control of the disposition of such conserved person’s or principal’s body upon the death of such conserved person or principal. No person having the custody and control of the disposition of a deceased person’s body shall knowingly provide for a disposition of the body in a manner that is inconsistent with a document executed in accordance with the aforementioned requirements, unless such disposition is otherwise approved by the Probate Court.
- b. **Section 2: Who Can Make Decisions Regarding the Disposition of One’s Body Upon Death When No Official Person has Been Designated (effective October 1, 2014).** In the absence of a written designation of an individual to make the decision regarding the disposition of one’s body after death or in the event that an individual and any alternate declines to act or cannot be located within 48 hours after the time of death or the discovery of the body, the Connecticut General Statutes set forth categories of persons (e.g. children, parents and siblings of the deceased) that shall have the right to custody and control of the disposition of a person’s body upon the death of such person. The Act now provides that in the event that the applicable class of persons set forth above contains more than one person, the custody and control of the body shall be in a majority of the members of the class who can be located and indicate willingness to participate in making arrangements for the disposition within a reasonable time not to exceed ten days

12 For purposes of the Act, “primary care” is family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics, or primary care gynecology, without regard to board certification.

13 For purposes of the Act, a “hepatitis C screening test” is a laboratory test to detect the presence of hepatitis C virus antibodies in the blood and a “hepatitis C diagnostic test” is a laboratory test that detects the presence of the virus in the blood and confirms whether the person whose blood was tested has a hepatitis C virus infection.

after the date on which the deceased person is identified. Such class members shall indicate their decision in writing.

23. AN ACT CONCERNING THE PROVISION OF BEHAVIORAL HEALTH AND SUBSTANCE USE TREATMENT SERVICES BY MULTI-CARE INSTITUTIONS. See Public Act No. 14-211.

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00211-R00SB-00417-PA.htm>

a. **Sections 1-2: Behavioral Health and Substance Abuse Treatment in “Multi-Care Institutions” (effective October 1, 2014).**

- **Definition of a New Type of Provider:** First, DPH’s facility and licensing statutes have been revised by Public Act 14-211 (the “Act”) to incorporate a new type of provider classified as a “multi-care institution”. A multi-care institution means “a hospital, psychiatric outpatient clinic for adults, free-standing facility for the care or treatment of substance abusive or dependent persons, hospital for psychiatric disabilities or a general acute care hospital that provides outpatient behavioral health services that: (A) is a licensed health care institution pursuant to Chapter 368v of the Connecticut General Statutes; (B) has more than one facility or one or more satellite units owned and operated by a single licensee; and (C) offers complex patient health care services at each facility or satellite unit.” A multi-care institution may, under the terms of its existing license, provide behavioral health services or substance use disorder treatment services on the premises of more than one facility, at a satellite unit or at another location outside of its facilities or satellite units that is acceptable to the patient receiving services and is consistent with the patient’s assessment and treatment plan.
- **DPH Approval Requirements:** Any multi-care institution that intends to offer services at a satellite unit or other location outside of its facilities or satellite units, shall submit an application for approval to offer services at such location to DPH. Such application shall be submitted on a form and in the manner prescribed by DPH. Not later than 45 days after receipt of such application, DPH shall notify the multi-care institution of the approval or denial of such application. If the satellite unit or other location is approved, that satellite unit or location shall be deemed to be licensed and shall comply with all applicable regulatory requirements.

24. AN ACT CONCERNING A TASK FORCE TO STUDY STROKE AND REPORTING ON HEALTH CARE-ASSOCIATED INFECTIONS. See Public Act No. 14-214.

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00214-R00SB-00438-PA.htm>

- a. **Section 2: Hospital Infection Reporting and Publication (effective October 1, 2014).** Pursuant to Connecticut General Statutes Section 19a-490o, DPH annually submits a report to the General Assembly on the information collected by DPH regarding healthcare associated infections. Public Act 14-214 has expanded the reporting requirements for facilities to now include information reported to DPH or the Medicare Hospital Compare program concerning the number and type of infections, including, but not limited to, central line-associated bloodstream infections, catheter-associated urinary tract infections, surgical site infections, methicillin-resistant staphylococcus aureus (MRSA) infections and Clostridium difficile infections. DPH will now post this information on its web site regarding health care-associated infections to assist the public in learning about health care facility acquired infections.

25. AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR ENDING JUNE 30, 2015. **See Public Act No. 14-217.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00217-R00HB-05597-PA.htm>

- a. **Sections 1-16: Expansion of the Connecticut False Claims Act (effective June 13, 2014).** Public Act 14-217 (the “Act”) expands the scope of the Connecticut False Claims Act (the “CFCA”) by stating that it will apply to and cover all “state-administered health or human services programs”, which means all “programs administered by any of the following: The Department on Aging, the Department of Children and Families, the Department of Developmental Services, the Department of Mental Health and Addiction Services, the Department of Public Health, the Department of Rehabilitation Services, the Department of Social Services, the Office of Early Childhood, and the Office of the State Comptroller, for the State Employee and Retiree Health programs, as well as other health care programs administered by the Office of the State Comptroller, and the Department of Administrative Services, for Workers’ Compensation medical claims, including such programs reimbursed in whole or in part by the federal government.”
- b. **Section 21: Sale or Transfer of Ownership of a “Primary Service Area Responder” (effective June 13, 2014).** The Act requires that a primary service area responder, as defined in Connecticut General Statutes Section 19a-175¹⁴, shall notify DPH and the chief elected official or the chief executive officer of the municipality to which it is assigned not later than 60 days prior to the sale or transfer of more than 50% percent of its ownership interest or assets. Any person who intends to obtain ownership or control of a primary service area responder in a sale or transfer for which notification is required shall submit an application for approval of such purchase or change in control on a form prescribed by DPH. DPH shall, in determining whether to grant approval of the sale or transfer, consider: (1) the applicant’s performance history in the state or another state; and (2) the applicant’s financial ability to perform the responsibilities of the primary service area responder in accordance with the local emergency medical services plan. DPH shall approve or reject the application not later than 45 calendar days after receipt of the application. DPH shall consult with any municipality or sponsor hospital in the primary service area in making a determination on the application and may hold a hearing on the application.
- c. **Section 74: Medicaid Drug Coverage Expansion (effective June 13, 2014).** In general, DSS is not permitted to pay for (on behalf of Medicaid beneficiaries) over-the-counter drugs, with the following exceptions: (1) over-the-counter drug coverage through the Connecticut AIDS Drug Assistance Program; (2) insulin or insulin syringes; or (3) nutritional supplements for people who (a) must be tube fed or (b) cannot safely get nutrition in any other form; and (4) smoking cessation drugs. The Act now expands the list of over-the-counter drugs that DSS may pay for through its medical assistance programs to include those that must be covered as essential health benefits under the federal Affordable Care Act, including drugs rated “A” or “B” in the current U.S. Preventive Services Task Force recommendations for people with specific diagnoses. Such drugs include: (1) aspirin for men age 45 to 79 and women age 55 to 79 to prevent cardiovascular disease; and (2) folic acid for women who are pregnant or capable of pregnancy.

14 Connecticut General Statutes Section 19a-175 states that: (1) “Primary service area responder” means an emergency medical services provider who is designated to respond to a victim of sudden illness or injury in a primary service area; (2) “Provider” means any person, corporation or organization, whether profit or nonprofit, whose primary purpose is to deliver medical care or services, including such related medical care services as ambulance transportation; and (3) “Primary service area” means a specific geographic area to which one designated emergency medical services provider is assigned for each category of emergency medical response services”.

d. **Section 77: Hospital Based Facility Fees (effective June 13, 2014).**

- **Analysis of Facility Fee Impact:** Pursuant to the Act and not later than December 1, 2014, the State Comptroller shall analyze the impact of facility fees and the total fees charged or billed by a hospital or health system for outpatient hospital services on group hospitalization and medical and surgical insurance plans. Such analysis shall include not less than five service types or categories: (1) to which facility fees are charged or billed by one or more hospitals or health systems; or (2) for which the total fees charged or billed by a hospital or health system exceed those charged by other providers for comparable services. In addition, the Act requires the Comptroller by no later than March 1, 2015, to determine: (1) in collaboration with insurers or third-party administrators that issue or administer such insurance plans, the amounts of the facility fees and the total fees charged or billed by hospitals or health systems for the selected service types or categories, on an aggregate basis and by individual hospitals and health systems; (2) the appropriateness and reasonableness of such facility fees and total fees charged or billed to such insurance plans and the enrollees of such plans, using criteria that include, but are not limited to, (A) a comparison of the typical amount of the facility fee in proportion to the professional fee charged or billed by the provider of the medical service, (B) a comparison of the total fees charged or billed by a provider prior to and after such provider's affiliation with a hospital or health system, and (C) the extent to which the facility fee or any increase in total fees charged or billed by a hospital or health system is associated with improving service to and outcomes for insurance plan enrollees; and (3) the feasibility of removing reimbursements, beginning not later than July 1, 2015, for such fees the Comptroller has determined to be inappropriate or unreasonable.
- **Facility Fee Impact Report:** Not later than October 1, 2015, the Comptroller shall submit a report to the Governor, the General Assembly and the Health Care Cost Containment Committee of the results of the analysis and determinations referenced above, and the impact of limiting facility fees or total fees or both on such insurance plans and enrollees of such plans.

e. **Section 131: Disposal of Pharmaceuticals (effective October 1, 2014).**

Pursuant to the Act, the Department of Consumer Protection ("DCP") shall, in consultation with the Connecticut Pharmacists Association and the Connecticut Police Chiefs Association, develop and implement a program for the collection and disposal of unwanted pharmaceuticals. Such program shall provide for: (1) a secure locked box that is accessible to the public on a 24-hour daily basis for the anonymous drop-off of unwanted pharmaceuticals at each municipal police station; and (2) the transport of such pharmaceuticals to an appropriate facility for witnessed incineration. DCP shall also, within available appropriations, organize a public awareness campaign to educate the public concerning the dangers of unsafe disposal of pharmaceuticals and of the availability of the pharmaceutical collection and disposal program at municipal police stations.

f. **Section 154: Physician and APRN Profiles (effective October 1, 2014).**

Current law requires DPH, within available resources, to collect certain information to create individual profiles for health care providers for dissemination to the public. The Act eliminates the "within available appropriations" restriction with regard to collecting information on physicians and APRNs. The Act also adds to the profile information: (1) whether or not the practitioner provides primary care services; and (2) for an APRN, whether he or she is practicing independently or in collaboration with a physician to the list of collected information.

- g. **Section 192: DSS Reporting for FQHCs (effective July 1, 2014).** Pursuant to 17b-245d, each federally qualified health center (“FQHC”) shall file with DSS the following documents for the previous state fiscal year: (1) Medicaid cost report; (2) audited financial statements; and (3) any additional information reasonably required by the department. The Act now permits an FQHC that does not use the state fiscal year as its fiscal year shall have six months from the completion of such health center’s fiscal year to file said documents with the department.
- h. **Section 193: Electronically Prescribing DME (effective June 13, 2014).** Not later than July 1, 2014, DSS shall accept electronic transmission of prescriptions for reimbursements under the medical assistance program for durable medical equipment including, but not limited to, wheelchairs, walkers and canes. Any such electronic prescription shall be electronically signed by a licensed health care provider with prescriptive authority.
- i. **Section 194: DSS Payment Methodology for Pediatric Psychiatric Care (effective July 1, 2014).** Upon DSS’ reimbursement conversion to a hospital DRG payment methodology, DSS shall evaluate payments for all hospital services, including, but not limited to, a review of pediatric psychiatric inpatient units within hospitals. DSS may, within available appropriations, implement a pay-for-performance program for pediatric psychiatric inpatient care.
- j. **Section 220: New Categories of Independent Practitioners (effective July 1, 2014).** Not later than October 1, 2014, DSS shall amend the Medicaid state plan to include services provided by the following licensed behavioral health clinicians in independent practice to Medicaid recipients who are 21 years of age or older: (1) Psychologists; (2) clinical social workers; (3) alcohol and drug counselors; (4) professional counselors; and (5) marital and family therapists. DSS shall include such services as optional services covered under the Medicaid program and provide direct Medicaid reimbursements to such licensed behavioral health clinicians who are enrolled as Medicaid providers and who treat such Medicaid recipients in independent practice settings.

26. AN ACT CONCERNING THE PHARMACY PRACTICE ACT AND COUNTERFEIT DRUGS OR DEVICES. **See Public Act No. 14-224.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00224-R00HB-05262-PA.htm>

- a. **Section 1: The Prescribing of Non-Generic Medications (effective July 1, 2014).** Prescribing practitioners may specify in writing or by a telephonic or other electronic communication that there shall be no substitution for the specified brand name drug specified on any prescription form. Public Act 14-224 (the “Act”) still permits such notations, provided that: (1) for written prescriptions, the practitioner shall specify on the prescription form that the drug product is “brand medically necessary” or “no substitution”; (2) for prescriptions transmitted by telephonic means, the pharmacist shall specify “brand medically necessary” or “no substitution” on the prescription form in the pharmacist’s handwriting or in the electronic prescription record and shall record on the prescription form the time the telephonic authorization was received and the name of the person who communicated the telephonic authorization to the pharmacist; and (3) for prescriptions transmitted by any other electronic communication, the practitioner shall select the dispense as written code on the certified electronic prescription form to indicate that a substitution is not allowed by the practitioner. No prescription form may default to “brand medically necessary” or “no substitution”.

b. **Section 2: DCP's Increased Oversight of Sterile Compounding Pharmacies (effective July 1, 2014).**

- **Summary:** The Act gives the DCP more oversight over sterile compounding pharmacies by, among other things, requiring them to file more reports with DCP and comply with the latest pharmacopeia standards on sterile pharmaceutical preparations. It also requires sterile compounding pharmacies that provide compounded sterile products without a patient-specific prescription or medical order to obtain a DCP manufacturing license.
- **Sterile Compounding Compliance Requirements:** The Act requires “sterile compounding pharmacies”¹⁵ to comply with: (1) the latest United States Pharmacopeia, Chapter 797, Pharmaceutical Compounding – Sterile Preparations, as amended from time to time (“Pharmacopeia Standards”); and (2) all applicable federal and state law and regulations. Such pharmacies must prepare and maintain a policy and procedure manual that complies with the Pharmacopeia Standards, including, among other things, information on sterilization methods and training.
 - o **Institutional Pharmacies:** The Act also states that institutional pharmacies that are located within a facility licensed pursuant to Connecticut General Statutes Section 19a-490 and which compound sterile pharmaceuticals must also comply with all the aforementioned standards and the requirement to maintain a policy and procedure manual.
- **Amending Pharmacy Applications and Registrations:** For new pharmacy license applicants or current licensees who wish to compound sterile pharmaceuticals for the first time after July 1, 2014, such pharmacies must file an addendum to their pharmacy application with DCP before compounding sterile pharmaceuticals for use in Connecticut. The addendum must include notice that they are engaged in sterile compounding and a description of changes to the pharmacy layout. DCP will then inspect the changes and DCP and the Pharmacy Commission must approve them before a pharmacy can begin compounding sterile pharmaceuticals.
 - o If an applicant for a nonresident pharmacy registration intends to compound sterile pharmaceuticals for sale or delivery in Connecticut, the applicant shall file an addendum to its application to include sterile pharmaceutical compounding. The applicant shall provide DCP with written proof it has passed inspection by the appropriate state agency in the state where such nonresident pharmacy is located. Such pharmacy shall not compound sterile pharmaceuticals for sale or delivery in Connecticut until it receives notice that the addendum application has been approved by DCP and the Commission of Pharmacy. If a registered nonresident pharmacy intends to compound sterile pharmaceuticals for sale or delivery in this state for the first time on or after July 1, 2014, the nonresident pharmacy shall file an addendum to its application to include sterile pharmaceutical compounding. The nonresident pharmacy shall provide DCP with written proof it has passed inspection by the appropriate state agency in the state where such nonresident pharmacy is located. Such pharmacy shall not compound sterile pharmaceuticals until it receives notice that the addendum application has been approved by DCP and the Commission of Pharmacy.

¹⁵ The Act states that: “Sterile compounding pharmacy” means a pharmacy, as defined in section 20-594 of the general statutes, or a nonresident pharmacy registered pursuant to section 20-627 of the general statutes ... that dispenses or compounds sterile pharmaceuticals; and “Sterile pharmaceutical” means any dosage form of a drug, including, but not limited to, parenterals, injectables, surgical irrigants and ophthalmics devoid of viable microorganisms.

- **Patient-Specific Requirements:** The Act states that a sterile compounding pharmacy may only provide patient-specific sterile pharmaceuticals to patients, practitioners of medicine, osteopathy, podiatry, dentistry or veterinary medicine, or to an acute care or long-term care hospital or health care facility licensed by DPH.
 - **Manufacturing License:** The Act requires sterile compounding pharmacies that provide compounded sterile products without a prescription or medical order to get a DCP manufacturing license and any required federal license or registration. A sterile compounding pharmacy may prepare and maintain on-site up to a 30-day supply of sterile pharmaceuticals. The 30 days start from the day compounding is completed, including third party analytical testing performed according to Pharmacopeia Standards.
 - **Remodeling:** The Act requires sterile compounding pharmacies to notify DCP at least ten days before remodeling or relocating a pharmacy clean room; or upgrading or starting nonemergency repairs to the heating, ventilation, air conditioning, or primary engineering controls for a clean room. They must notify DCP, in writing, as soon as possible after making any emergency repair. If the remodel, relocation, upgrade, or repair requires sterile recertification, the pharmacy must provide DCP with a copy of the recertification. An independent licensed environmental monitoring entity must perform the recertification.
 - **Reporting Requirements:** The Act requires sterile compounding pharmacies, other than those in health care institutions, to give DCP a written report of any known violation or noncompliance with viable and nonviable environmental sampling testing, as defined by pharmacopeia standards, within one business day after discovery. A sterile compounding pharmacy within a health care facility must report the violation or noncompliance to DPH. A sampling test measures the number of particles and microorganisms in the air around the compounding area. Sterile compounding pharmacies must also report to DCP any administrative or legal action commenced against them by any state or federal regulatory agency or accreditation entity within five business days after becoming aware of such an action. A physician, hospital, or health care facility that receives sterile pharmaceuticals must report to DCP any: (1) dispensing errors; or (2) suspected adulterated sterile pharmaceuticals.
 - **Recalls:** The Act requires sterile compounding pharmacies to notify certain people when they recall sterile pharmaceuticals. By the end of the business day following the recall, they must notify: (1) each patient or patient caregiver, the prescribing practitioner, and DCP when the pharmaceutical was dispensed as a patient-specific prescription or medical order; and (2) each purchaser of the pharmaceutical, DCP, and the federal Food and Drug Administration (“FDA”) for pharmaceuticals that were not dispensed as a patient-specific prescription or medical order.
- c. **Sections 6-8: DCP’s Increased Oversight of Counterfeit Drug/Device Activities (effective July, 1, 2014).**
- **Repeal of the Current Counterfeit Drug Law:** First, the Act repeals the current Connecticut General Statutes pertaining to counterfeit drugs because it has no penalties or enforcement procedures.
 - **New Definition:** Next, the Act sets forth a new definition for “counterfeit drug or device” and states that a counterfeit drug or device means “a drug or device, or

the container or labeling of which, that without authorization, bears the trademark, trade name or other identifying mark, imprint, number or device, or any likeness thereof, of a manufacturer, distributor or dispenser other than the person or persons who in fact manufactured, distributed or dispensed such drug or device and that thereby falsely purports or is represented to be the drug or device of, or to have been distributed by, such other manufacturer, distributor or dispenser.”

- **The Prohibition:** No person shall knowingly purchase for resale, sell, offer for sale or deliver in any manner a counterfeit drug or device.
- **DCP Investigatory Powers and Hearings:** DCP shall conduct any necessary investigation regarding possible violations. In connection with any such investigation, DCP may administer oaths, issue subpoenas, compel testimony and order the production of books, records and documents. If any person refuses to appear, to testify or to produce any book, record or document when so ordered, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement. DCP may also conduct hearings regarding violations. Such hearings shall be conducted in accordance with Connecticut administrative law. In connection with any such hearing, DCP may administer oaths, issue subpoenas, compel testimony and order the production of books, records and documents. If any person refuses to appear, testify or produce any book, record or document when so ordered, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement.
- **Penalties:** For any violation, DCP may: (1) suspend, revoke, refuse to renew, or place on probationary status a license or registration issued by DCP; (2) assess a civil penalty of not more than one thousand dollars per violation; (3) issue an appropriate order to any person found to be in violation to provide for the immediate discontinuance of the violation; and (4) issue an appropriate order to any person found to be in violation, requiring the person to make restitution for any damage caused by the violation. Any person who commits a violation shall be fined not more than \$10,000 or imprisoned not more than one year, or both, for each violation.

27. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES. **See Public Act No. 14-231.**

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00231-R00HB-05537-PA.htm>

- a. **Section 1: OHCA Reporting Obligations (effective October 1, 2014).** Public Act 14-231 (the “Act”) requires outpatient surgical facilities to respond to a biennial OHCA questionnaire that asks for the: (1) facility’s name, location, and operating hours; (2) type of facility and services provided; and (3) number of clients, treatments, patient visits, and procedures or scans performed per year. Beginning no later than July 1, 2015, OHCA may also require additional reporting of outpatient data.
- b. **Section 4: School Nurse Access to Immunization Registry (effective October 1, 2014).** Pursuant to the Act, a school nurse who is required to verify students’ immunization status may access DPH’s childhood immunization registry to: (1) determine which children living in the nurse’s jurisdiction are overdue for scheduled immunizations; and (2) provide outreach to assist such children in obtaining vaccinations. The Act grants this access to school nurses in both public and private schools.

- c. **Section 7: Nursing Facility Plan of Correction (effective October 1, 2014).** The Act permits DPH to require a nursing facility license holder and a nursing facility management service certificate holder to jointly submit a plan of correction to DPH in the event that DPH finds there has been a substantial failure to comply with applicable statutes and regulations.
- d. **Section 9: Lead Poisoning Prevention (effective October 1, 2014).** Primary care providers are required to test children for lead poisoning in accordance with Connecticut law. The Act now requires primary care providers to provide, prior to conducting such lead test, educational materials or anticipatory guidance information concerning lead poisoning prevention to such child's parent or guardian. In addition, the Act changes the existing requirement for primary care providers to conduct a medical risk assessment at least annually for each child 36 to 71 months old. Now, the medical assessment must be conducted annually for each child 36 to 72 months old.

S&G Note: *The change to 72 months was made to align the requirement with a child's 6th birthday.*

- e. **Section 10: Use of Electronic Signatures in Nursing and Rest Homes (effective October 1, 2014).** The Act permits chronic or convalescent nursing homes and rest homes with nursing supervision to use electronic signatures for patient medical records, provided that such facility has written policies in place to maintain the privacy and security of such electronic signatures.

S&G Note: *Nursing and rest homes should determine if their current privacy and security policies would satisfy this new requirement or if revisions, or new policies, are necessary.*

- f. **Section 11: Emergency Medical Service Vehicle Inspections (effective October 1, 2014).** Current Connecticut law requires each ambulance or rescue vehicle used by an ambulance or rescue service to be certified by DPH prior to being registered by the Department of Motor Vehicles and inspected by DPH once every two years thereafter. The Act modifies application of this requirement by replacing "rescue vehicle used by an ambulance or rescue service" with "invalid coach and intermediate or paramedic intercept vehicle used by an emergency medical service organization." The Act also removes the requirement for such vehicles to be inspected biennially by DPH and instead permits such inspection to be performed by persons qualified to do so in accordance with federal law, provided that such inspection be conducted in accordance with federal law.
- g. **Section 13: Nursing and Rest Home Medical Examinations (effective October 1, 2014).** The Act requires chronic and convalescent nursing homes and rest homes with nursing supervision to complete a comprehensive medical history and medical examination for each patient upon that patient's admission to the facility and annually thereafter. The requirements for such history and examination shall be set forth in regulations to be published by DPH, though the statute specifies that a urinalysis will be not required as part of such tests.

- h. **Section 14: Application of Summary Orders (effective October 1, 2014).** Currently, DPH may, upon finding that emergency action is imperative to protect the health, safety or welfare of a patient, issue a summary order to either a home health agency or a homemaker-home health aide agency. The summary order may, among other things, revoke or suspend the facility's license, prohibit

the facility from contracting with new patients, limit a facility's license such as with respect to patient capacity or services offered or compel compliance with applicable statutes or DPH regulations. Now, the Act expands the types of facilities to which DPH may issue such summary orders to include hospitals¹⁶, residential care homes, health care facilities for the handicapped, nursing homes, rest homes, mental health facilities, assisted living agencies, substance abuse treatment facilities, outpatient surgical facilities, on-campus infirmaries and residential facilities for the mentally retarded.

- i. **Section 15: Waiver of Physical Plant Requirements (effective October 1, 2014).** Currently, DPH may waive any provision of regulations affecting the physical plant requirements of residential care homes if DPH determines that such waiver would not endanger the health, safety or welfare of a resident. Now, the Act expands the types of facilities for which DPH may waive physical plant requirements to include hospitals, home health care agencies, homemaker-home health agencies, health care facilities for the handicapped, nursing homes, rest homes, mental health facilities, assisted living agencies, substance abuse treatment facilities, outpatient surgical facilities, on-campus infirmaries and residential facilities for the mentally retarded.
- j. **Sections 16 and 17: Licensure of Paramedic Intercept Services (effective October 1, 2014).** The Act requires paramedic intercept services to be licensed or certified by DPH. The Act defines "paramedic treatment services" as an entity that provides paramedic treatment services but does not provide the ground ambulance transport. The requirements for paramedic intercept services are generally similar to those for ambulance services, including: (1) licensure applicants must show proof of financial responsibility and hold set amounts of insurance; (2) licenses must be renewed annually; and (3) specified information about their service delivery must be reported to DPH on a quarterly basis.
- k. **Section 18: EMS Organization Requirements (effective October 1, 2014).** The Act requires emergency medical service organizations to ensure that: (1) its personnel are appropriately licensed or certified by DPH; (2) such licenses or certifications remain valid; (3) any employment agency or personnel pool from which it obtain personnel meets certain general and professional liability insurance limits; and (4) any personnel obtained from such an agency or pool are covered by such insurance.
- l. **Section 19: EMS Notification to DPH (effective October 1, 2014).** The Act permits any ambulance service or paramedic intercept service operated or maintained on or before October 1, 2014 to notify DPH of such operation and to attest to DPH that its operations are in accordance with all applicable statutes and regulations. Any such ambulance service or paramedic intercept service that so attests shall be deemed licensed or certified, as applicable. Such notification and attestation must be made no later than September 1, 2014.
- m. **Section 20: EMT/EMR Licenses and Certificates (effective October 1, 2014).** The Act modifies the requirements for an EMT to obtain a Connecticut license by requiring that the applicant complete a training program consistent with the National Emergency Medical Services Education Standards by an accredited

¹⁶ Prior to issuing a summary order that revokes or suspends a hospital's license, the Act requires DPH to prepare, in collaboration with the hospital and one or more health care providers that provide services in the same geographic area as the hospital, a detailed plan for the relocation of the hospital's inpatients and the provision of comparable services for the hospital's outpatients.

organization. The Act also makes additional modifications to the requirements to obtain EMT or EMR certificate, temporary certificates or instructor certificates.

- n. **Section 24: Use of Non-Primary Service Area Responders (effective October 1, 2014).** The Act permits general and children's hospitals to utilize a ground or air ambulance service other than the primary service area responder for emergency inter-facility transports of patients when: (1) the primary service area responder is not authorized to the level of care required for the patient; (2) the primary service area responder does not have the equipment necessary to transport the patient safely; or (3) the transport takes the primary service area responder out of its service area for more than two hours and there is another ambulance service with the appropriate level of medical authorization and proper equipment available. The patient's attending physician shall determine when it is necessary to utilize the primary service area responder or other ambulance service for an expeditious and medically appropriate transport.
- o. **Sections 28 and 49: Administration of Vaccines (effective October 1, 2014).** The Act expands the types of flu and pneumococcal¹⁷ vaccines hospitals, home health agencies and homemaker-home health aide agencies may administer to patients by eliminating the requirement that such vaccines be polysaccharides¹⁸.
- p. **Section 29: Modifications to Connecticut Tumor Registry (effective October 1, 2014).** By law, the Connecticut Tumor Registry includes reports of all tumors and conditions that are diagnosed or treated in the state for which DPH requires reports. The Act eliminates such reporting requirements for the following health professionals: (1) athletic trainers; (2) physical, occupational, and massage therapists; (3) psychologists; (4) behavior analysts; (5) marriage and family therapists; (6) alcohol and drug counselors; (7) professional counselors; (8) master and clinical social workers; (9) radiographers, radiologic technologists, and radiologist assistants; (10) midwives; (11) nurse's aides; (12) dental hygienists; (13) optometrists; (14) opticians; (15) respiratory care practitioners; (16) perfusionists; (17) pharmacists; (18) veterinarians; (19) electrologists; (20) hearing instrument specialist; and (21) speech and language pathologists. The Act continues to require doctors, chiropractors, naturopaths, podiatrists, nurses, dentists, and emergency medical service providers to report to the registry. The Act now requires these providers to include the occupation and industry of patients when making a report to the Tumor Registry. The Act also requires entities to update registry reports annually for the duration of a patient's life.
- q. **Sections 35 and 36: Professional Counselor and Social Worker License Requirements (effective October 1, 2014).** The Act allows an applicant for licensure as a professional counselor or social worker who is licensed or certified in another state to substitute out-of-state work experience for certain licensure requirements. The substitutions may be made only if DPH finds that such experience is equal to or greater than the Connecticut licensure requirements. Under the Act, applicants for licensure as a: (1) professional counselor may substitute three years of out-of-state work for the 3,000 hours of post-graduate-degree-supervised experienced requirement; and (2) social worker may substitute three years of out-of-state work for the 3,000 hours of post-master's social work experience requirement.

17 Pneumococcal vaccines are used to help prevent pneumococcus. *Streptococcus pneumoniae* bacteria cause pneumococcal disease. It is a leading cause of vaccine preventable illness and death in the United States. According to the Center for Disease Control and Prevention, pneumococcus is a common cause of pneumonia, meningitis and middle ear infections in young children.

18 The vaccines administered may now be based upon other molecular formats.

- r. **Sections 40 and 45: Nuclear Medicine Technologist Scope of Practice (effective October 1, 2014 and July 1, 2014 respectively).** The Act provides that a technologist who: (1) operates a bone densitometry system under a physician's supervision, control, and responsibility; and (2) is certified by the International Society for Clinical Densitometry or the American Registry of Radiologic Technologists, does not need to be licensed as a radiographer.
- s. **Section 48: Physical Therapist Assistant License (effective October 1, 2014).** The Act permits DPH, from October 1, 2014 to July 1, 2015, to issue a physical therapist assistant license to any applicant who: (1) presents evidence that he or she was eligible to register as a physical therapist assistant on or before April 1, 2006; and (2) pays a \$150 fee.
- t. **Section 56: Psychologist Continuing Education Requirements (effective October 1, 2014).** Beginning for registration periods beginning on or after October 1, 2014, psychologists must complete at least ten hours of continuing education per 12-month registration period. Each psychologist must obtain a certificate of completion from a continuing education provider for all continuing education activities completed, and the psychologist must retain that certificate for at least three years after the license renewal date for the registration period in which the continuing education activity was completed.
- u. **Section 58: Disclosure of Lab Test Results (effective October 1, 2014).** Connecticut law permits a provider who orders medical tests on behalf of a patient to direct a clinical laboratory to provide medical test results relating to the patient to any other provider who is treating the patient for the purposes of diagnosis, treatment or prognosis of such patient. Now, the Act also permits a patient or provider who orders medical tests on behalf of the patient to direct a clinical laboratory to provide medical test results to the patient.
- v. **Section 69: Practice of Naturopathy (effective October 1, 2014).** The Act modifies the Connecticut's current definition of the practice of naturopathy by clarifying that the practice "comprises diagnosis, prevention and treatment of disease and health optimization by stimulation and support of the body's natural healing processes." The Act also expands the scope of practice for naturopaths to include: (1) the ordering of certain diagnostic tests; (2) ordering medical devices and durable medical equipment; and (3) removing ear wax, spirometry¹⁹, tuberculosis testing and venipuncture for blood testing.
- w. **Section 70: Physician Assistant Orders and Prescription Forms (effective October 1, 2014).** The Act eliminates the current requirement that the signature of the physician and the printed name of the supervising physician follow all orders written by a physician assistant. The Act also eliminates the current requirement that prescription forms used by physician assistants contain the printed name, license number, address and telephone number of the physician under whose supervision the physician assistant is prescribing.

19 Spirometry is a pulmonary function test measuring lung function.



28. AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE STUDY ON ACCESS TO SUBSTANCE USE TREATMENT FOR INSURED YOUTH AS THEY RELATE TO THE DEPARTMENT OF CHILDREN AND FAMILIES. **See Special Act No. 14-7.** <http://www.cga.ct.gov/2014/ACT/SA/2014SA-00007-R00HB-05371-SA.htm>

- a. **Section 1: Establishment of Behavioral Health Urgent Care Center (effective May 28, 2014).** Special Act 14-7 (the “Act”) requires DMHAS, DPH and Department of Children and Families (“DCF”) to develop a proposal to establish an urgent care center for individuals with behavioral health concerns. The center is to be operated by both public and private entities. The proposal must be submitted to the General Assembly by February 1, 2015.
- b. **Section 2: Provider Reporting Obligations (effective May 28, 2014).** The Voluntary Services program is a DCF operated program for children and youth with serious emotional disturbances, mental illnesses and/or substance dependency. Through this program, DCF may provide, on a voluntary basis (at the request of the family), casework, community referrals and treatment services for children who are not committed to DCF.

The Act imposes new reporting requirements on entities providing professional services to children participating in the program. Specifically, each entity must record the following information for a three-month period prescribed by DCF and report such information to DCF.

- The name of the insurance carrier, if applicable, of any child whose parent or guardian seeks treatment for the child through a program offered by an in-home behavioral health care service, or the name of the parent or guardian’s employer if the employer’s health care plan is self-insured;
- Either of the following: (1) if such child or youth was accepted into such program, whether (a) the insurance carrier agreed to cover the treatment, and (b) such child or youth participated in the program; or (2) if such child or youth was not accepted into the program, (a) the cost of treatment for such child or youth, and (b) whether the denial of coverage was due to exceeding the coverage limits of the insurance policy; and
- If such child was accepted into the program and participated in such program, and the carrier agreed to such coverage, the terms of the cost-sharing agreement.

- c. **Section 3: Substance Abuse Recovery Support Plan (effective May 28, 2014).** The Act requires DMHAS to develop a substance abuse recovery support plan to provide services to adolescents and young adults in Connecticut. The plan will include: (1) methods to increase community support for such adolescents and young adults; (2) methods to alert such adolescents and young adults that such support is available; and (3) options for the implementation of such plan.

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