REVIEW OF KEY LEGISLATION RELATING TO PROVIDERS OF SERVICES TO THE ELDERLY

2011 REGULAR LEGISLATIVE SESSION

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ARRA	American Recovery and Reinvestment Act of 2009
ASO	Administrative Services Organization
BRS	Bureau of Rehabilitative Services
CFCA	Connecticut False Claims Act
CHCPE	Connecticut Home Care Program for Elders
CHFA	Connecticut Housing Finance Authority
CHRO	Commission on Human Rights and Opportunities
CMS	Centers for Medicare and Medicaid Services
ConnPACE	Connecticut Department of Social Services Pharmaceutical Assistance Contract to the Elderly and Disabled
CON	Certificate of Need
DCF	Department of Children and Families
DDS	Department of Developmental Services
DECD	Department of Economic and Community Development
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSS	Department of Social Services
GO	General Obligation
HUD	Department of Housing and Urban Development
MLIA	Medicaid for Low Income Adults
OHCA	Office of Health Care Access
OPM	Office of Policy and Management

OSHA	Occupational Safety and Health Administration
PPACA	Patient Protection and Affordable Care Act
SAGA	State Administered General Assistance

I. ACTS CONCERNING BUDGET AND BUDGET IMPLEMENTATION

PUBLIC ACT 11-44. AN ACT CONCERNING THE BUREAU OF REHABILITATION SERVICES AND IMPLEMENTATION OF PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH.
Effective Dates: As noted

§§ 1-4 – Creation of Bureau of Rehabilitative Services and Transfer of Commission on the Deaf and Hearing Impaired and the Board of Education and Services for the Blind to the Bureau of Rehabilitative Services.
Effective Date: July 1, 2011

Section 1 creates the Bureau of Rehabilitative Services ("BRS") to provide services, including rehabilitation services, to the deaf and hearing impaired and to the blind and visually impaired. Sections 2 and 3 respectively transfer all functions, powers and duties of the Commission on the Deaf and Hearing Impaired and the Board of Education and Services for the Blind to the BRS. Section 4 provides for the transfer of all functions, powers and duties of the Bureau of Rehabilitation services within the Department of Social Services ("DSS") to the newly created BRS, which will be within DSS for administrative purposes only.

§ 73 – Nursing Home Rates.
Effective Date: July 1, 2011

This section freezes the Medicaid reimbursement rates for nursing facilities at rates in effect for the period ending June 30, 2011 until June 30, 2013, except that facilities that would have received a lower rate for the fiscal year ending June 30, 2012 or the fiscal year ending June 30, 2013 due to interim rate status or an agreement with DSS will receive such lower rate. This section also extends existing limitations on fair rent increases through June 20, 2013; only facilities with an approved Certificate of Need ("CON") may receive fair rent increases.

The Commissioner of Social Services may, within available appropriations, increase rates issued to chronic and convalescent nursing homes and rest homes with nursing supervision; however, the Act does not specify criteria the Commissioner may use in providing such increases. The expectation is that any such increases will be funded through an increase in the nursing home provider tax. See separate summary of Public Act No. 11-6, §150, which increases the aggregate cap on the nursing home resident user fee (provider tax) effective October1, 2011.

§ 75 – Rates for Residential Care Homes.
Effective Date: July 1, 2011

This section freezes rates for residential care homes at the rates in effect for the period ending June 30, 2011 until June 30, 2013, with three exceptions: (1) facilities that would have received a lower rate due to interim status during that time will receive the lower rate, (2) the Commissioner of Social Services may raise rates for a facility to reflect reasonable costs associated with the facility's compliance with the provisions of § 19a-495a concerning the administration of

medication by unlicensed personnel, and (3) the Commissioner may provide fair rent increases to any facility that has undergone a material change related to fair rent and has an approved CON.

§ 76 – Reimbursement for Outpatient Prescription Drugs Dispensed to DSS Medical Assistance Recipients.
Effective Date: July 1, 2011

This section reduces the rate of reimbursement for legend drugs under medical assistance programs administered by DSS (e.g., Medicaid and ConnPACE) to the lower of three rates, one of which is the average wholesale price minus sixteen (formerly fourteen) per cent. It further reduces the professional fee per prescription paid to licensed pharmacies from $2.90 to $2.00.

§§ 78-79 – Decrease in Personal Needs Allowance.
Effective Date: July 1, 2011

These sections reduce from $69 to $60 the personal needs allowance for residents of long-term care facilities, including chronic and convalescent nursing homes, chronic disease hospitals, and rest homes with nursing supervision.

§ 81 – Medicaid Non-Emergency Dental Services.
Effective Date: July 1, 2011

This section directs the Commissioner of Social Services to modify nonemergency adult dental services provided under Medicaid. These modifications must include providing one periodic exam, one dental cleaning, and one set of bitewing x-rays per year. Section 158 of Public Act No. 11-61 (summarized below) makes minor technical changes to this section.

§ 83 – DSS Report on Regulation Process and Policies and Procedures
Effective Date: June 13, 2011

This section requires the Commissioner of Social Services, not later than July 1, 2012, to report to various committees of the General Assembly concerning the DSS regulation process and the status of policies and procedures implemented by DSS for which proposed regulations have not been submitted to the regulation review committee of the General Assembly. The report must include, among other details, a timetable for submitting proposed regulations to the regulation review committee.

§ 84 – Medicaid Reimbursement for Emergency Medical Transportation.
Effective Date: July 1, 2011

This section requires the Commissioner of Social Services to limit reimbursement to providers of emergency medical transportation for Medicaid coinsurance and deductible payments to ensure that combined Medicare and Medicaid payments do not exceed the maximum allowable amount under the Medicaid fee schedule plus a percentage established by the Commissioner of Social Services.

Sections 125 and 126 of Public Act No. 11-61 (summarized below) modify this requirement, requiring instead that the Commissioner reduce rates for emergency medical transportation.

§ 85 – Foreign Language Interpreters and Podiatry Coverage.
Effective Date: July 1, 2011

This section requires the Commissioner of Social Services to amend the Medicaid state plan to (1) include foreign language interpreter services as of July 1, 2013 (prior law required the Commissioner to do so no later than February 1, 2011); and (2) include Medicaid coverage of podiatry services as an optional service as of October 1, 2011.

§ 86 – Connecticut Home Care Program for Elders—Cost Sharing in State Funded Portion of Program.
Effective Date: July 1, 2011

This section increases the co-pay for the state-funded portion of the Connecticut Home Care Program for Elders ("CHCPE") from 6% to 7% of service costs.

§ 88-90 – ConnPACE for People Ineligible for Medicare.
Effective Date: July 1, 2011

These sections eliminate ConnPACE prescription drug coverage for people who qualify for Medicare or Medicaid. They also eliminate the Medicare Part D Supplemental Needs Fund, which previously paid for drugs for ConnPACE recipients that were not covered by their Medicare Part D plan.

§ 94 – Eyeglass Coverage under Medicaid.
Effective Date: July 1, 2011

This section reduces payment under Medicaid from one pair of eyeglasses every year to one pair every two years. Section 1 of Public Act No. 11-48 (summarized below) makes substantive changes to this section, permitting a Medicaid recipient to receive a second pair of eyeglasses during a two-year period if medically necessary.

§ 95 – Limitation on Small House Nursing Home Projects.
Effective Date: July 1, 2011

This section makes the small house nursing home pilot program permissive, rather than mandatory, and allows the Commissioner of Social Services to approve only one small house nursing home project (reduced from up to ten such projects) with up to 280 beds before June 30, 2011. Further, this section amends the definition of "small house nursing home" to include houses with no more than fourteen (formerly ten) individuals per unit and repeals provisions in current law permitting nursing homes to develop and relocate beds to small house nursing homes.

§ 96 – Security Deposit Guarantee Program.
Effective Date: July 1, 2011

The existing Security Deposit Guarantee Program provides landlords with a guaranteed security deposit when they rent a unit to certain categories of tenants, including recipients of state-administered general assistance, shelter residents, or individuals and families subject to eviction proceedings. Under this section, tenants (1) with income greater than 150% of the federal poverty level, and (2) on behalf of whom DSS has paid a damage claim to a prior landlord, must now contribute five percent of their income towards payment of a security deposit. The Commissioner of Social Services may waive this requirement for cause.

This section also permits a landlord to submit a claim for damages within forty-five days of the termination of a tenancy. DSS will only make payment on a claim that includes receipts for repairs made and will not issue payment for an apartment a tenant vacated because it was uninhabitable, as determined by a local, state, or federal regulatory agency.

§ 104 – Asset Transfers by Nursing Home Residents.
Effective Date: June 13, 2011

Current law penalizes institutionalized individuals for transferring or assigning their assets for less than fair market value in order to qualify for Medicaid. This section provides that an individual shall not be penalized for such a transfer if the entire amount of the transferred asset is returned to the individual; however, partial return of a transferred asset will not reduce the penalty period.

Specifically, when an asset has been transferred or assigned for less than fair market value, and subsequently returned to the institutionalized individual, the entire amount of the transferred asset will be considered available to the individual for the purposes of determining Medicaid eligibility. The time at which this asset will be considered available depends on the circumstances of the transfer: if DSS determines from the circumstances of the transfer that the intent of the individual or his/her spouse or representative was to alter the start of a penalty period or qualify the individual for Medicaid, the entire amount of the asset will be considered available to the individual from the date of transfer; however, if DSS determines from the circumstances that the purpose of the transfer was not to alter a penalty period or to qualify the individual for Medicaid, the asset will be considered available to the individual from the date of its return.

§ 110 – Medical Homes.
Effective Date: June 13, 2011

This section permits the Commissioner of Social Services to establish medical homes as a model for delivering care to individuals who are eligible for medical assistance programs and who have one or more of (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. The components of the medical home model include comprehensive case management; care coordination and health promotion; transitional care; patient and family support; referrals to support services; and use of health information technology to link services.

In addition, this section authorizes the Commissioner of Social Services to implement policies and procedures to carry out optional initiatives authorized under the federal Patient Protection and Affordable Care Act ("PPACA") relating to establishment of several program, including, without limitation: an incentive program for prevention of chronic diseases; provision of health homes to medical assistance beneficiaries with chronic conditions; a dual eligible demonstration program; a balancing incentive program for home and community-based services; a "Community First Choice Option"; and a demonstration project to make bundled payments to hospitals.

§ 114 – Fee Schedules for Home Health Care Agencies.
Effective Date: July 1, 2011

This section eliminates the Commissioner of Social Services' discretionary authority to annually increase rates paid to home health care and homemaker-home health aide agencies based on an increase in the cost of services. Under this section, the Commissioner of Social Services is permitted to modify the home health care and homemaker-home health aide agency fee schedules to ensure changes are cost neutral to such agencies, in the aggregate, when Medicaid converts from a managed care model to an ASO model, and to ensure patient access. Section 123 of Public Act No. 11-61 (discussed below) amends this section, adding that utilization may not be a factor in determining cost neutrality.

§ 116 – Alternative Medicaid Benefit Package for Low-Income Adults.
Effective Date: July 1, 2011

This section allows the Commissioner of Social Services to establish an alternative benefit package for Medicaid recipients under the Low Income Adult ("LIA") coverage group (formerly SAGA), which may include limits on licensed home care agency services.

§ 117 – Residential Facility for Former Prisoners and DMHAS Clients.
Effective Date: July 1, 2011

This section permits the Commissioners of Social Services, Correction, and Mental Health and Addiction Services to establish or contract for the establishment of a chronic or convalescent nursing home on state-owned property to serve individuals who require the level of care provided by a nursing home, are transitioning out of a state correctional facility, or receive services from the Department of Mental Health and Addiction Services ("DMHAS").

§ 118 – Limited Medical Services to Legal Immigrants Living in the U.S. for Less Than Five Years.
Effective Date: June 13, 2011

This section provides that (1) legal aliens receiving home and community-based services equivalent to the services provided under the Medicaid waiver portion of the CHCPE on June 30, 2011, shall continue to receive such services if they meet Medicaid eligibility requirements; (2) legal aliens receiving nursing facility care in under the state-funded medical assistance program on June 30, 2011, shall continue to receive coverage for such care so long as they apply for state-funded medical assistance before June 1, 2011; and (3) legal aliens receiving nursing facility care and who have applied for state-funded medical assistance before June 1, 2011, shall be provided such assistance for so long as they meet Medicaid eligibility requirements for nursing facility care except for alien status (subject to some exceptions not relevant to CANPFA members).

§ 119 – Limited Coverage for Illegal Immigrants.
Effective Date: June 13, 2011

This section permits the Commissioner of Social Services, after consultation with the Commissioner of Mental Health and Addiction Services and the Secretary of the Office of Policy and Management ("OPM"), to provide payments to long-term care facilities for the care of certain illegal immigrants admitted to a long-term care facility before July 1, 2011.

§§ 120-141- Elimination of State-Administered General Assistance ("SAGA") Medical Assistance Program.
Effective Date: July 1, 2011

These sections eliminate all statutory references to the SAGA program and replace them with references to Medicaid for Low-Income Adults ("MLIA") where appropriate. In 2010, SAGA was converted to Medicaid and renamed MLIA under PPACA and Public Act No. 10-3.

§ 143 – Medicaid Therapy Management Services.
Effective Date: July 1, 2011

This section requires the Commissioner of Social Services to contract with a pharmacy organization—to include a school of pharmacy—to provide Medicaid therapy management services, including, but not limited to, review of recipient medical and prescription history and development of patient medication action plans to reduce adverse medication interactions and health problems. This section is modified by Section 127 of Public Act No. 11-61 (discussed below), which adds patient-centered medical homes and health homes to the potential providers of Medicaid therapy management services, in addition to pharmacy organizations.

§ 144 – Legislative Oversight of Medicaid State Plan Amendments.
Effective Date: July 1, 2011

Current law requires the Commissioner of Social Services to notify the Human Services and Appropriations committees of the General Assembly when DSS intends to submit an application for federal waiver (or amendment to a waiver) of any assistance program, unless the application relates to routine operational issues. Under this section, the Commissioner must submit the actual waiver document to the committees, and not notice alone, as was previously required.

In addition, this section requires the Commissioner to notify the Human Services and Appropriations committees when it seeks a Medicaid state plan amendment for a change in program requirements that would have required a waiver, but for PPACA. If the committee chairs receive such notification, they must notify the Commissioner if they plan to hold a hearing, and if so, the date the hearing will be held, which must be within sixty days of receipt of the notification of the amendment.

§§ 145-146 – Delay in Establishing Department of Aging.
Effective Date: July 1, 2011

Under this section, the reestablishment of the Department of Aging is postponed until July 1, 2013.

§§ 153-159 — False Claims Act.
Effective Date: June 13, 2011

These sections make changes to the Connecticut False Claims Act ("CFCA"), which was enacted in 2009. The CFCA applies to all DSS-administered medical assistance programs, including Medicaid.
These sections broaden the circumstances under which a person is liable for submitting false or materially misleading information in order to obtain or keep funds owed to a state medical assistance provider. They also permit more individuals to file CFCA suits and increases penalties for violations of the CFCA's provisions.

These sections modify the prohibitions under the CFCA such that it now additionally prohibits:

- knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval (prior law only covered claims submitted to state officers or employees);

- knowingly making, using, or causing to be made or used, a false record or statement material to (rather than to secure payment or approval of) a false or fraudulent claim;

- conspiring to violate the CFCA (rather than to defraud the State by securing the allowance or payment of a false or fraudulent claim);

- knowingly making, using, or causing to be made or used, a false record or statement material to (rather than to conceal avoid, or decrease) an obligation to pay or transmit money or property to the State;

- knowingly buying, or receiving as a pledge of an obligation or debt, public property from a state employee or officer who may not legally sell or pledge the property; and

- knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the State.

The following prohibitions were retained:

- having possession, custody, or control of property or money used, or to be used, by the State relative to DSS-administered medical assistance programs, and, with intent to defraud the State or willfully conceal the property, delivering or causing to be delivered less property than the amount for which the person receives a receipt or certificate;

- being authorized to make or deliver a document certifying receipt of property used, or to be used, by the State relative to these programs and, with intent to defraud the State, making or delivering the document without completely knowing that the information on it is true; and

- knowingly buying or receiving as a pledge of an obligation or debt public property from a state officer, or employee who may not lawfully seal or pledge the property.

These sections clarify that something is "material" if it has a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. In addition, an "obligation" is defined as an "established duty," whether fixed or not, arising from an express or implied contractual or grantor-grantee or licensor-licensee relationship, a fee-based or similar relationship, statute or regulation, or the retention of an overpayment.

In addition, these sections increase the penalties for any violation from between $5,000 and $10,000 to between $5,500 and $11,000, or as adjusted from time to time by federal law. They expand the whistleblower protections to apply not only to employees, but to contractors and agents as well; section 119 of Public Act 11-61 (summarized below) amends this Act by adding "associated others" to this list. Finally, these sections establish a three year limitations period for bringing a suit alleging adverse job action as a result of participating in a CFCA investigation or action.

§ 166 – Increase in DSS Payments for Adult Day Care Services.
Effective Date: July 1, 2011

This section increases by $4.00 per day the rate paid by the Commissioner of Social Services per person for adult day care services. Effective July 1, 2011, the new rates are $70.22 for full day care with approved medical model providers, $66.18 for full day care with non-medical model providers, and $44.54 for half day care.

§ 167 – Council Overseeing DSS Medical Assistance Programs.
Effective Date: July 1, 2011

This section renames the Council on Medicaid Care Management Oversight to the Council on Medical Assistance Program Oversight and changes its composition.

§ 178 – Repealers.
Effective Date: July 1, 2011

This section repeals the following statutory provisions (among others):

- Conn. Gen. Stat. § 17b-192, which required the Commissioner of Social Services to implement a state medical assistance component of SAGA for certain persons, including individuals who do not meet the categorical eligibility criteria for Medicaid on the basis of age, blindness or disability;

- Conn. Gen. Stat. § 17b-261k, which permitted the community spouse of an institutionalized individual applying for Medicaid to keep the maximum community spouse protected amount;

- Conn. Gen. Stat. § 17b-265e, which established the Medicaid Part D Special Needs Fund; and

- Conn. Gen. Stat. § 17b-371, which established the Long-Term Care Reinvestment account within the General Fund.

PUBLIC ACT 11-6. AN ACT CONCERNING THE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2013.
Effective Dates: As Noted

§ 31 – Advance Payments to Nursing Facilities.
Effective Date: July 1, 2011

This section authorizes the Commissioner of Social Services, upon a nursing facility's request and after consultation with the Secretary of OPM, to make a Medicaid payment to the facility in advance of the normal Medicaid payment schedule. The amount of any such advance payment may not exceed the estimated amount due to the facility for services provided to Medicaid beneficiaries over the most recent two-month period.

The Commissioner must recover an advance within ninety days of payment, either through deductions to future payments due to the facility or through cash receipt, and must take "prudent measures" to ensure that advance payments are not made to nursing facilities at risk of bankruptcy or insolvency. This section does not specify what other factors the Commissioner may take into account in deciding whether to make an advance payment.

§ 150 – Nursing Home User Fee.
Effective Date: July 1, 2011

Beginning October 1, 2011, this section increases the aggregate cap on the nursing home resident user fee (provider tax) from 5.5% to 6%, the maximum allowable under federal law. It is anticipated that this increase in the aggregate cap will result in an increase in the per bed user fee amount. (See separate summary of Public Act No. 11-44, § 73.)

This section also removes obsolete reporting requirements regarding user fees.

PUBLIC ACT 11-48. AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET CONCERNING GENERAL GOVERNMENT.
Effective Dates: As noted

§ 1 – Restoration of Eyeglass Benefit.
Effective Date: July 1, 2011

Section 94 of Public Act 11-44 (summarized above) reduces eyeglass coverage under Medicaid to one pair of eyeglasses every two years. This section adds an exception, permitting a Medicaid recipient to receive a second pair of eyeglasses in a two-year period if the recipient's medical provider determines it is necessary due to a change in the recipient's medical condition.

§ 29 – Electronic Business Portal.
Effective Date: January 1, 2012

By law, various types of businesses must register with the secretary of the Commercial Recording Division of the Office of the Secretary of the State. This section requires that the

secretary of the division establish an electronic business portal to serve as a point of entry for businesses seeking to register with the secretary, as well as to provide access to a variety of explanatory information and links to other relevant state agencies.

PUBLIC ACT 11-61. AN ACT IMPLEMENTING THE REVENUE ITEMS IN THE BUDGET AND MAKING BUDGET ADJUSTMENTS, DEFICIENCY ADJUSTMENTS, DEFICIENCY APPROPRIATIONS, CERTAIN REVISIONS TO BILLS OF THE CURRENT SESSION AND MISCELLANEOUS CHANGES TO THE GENERAL STATUTES.
Effective Dates: As noted

§ 41 – Sales Tax Changes.
Effective Date: July 1, 2011, and applicable to sales occurring on or after July 1, 2011

This section excludes nonemergency medical transportation provided under Medicaid and dial-a-ride services from the sales tax applicable to intrastate transportation services. Transportation services provided in connection with funerals are already exempt.

§ 57 – Electronic Funds Transfers for Withholding Tax Payments from Nonpayroll Accounts.
Effective Date: July 1, 2011, and applicable to tax periods ending on or after July 1, 2011

This section permits the Commissioner of Revenue to require employers who are deducting and withholding Connecticut income tax from non-payroll amounts to pay this tax by electronic funds transfer. Non-payroll amounts include pension and annuity distributions and unemployment compensation to Connecticut residents.

§ 58 – Successor Liability for Withholding Taxes.
Effective Date: July 1, 2011

When an employer required to deduct and withhold tax from employee wages sells or quits the business, this provision requires the employer's successor or assigns to withhold enough funds from the purchase price to cover the amount of such withheld taxes due and unpaid. If the purchaser does not withhold funds from the purchase price to cover withheld taxes due and unpaid, then the purchaser shall be liable for the amount.

§ 65 – Penalty for Failing to Pay Taxes Electronically.
Effective Date: June 21, 2011, and applicable to tax periods commencing on or after January 1, 2012

The Department of Revenue Services may require taxpayers and employers to pay electronically tax bills in excess of $4,000 in annual liability or $2,000 in annual withholding tax payments. If a tax payment is required to be made electronically and was not, this provision imposes an incremental series of penalties for successive failures to pay electronically. If a tax payment was made electronically, but not on or before the due date, penalties and interest will apply.

§ 67 – Budget Adjustments.

Effective Date: July 1, 2011

This section lists the amounts appropriated from the general fund to the following: the Elderly Congregate Rent Subsidy; Medicaid Administration; Community Respite Care Programs; Medicaid; Old Age Assistance; Contract to the Elderly; Services to the Elderly; Alzheimer Respite Care; and Services to the Elderly—Municipality.

§ 119 – False Claims Act.
Effective Date: June 21, 2011

Section 158 of Public Act No. 11-44 (summarized above) expands the whistleblower protections of the CFCA to apply not only to employees, but to contractors and agents as well, provided certain conditions are met. This section further amends the CFCA by adding "associated others" to the list of individuals eligible for whistleblower protection.

§§ 123-124 – Cost Neutral Rates for Home Health Care and Homemaker-Home Health Aide Agencies.
Effective Date: July 1, 2011

Section 114 of Public Act No. 11-44 (summarized above) requires the Commissioner of Social Services to establish a fee schedule for home health care and homemaker-home health aide services, permits the Commissioner to modify this schedule annually to ensure rates remain cost neutral to home health care and homemaker-home health aide agencies in the aggregate, and prohibits the Commissioner from considering utilization as a factor in determining cost neutrality. This section amends Section 114 of Public Act No. 11-44 to add that utilization may not be a factor in determining cost neutrality.

§§ 125-126 – Ambulance Rate Reduction.
Effective Date: July 1, 2011

Section 84 of Public Act No. 11-44 (summarized above) limits DSS payments for emergency medical transportation to assure that the combined Medicare and Medicaid payment to the provider does not exceed the maximum allowable under Medicaid plus a percentage set by the Commissioner of Social Services. This section requires instead that the Commissioner reduce rates for emergency medical transportation by up to ten percent of the rates in place on December 31, 2010, provided the Commissioner increases these rates based on a determination that there are both sufficient funds and a reasonable need for an increase. The new, reduced rates take effect on July 1, 2011.

§ 127 – Medicaid Therapy Management Services.
Effective Date: July 1, 2011

Section 143 of Public Act No. 11-44 (summarized above) requires the Commissioner of Social Services to contract with a pharmacy organization to provide Medicaid therapy management services. This section permits the Commissioner to contract with patient-centered medical homes and health homes, as well as pharmacy organizations, for Medicaid therapy management

services, which may include review of recipient medical and prescription history and development of patient medication action plans to reduce adverse medication interaction and health problems.

§ 156 – Elimination of Spreading June Nursing Home Payments into Next Fiscal Year.
Effective Date: June 21, 2011

This section eliminates the existing requirement that DSS pay nursing homes half of the June payment for Medicaid residents in June and the other half in July.

§ 158 – Adult Dental Services.
Effective Date: July 1, 2011

This section makes clarifying changes to Section 81 of Public Act No. 11-44 (summarized above) concerning the availability under Medicaid of nonemergency dental services for individuals twenty-one years of age and older.

II. SPECIFIC ACTS OF INTEREST

PUBLIC ACT 11-32. AN ACT REQUIRING HEALTH CARE PROVIDERS TO DISPLAY PHOTOGRAPHIC IDENTIFICATION BADGES DURING WORK HOURS.
Effective Date: October 1, 2011

This Act requires any person employed by or acting on behalf of a health care facility or institution — to include hospitals, nursing homes, rest homes, home health care agencies, homemaker-home health aide agencies, and assisted living services agencies — to wear a photo ID during work hours if they provide direct patient care. The photo ID must contain the name of the health care facility or institution, the individual health care provider's name and the type of license that he or she holds at the facility or institution.

The Act also requires all health care facilities and institutions, in consultation with the Department of Public Health ("DPH"), to develop policies and procedures concerning the badge size, content and format, and any necessary exemptions to ensure the health and safety of patients and health care providers.

PUBLIC ACT 11-40. AN ACT CONCERNING THE ADMINISTRATION OF PERIPHERALLY-INSERTED CENTRAL CATHETERS IN LONG-TERM CARE SETTINGS.
Effective Date: October 1, 2011

This Act permits an intravenous ("IV") therapy nurse to administer a peripherally-inserted central catheter to a resident of a chronic and convalescent nursing home or a rest home with nursing supervision. "IV therapy nurse" is defined as a registered nurse, qualified by education and training, who has demonstrated proficiency in the theoretical and clinical aspects of IV therapy. DPH must adopt implementing regulations.

PUBLIC ACT 11-76. AN ACT CONCERING PATIENT ACCESS AND CONTROL OVER MEDICAL TEST RESULTS.
Effective Date: October 1, 2011

This Act requires a clinical laboratory, upon the request of a patient or a provider who orders medical tests on behalf of a patient, to provide the patient's test results to any other treating provider for the purposes of diagnosis, treatment or prognosis of the patient. The term "provider" in the Act presumably refers to those individual practitioners specified in Conn. Gen. Stat. § 20-7b.

The Act also permits the use of a single authorization by a provider to allow a clinical laboratory or other entity performing medical testing to give the test results directly to the patient when the provider requests that his or her patient submit to repeated medical testing at regular intervals over a specified period of time for purposes of ascertaining a diagnosis, prognosis or recommended course of treatment for the patient. The Act requires the Commissioner of Public Health to adopt implementing regulations. Section 79 of Public Act No. 11-242 (summarized below) makes minor technical changes to this Act.

PUBLIC ACT 11-224. AN ACT CONCERNING INVESTIGATIONS BY PROTECTIVE SERVICES FOR THE ELDERLY.
Effective Date: October 1, 2011

Under current law, the Commissioner of Social Services is required to investigate claims of elder abuse. Such investigation must include an interview alone with an alleged victim, with two exceptions: (1) if the alleged victim refuses to consent to the interview, or (2) if the Commissioner determines that the interview is not in the best interest of the alleged victim. This Act adds a third exception: the Commissioner may not interview a victim of alleged elder abuse alone if a physician who examined the alleged victim within the prior thirty days provides a letter indicating that an interview with the alleged victim alone is medically contraindicated.

The Act also expands liability for making a fraudulent or malicious report, or providing false testimony, in a judicial or administrative proceeding regarding the abuse, neglect, exploitation or abandonment of an elderly person, making it a Class A misdemeanor.

PUBLIC ACT 11-230. AN ACT CONCERNING HOMEMAKER SERVICES AND HOMEMAKER-COMPANION AGENCIES.
Effective Date: January 1, 2012

This Act imposes consumer notice requirements on each homemaker or homemaker-companion "registry," defined as any person or entity engaged in the business of supplying or referring an individual to, or placing an individual with, a consumer to provide homemaker or companion services provided by such individual, when the individual providing such services is either (a) directly compensated, in whole or in part, by the consumer, or (b) treated, referred to or considered by such person or entity as an independent contractor.

The Act requires each registry to notify a consumer within seven days of providing a referral or placement, that the consumer may be considered the employer of the homemaker or companion and thus responsible for withholding applicable taxes or making other payments. The notice must:

- be written in plain language;

- include a statement identifying the registry as an employer, joint employer, leasing employer or non-employer, as applicable, along with a statement advising the consumer that he or she may be considered an employer under law and, if that is the case, the consumer may be responsible for the payment of federal and state taxes, Social Security, overtime and minimum wage, unemployment, workers' compensation insurance payments and any other applicable payment required under state or federal law; and

- also include a statement that the consumer should consult a tax professional if he or she is uncertain about his or her responsibility for the payment of such taxes or payments.

The Commissioner of Consumer Protection may revoke, suspend, or refuse to issue or renew the certificate of registration of, place on probation, or issue a letter of reprimand to, any homemaker-companion agency acting as a registry that fails to comply with the notice requirement.

PUBLIC ACT 11-233. AN ACT CONCERNING MISCELLANEOUS PROVISIONS INCLUDING NURSING HOME CLOSURES, STAFFING AT THE POLICE OFFICERS STANDARDS AND TRAINING COUNCIL, THE REPEAL OF PROVISIONS CONCERNING THE DIVISION OF SPECIAL REVENUE, HIGHWAY REST AREAS AND AN EXEMPTION TO THE ELECTRIC GENERATION TAX.

§ 1 – Exceptions to Nursing Home Waiting List Admissions.
Effective Date: October 1, 2011[1]

Section 1 of this Act modifies the nursing home wait list law to provide that a nursing facility, regardless of waiting list order, may admit an applicant for admission who seeks to transfer from a nursing facility in which the resident was placed following the closure of the nursing facility in which the applicant previously resided or, in the case of a nursing home placed in receivership, the anticipated closure of the nursing facility where the applicant previously resided, provided:

- the transfer occurs not later than sixty days following the date on which the applicant was transferred from the nursing home where he or she previously resided, and

- the applicant submitted an application to the nursing facility to which he or she seeks admission at the time of this initial transfer.

Section 52 of Public Act No. 11-242 (summarized below) makes technical changes to this Act.

PUBLIC ACT 11-236. AN ACT CONCERNING THE TRANSFER AND DISCHARGE OF NURSING FACILITY RESIDENTS AND AUDITS OF CERTAIN LONG-TERM CARE FACILITIES.
Effective Dates: As noted

[1] As amended by § 52 of Public Act No. 11-242.

§§ 1-4 – Transfer and Discharge of Nursing Home Residents
Effective Date: July 13, 2011

This Act makes several changes to the involuntary transfer/discharge and bed hold requirements applicable to nursing facilities. These changes include, for example, expansion of time frames for resident appeals of transfers/discharges, establishment of a consultative process for readmission from the hospital and a resident right to appeal facility refusals to readmit. A complete summary of these changes is available at http://www.canpfa.org/mc/page.do?sitePageId=94331&orgId=canpa.

§ 5 – Exemption from Existing Audit Provisions.
Effective Date: July 1, 2011

This section exempts nursing homes, chronic disease hospitals associated with a nursing home, residential care homes, and rest homes with nursing supervision from Conn. Gen. Stat. § 17b-99, the statute that governs the procedures by which the Commissioner of Social Services must conduct Medicaid audits of providers.

§ 6 – Audit of Long-Term Care Facilities.
Effective Date: July 13, 2011

This section establishes many of the same audit procedures set forth in Conn. Gen. Stat. § 17b-99 in a separate provision applicable to nursing homes, chronic disease hospitals associated with a nursing home, residential care homes, and rest homes with nursing supervision.

Notice. The Commissioner is required to provide written notice to any such facility at least thirty days before an audit begins, except in instances where the Commissioner makes a good faith determination that (1) a service recipient's health or safety is at risk, or (2) the facility is engaging in vendor fraud as defined in Conn. Gen. Stat. § 53a-290.

Clerical Errors, Extrapolations, and Discrepancies. This section provides that any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, in any record or document produced for an audit may not, without more, constitute a willful violation of the Medicaid rules unless proof of intent to commit fraud or otherwise violate Medicaid rules is established. This section also prohibits findings of overpayment or underpayment based on extrapolated projections unless (1) there is a sustained or high level of payment error involving the facility, (2) documented educational intervention has failed to correct the level of payment error, or (3) the aggregate value of the claims exceeds $150,000 annually. A facility must be given at least thirty days to provide documentation as it relates to a discrepancy discovered during an audit.

Audit Reports. The Act requires the Commissioner to provide a facility with a preliminary written audit report within sixty days of the audit's conclusion. In addition, the Commissioner must hold an exit conference with the facility to discuss the report. Within sixty days thereafter,

the Commissioner must provide the facility with a final written audit report unless a later date is agreed to or there are other referrals or pending investigations concerning the facility.

Appeals. Any facility receiving a final report may request a rehearing to be held by the Commissioner (or his or her designee) by providing a detailed description of all contested issues within ninety days of the Commissioner's final report. The rehearing must be held within thirty days of the facility filing this written description. The Commissioner must then issue a final decision within sixty days of the close of evidence or the date on which final briefs are filed. Any unresolved items at the rehearing must be submitted for binding arbitration to a three-member board consisting of one facility appointee, one Commissioner appointee, and one Chief Court Administrator appointee (from among the Superior Court's retired judges).

Penalties for False Information. The Act provides for the suspension of payments to a facility that submits false or misleading fiscal information or data to the Commissioner. In addition, any person or organization that knowingly makes or causes to make false or misleading statements regarding fiscal information or data on forms approved by the Commissioner is guilty of a Class D felony.

Investigative Authority. The Commissioner and his or her agents may conduct investigations, administer oaths, take testimony, subpoena witnesses, and require production of relevant documents. If any person disobeys the process, the Commissioner may apply to the Superior Court (in Hartford or local to that person) to compel such person's compliance.

PUBLIC ACT 11-242. AN ACT CONCERNING VARIOUS REVISIONS TO PUBLIC HEALTH RELATED STATUTES.
Effective Dates: As noted

§ 1 – Health Practitioner Discipline.
Effective Date: July 1, 2011

This section permits DPH to take disciplinary action against a practitioner's or permittee's license if a practitioner or permittee was subject to professional disciplinary action outside of Connecticut similar to that which can be taken within the State. The board, commission or DPH may rely on the findings and conclusions made by the out-of-state agency in taking disciplinary action.

§ 16 – Licensure Fee for Child Day Care Centers.
Effective Date: October 1, 2011

This section clarifies that the child day care center licensure fee must accompany an initial licensure or renewal application or DPH cannot grant or renew the license.

§§ 24-25 – Certificate of Need Filing Deadline.
Effective Date: October, 2011

Current law requires an applicant for a CON to publish notice in a newspaper at least twenty days prior to filing the CON application with the Office of Health Care Access ("OHCA") division of DPH. Section 25 of this Act requires that a CON application be filed within ninety days after publishing the newspaper notice.

Sections 24 and 25 make other minor and technical changes to the CON statutes.

§ 33 – Licensed Practical Nurses.
Effective Date: From passage

This section provides that a licensed practical nurse may carry out the orders of a physician assistant, podiatrist, or optometrist (as well as a physician or dentist as under prior law) under the direction of a registered nurse.

§ 38 – Freedom of Information.
Effective Date: October 1, 2011

This section exempts from disclosure under the Connecticut Freedom of Information Act all records obtained during an inspection, investigation, examination, or audit of a health care institution that are confidential pursuant to a contract between DPH and the U.S. Department of Health and Human Services related to the Medicare or Medicaid programs. Health care institutions affected by this provision include, but are not limited to, nursing homes, residential care homes, rest homes with nursing supervision, home health care agencies, homemaker-home health aide agencies, and assisted living services agencies.

§ 52 – Exceptions to Nursing Home Waiting List Requirements.
Effective Date: October 1, 2011

This section makes technical changes to Section 1 of Public Act No. 11-233 (summarized above).

§ 55 – Uniform State License for Community-Based Providers.
Effective Date: July 13, 2011

This section designates a small group to study the feasibility of establishing and implementing a uniform state licensing process for community-based providers.

§ 56 – Residential Care Homes.
Effective Date: July 1, 2011

This section contains provisions that are helpful to residential care homes. First, this section permits a residential care home collocated with a chronic and convalescent nursing home or a rest home with nursing supervision, to request permission from DPH to use shared personnel to meet the requirements of § 19-13-D6(j) of the Public Health Code pertaining to attendants in residence from 10:00 p.m. to 7:00 a.m.

Second, this section requires a residential care home to maintain the temperature in resident rooms and all other areas used by residents at a minimum of seventy-one degrees Fahrenheit, reduced from seventy-five degrees Fahrenheit.

Third, this section removes the following existing requirements: (1) that a person seeking a license to operate a residential care home supply DPH with a certificate of physical and mental health, and (2) that DPH approve the scheduling of regular meals and snacks in residential care homes. The Commissioner of Public Health must amend the Public Health Code to reflect the requirements of this section.

This section also requires a residential care home to ensure that no more than fourteen hours pass between a resident's evening meal and breakfast, unless substantial bedtime nourishment is offered.

§ 74 – Committee on Patient Privacy and Security.
Effective Date: July 1, 2011

This section requires the board of directors of the Health Information Technology Exchange of Connecticut to establish an advisory committee on patient privacy and security. This committee will monitor developments in federal law concerning patient privacy and security relating to health information technology and will report to the board on national and regional trends, federal policies, and guidance in this area.

§ 76 – Additional Powers of DPH Concerning Child Day Care Centers.
Effective Date: October 1, 2011

This section permits DPH to administer oaths, issue subpoenas, compel testimony, and order the production of books, records, and documents in any investigation concerning an application, reinstallment or renewal of a license for a child day care center.

§ 79 – Patient Access and Control over Medical Testing Results.
Effective Date: October 1, 2011

This section makes technical changes to Public Act No. 11-76 (summarized above).

§§ 83-84 – Strategic Plan for Long-Term Care Rebalancing.
Effective Date: July 1, 2011

In 2011, Connecticut received a federal rebalancing grant through the Money Follows the Person program, to cover in part the development of a statewide rebalancing strategic plan. These sections outline the State's strategic planning initiative and reflect some important concepts that CANPFA advocated for as part of its "One Solution at a Time" strategy. Section 83 requires the Commissioner of Social Services to develop a strategic plan to rebalance Medicaid long-term care supports and services, including, but not limited to, those provided in home, community-based and institutional settings. The Commissioner must involve home, community-based, and institutional providers in the development of the strategic plan, and must consider the following topics in developing the plan:

- regional trends concerning the state's aging population;
- trends in the demand for home, community-based and institutional services;
- gaps in the provision of home and community-based services which prevent community placements;
- gaps in the provision of institutional care;
- the quality of care provided by home, community-based and institutional providers;
- the condition of institutional buildings;

- the State's regional supply of institutional beds;

- the current rate structure applicable to home, community-based and institutional services;

- the methods of implementing adjustments to the bed capacity of individual nursing facilities; and

- a review of the provisions of Conn. Gen. Stat. § 17b-354(a) as amended by this Act.

To carry out the plan, the Commissioner may contract with nursing facilities as well as home and community-based providers. The Commissioner may revise a facility's rate to effectuate the plan and may fund strategic plan initiatives through federal grants from Money Follows the Person or the State Balancing Initiatives Payments program.

Section 83 permits the Commissioner of Public Health or a designee to waive provisions in the Public Health Code concerning nursing homes, residential care homes, and assisted living services agencies if doing so is (1) necessary for a regulated provider to carry out the strategic plan, and (2) the Commissioner or designee concludes that such a waiver would not endanger the provider's residents' or clients' health or safety. The Commissioner or designee may impose conditions on such a waiver to ensure as much and may revoke a waiver on a finding of health or safety being jeopardized.

Section 84 permits DSS to accept or approve requests for additional nursing home beds, or to modify the capital cost of a prior approval, where the request is for Medicaid certified beds relocated from one facility to another to meet priority needs identified in the strategic plan.

§ 90 – Background Check Program for Long-Term Care Facilities.
Effective Date: January 1, 2012

In 2010, DPH received a federal grant under PPACA to design a comprehensive background check program for long-term care facilities. This section provides for implementation of the grant and requires that DPH, on or before July 1, 2012, create and implement a criminal history and patient abuse background check program for long-term care facilities including nursing homes, home health care agencies, assisted living services agencies, and agencies licensed to provide hospice care. A "background search" is defined as:

- Review of the registry of nurse's aides maintained by DPH,

- Checks of state and national criminal history records, and

- A review of any other registry specified by DPH.

Prior to offering employment to, or entering into a contract with, any individual who will have direct access to patients, a long-term care facility must require the individual to submit to a

background check, as prescribed by DPH. Compliance will not be required where the individual can demonstrate having submitted to and passed a background check within the prior three years.

Under this section, no long-term care facility may employ, contract with, or allow to volunteer, any individual required to submit to a background check if it receives notice from DPH that this individual has a disqualifying offense and was not granted a waiver.

DPH must review reports resulting from background checks and, if a report indicates that an individual has a disqualifying offense, must notify the individual and the facility and provide the individual with the opportunity to request a waiver. A waiver may be granted on the basis of mitigating circumstances. A "disqualifying offense" means:

- Conviction of any crime under 42 U.S.C. § 1320a-7(a), including:
    - A criminal offense related to the delivery of an item or service under a federal or state health care program;
    - Patient abuse;
    - Health care fraud; or
    - A felony related to a controlled substance, or
- A substantial finding of neglect, abuse, or misappropriation of property by a state or federal agency pursuant to an investigation of allegations of resident neglect and abuse and misappropriation of resident property under 42 U.S.C. § 1395i-3(g)(1)(C) or 42 U.S.C. § 1396r(g)(1)(C).

DPH must adopt implementing regulations.

§§ 91-94 – Background Check Requirements for Homemaker-Companion Agencies.
Effective Date: January 1, 2012

These sections require an applicant for a certificate of registration as a homemaker-companion agency to submit to state and national criminal history records checks, in addition to existing application requirements. Further, prior to offering employment to, or entering into a contract with, any individual, a homemaker-companion agency must require the individual to submit to a "comprehensive background check," and must retain a paper or electronic copy of any materials obtained during the check.

A "comprehensive background check" is defined as a background investigation of a prospective employee or contractor by a homemaker-companion agency, including:

- review of any application materials completed by the prospective employee;
- an in-person interview of the prospective employee;

- verification of the prospective employee's Social Security Number;
- verification that any license required is in good standing;
- check of the registry of sexual offenders;
- check of current state records of criminal convictions;
- check of records of criminal convictions of any other state in which the prospective employee resided in the prior three years; and
- review of any other information the agency deems necessary.

The Commissioner of Consumer Protection may revoke, suspend, or refuse to issue or renew a certificate of registration as a homemaker-companion agency, place an agency on probation, or issue a letter of reprimand for failure to comply with the background check requirements.

§ 95 – Background Check Requirements for Home Health Care Agencies.
Effective Date: January 1, 2012

Under this section, prior to offering employment to, or entering into a contract with, any individual, a home health care agency must require the individual to submit to a comprehensive background check. For purposes of this section, "comprehensive background check" includes all the elements of a comprehensive background check for homemaker-companion agencies (listed above) and additionally includes disclosure of any decision by a licensing agency imposing disciplinary action in or outside of the United States.

These requirements will be replaced by DPH's implementation of the criminal history and patient abuse background search program for home health agencies, in accordance with Section 90 of this Act. Thus, these background check requirements are valid only until the date the Commissioner of Public Health publishes notice in the Connecticut Law Journal of DPH's implementation of this program.

PUBLIC ACT 11-183. AN ACT REQUIRING CERTIFICATE OF NEED APPROVAL FOR THE TERMINATION OF INPATIENT AND OUTPATIENT SERVICES BY A HOSPITAL.
Effective Date: July 13, 2011

This Act requires any hospital, including a chronic disease hospital, seeking to terminate current inpatient or outpatient services to file a CON application with the OHCA division of DPH.

III. ACTS RELATING TO GOVERNMENT ASSISTANCE PROGRAMS

PUBLIC ACT 11-25. AN ACT CONCERNING THE LEGISLATIVE COMMISSIONER'S RECOMMENDATIONS FOR TECHNICAL REVISIONS TO THE HUMAN SERVICES STATUTES.

§ 10 – Preferred Drug List.
Effective Date: October 1, 2011

This section permits DSS to adopt a preferred drug list for use in the Medicaid and ConnPACE programs, in consultation with the Pharmaceutical and Therapeutics Committee.

PUBLIC ACT 11-176. AN ACT CONCERNING THE DETERMINATION OF UNDUE HARDSHIP FOR PURPOSES OF MEDICAID ELIGIBILITY AND DISABILITY DETERMINATIONS FOR BENEFICIARIES OF A SPECIAL NEEDS TRUST.
Effective Dates: As noted

This Act establishes new and codifies existing requirements concerning the imposition of a penalty period when an applicant for Medicaid benefits has transferred assets for less than fair market value within five years of applying for Medicaid.

§ 1 – Penalty Period and Undue Hardship Exception.
Effective Date: July 1, 2011

This section requires the Commissioner to impose a penalty period if:

- the applicant transferred or assigned assets to deliberately impoverish himself or herself in order to obtain or maintain eligibility for Medicaid, or

- the transfer or assignment of assets was made by the applicant's legal representative or the joint owner of the assets.

However, the Commissioner may waive the penalty period if:

- the applicant suffers from dementia or other cognitive impairment and cannot explain the transfer of assignment of assets;

- the applicant suffered from dementia or other cognitive impairment at the time the transfer or assignment of assets was made;

- the applicant was exploited into making the transfer or assignment of assets due to dementia or other cognitive impairment; or

- the applicant's legal representative or the record owner of a jointly held asset made the transfer or assignment of assets without the applicant's authorization.

Moreover, the Commissioner may <u>not</u> impose a penalty period if doing so would create an "undue hardship." The Act provides that an "undue hardship" exists when:

- the applicant's life or health would be endangered by the deprivation of medical care, or the applicant would be deprived of food, clothing, shelter or other necessities of life;

- the applicant would otherwise be eligible for Medicaid, but for the imposition of the penalty period;

- the applicant (i) is receiving long-term care services, and the provider of such services has notified the applicant that the provider intends to discharge or discontinue providing long-term care services to the applicant due to nonpayment, or (ii) is not receiving long-term care services at the time the penalty period is imposed, and a provider of long-term care services has refused to provide such services to the applicant due to the penalty period; and

- no other person or organization is willing and able to provide long-term care services to the applicant.

§ 2 – Notice, Contest and Determination of Penalty Period.
Effective Date: July 1, 2011

The Commissioner of Social Services is required to notify an applicant against whom the Commissioner intends to impose a penalty period for a transfer or assignment of assets. The notice must inform the applicant that he or she may contest the imposition of a penalty period by:

- filing a claim of undue hardship, or

- providing evidence to rebut the presumption (outlined in Conn. Gen. Stat. § 17b-261a(a)) that any transfer or assignment of assets resulting in the imposition of a penalty period was made with the intent, on the part of the transferor or the transferee, to enable the transferor to obtain or maintain Medicaid eligibility.

An applicant has fifteen days after the postmark of the notice to contest the imposition of a penalty period, and may request an extension to the time to file a claim. The Commissioner must grant one extension, and may grant additional extensions if reasonable. An applicant who fails to file a claim of undue hardship is not barred from making a claim of undue hardship at an administrative hearing.

If an applicant contests the imposition of a penalty period, the Commissioner, within ten days of when the claim was filed, must provide an interim decision notice to the applicant, which must indicate the Commissioner's decision to either reverse or uphold the imposition of the penalty period. If the latter, the Commissioner must also indicate the expected beginning and end dates of the penalty period. The Commissioner must provide a final decision notice to the applicant when the Commissioner has determined the applicant's eligibility for Medicaid, which must include a statement confirming the Commissioner's determination and information about the applicant's appeal rights.

If, during a penalty period, an applicant receives notice from a long-term care provider that the provider intends to discharge the applicant, discontinue providing long-term care services to the applicant, or refuses to provide such services to the applicant because of the imposition of a

penalty period, the applicant may file a claim of undue hardship with the Commissioner within sixty days after receiving such notice from the provider. The Commissioner, within ten days of receiving the applicant's undue hardship claim, must provide the applicant with a final decision notice informing the applicant of whether the penalty period will be waived due to a finding of undue hardship.

The Act permits a nursing facility, on behalf of an applicant, to request an extension of time to claim undue hardship if:

- the applicant is receiving long-term care services in the facility,
- the applicant has no legal representative, and
- the nursing facility provides certification from a physician that the applicant is incapable of caring for himself or herself or incapable of managing his or her affairs.

In addition, the Act permits a nursing facility to file a claim of undue hardship and to represent the applicant with regard to the claim if the applicant or his or her legal representative so permits.

PUBLIC ACT 11-122. AN ACT CONCERNING A CLARIFICATION OF THE DEPARTMENT OF SOCIAL SERVICES REQUIREMENT TO GIVE NOTICE REGARDING REPAYMENT OF SERVICES.
Effective Date: July 1, 2011

By law, the Commissioner of Social Services must notify each Medicaid and State supplement program applicant, at the time of the application, of the provisions in Conn. Gen. Stat. §§ 17b-93 to 17b-97 concerning repayment to the State for benefits received. This Act modifies the procedures for notifying potential legally liable relatives of their repayment obligations. Specifically, the Act requires DSS to notify potential legally liable relatives at the time of the application; if a legally liable relative is not known to DSS until after the application is granted, it must notify within thirty days of when DSS learns of the relative.

IV. ACTS CONCERNING EMPLOYMENT AND BUSINESS RESPONSIBILITIES

PUBLIC ACT 11-12. AN ACT CONCERNING INCREASING PENALTIES FOR REPEAT VIOLATORS OF THE PERSONNEL FILES ACT.
Effective Date: October 1, 2011

This Act increases the fine for first-time violations of the Personnel Files Act from $300 to $500, and the fine for each subsequent violation related to the same employee from $600 to $1,000.

The Personnel Files Act (i) requires employers to provide employees with access to their personnel file and any medical records maintained by the employer, and (ii) prohibits the disclosure of such files and records without the employee's consent.

PUBLIC ACT 11-52. AN ACT MANDATING EMPLOYERS PROVIDE PAID SICK LEAVE TO EMPLOYEES.
Effective Date: January 1, 2012

This Act requires most employers with fifty or more employees in the State to provide paid sick leave annually to all "service workers." The Act defines "service worker" as an employee who is (i) paid by the hour, or not exempt from the Fair Labor Standards Act minimum wage and overtime compensation requirements, and (ii) primarily engaged in an occupation with one of sixty-eight occupation code numbers and titles under the federal Bureau of Labor Statistics Standard Occupational Classification system or any successor system. Among the sixty-eight occupation code numbers and titles listed in the Act are:

- 11-9110 Medical and Health Services Managers;
- 29-1070 Physician Assistants;
- 29-1140 Registered Nurses;
- 29-1150 Nurse Anesthetists;
- 29-2050 Health Practitioner Support Technologists and Technicians;
- 35-2020 Food Preparation Workers; and
- 43-6010 Secretaries and Administrative Assistants.

"Service worker" does not include day or temporary workers.

Paid sick leave under the Act must accrue:

- beginning January 1, 2010, or for a service worker hired after that date, beginning on the service worker's date of employment;
- at a rate of one hour for every forty hours worked; and
- in one-hour increments, up to a maximum of forty hours per calendar year, and may be carried over to the following calendar year (subject to the maximum of forty hours per calendar year).

A service worker is entitled to use accrued paid sick leave upon completion of 680 hours of work for the employer from January 1, 2012, if hired prior to that date or, if hired after January 1, 2012, upon completion of 680 hours of work for the employer from the date of hire; *and provided that* the service worker worked on average at least ten hours per week for the employer in the most recent calendar quarter.

An employer subject to the Act must pay for paid sick leave at a pay rate equal to the greater of (1) the service worker's normal hourly wage, or (2) the minimum wage rate in effect for the pay period during which the employee uses the paid sick leave, and must permit service workers to use accrued paid sick leave for the purposes specified in the Act. The Act also specifies when other paid leave (such as paid vacation, personal days, or paid time off) is deemed to comply with the Act's requirements.

The Act prohibits employers from retaliating or discriminating against an employee because the employee uses or requests to use paid sick leave or files a complaint with the Commissioner of Labor alleging a violation of the paid sick leave requirements. Upon receipt of a complaint alleging unlawful retaliation or discrimination, the Commissioner of Labor may hold a hearing and, if the employer is found to have retaliated or discriminated against the employee as prohibited by the Act, the employer may be liable for a civil penalty of up to $100 for each violation. In addition, the Commissioner may award the employee payment for used paid sick leave, rehiring or reinstatement to the employee's previous job, payment of back wages, and reestablishment of employee benefits to which the employee otherwise would have been eligible if not subject to the unlawful retaliation or discrimination. A party aggrieved by the Commissioner's decision may appeal to the Superior Court.

Finally, an employer must notify each service worker, at the time of hire, of:

- the entitlement to paid sick leave, the amount of sick leave provided, and the terms under which paid sick leave may be used;

- that employers are prohibited from retaliating against a service worker for using or requesting to use paid sick leave; and

- the service worker's right to file a complaint with the Commissioner of Labor alleging violations of the paid sick leave requirements.

An employer may comply with this notice requirement by displaying a poster in a conspicuous place, accessible to service workers, that contains the above information in both English and Spanish. The Act authorizes the Commissioner of Labor to promulgate regulations establishing additional notice requirements.

PUBLIC ACT 11-55. AN ACT CONCERNING DISCRIMINATION.
Effective Date: October 1, 2011

This Act prohibits discrimination on the basis of gender identity or expression in, among other things, employment, housing and public accommodations. The Act defines "gender identity or expression" as:

> a person's gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth, which gender-related identity can be shown by providing evidence including, but not limited to,

medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held, part of a person's core identity or not being asserted for an improper purpose.

Individuals are authorized to file discrimination complaints with the Commission on Human Rights and Opportunities ("CHRO"), and CHRO is required to investigate any complaints filed. The Act makes it a Class A misdemeanor punishable by imprisonment, a fine, or both to deprive an individual of any rights, privileges, or immunities secured or protected by state or federal law because of gender identity or expression.

The provisions of the Act prohibiting discrimination on the basis of gender identity or expression do not apply to religious entities regarding employment of individuals to work for them, or regarding matters of discipline, faith, internal organization, or ecclesiastical rules, customs, or laws that they have established.

PUBLIC ACT 11-223. AN ACT PREVENTING THE USE OF CREDIT SCORES BY CERTAIN EMPLOYERS IN HIRING DECISIONS.
Effective Date: October 1, 2011

This Act prohibits employers and their agents, representatives, or designees from requiring an employee's or prospective employee's consent to a request for a credit report as a condition of employment unless:

- the employer is a "financial institution" (as defined in the Act);
- the employer reasonably believes the employee committed a violation of the law related to the employee's job;
- the report is required by law; or
- the report is substantially related to the employee's current or potential job or the employer has a bona fide reason to request or use information in the credit report that is substantially job-related and is disclosed to the employee or prospective employee.

The Act permits any employee or perspective employee to file a complaint with the Commissioner of Labor alleging a violation of the prohibition; the Commissioner must investigate a complaint within thirty days after it is filed and, if the findings warrant, may hold a hearing. Violators may be liable for a $300 civil penalty per violation, and the Attorney General must initiate a lawsuit to recover penalties if the Commissioner of Labor so requests.

PUBLIC ACT 11-87. AN ACT EXTENDING THE LOOK-BACK PERIOD TO DETERMINE ELIGIBILITY FOR UNEMPLOYMENT COMPENSATION EXTENDED BENEFITS.
Effective Date: July 8, 2011

This Act increases the availability of unemployment extended benefits (for weeks 79-99 of unemployment) by lengthening, from two to three years, the look-back period that is used to determine when extended benefits are available. This extended look-back period will remain in effect until December 31, 2011, or as long as the federal government continues to allow the extension and provide full funding for it, whichever is longer.

PUBLIC ACT 11-175. AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS.
Effective Dates: As Noted

§ 1 – Workplace Violence Prevention and Response Plan.
Effective Date: July 1, 2011

This Act requires each health care employer, by October 1, 2011, to establish and convene an ongoing workplace safety committee to address issues related to the health and safety of health care employees. "Health care employer" is defined to include (but is not limited to) residential care homes, nursing homes, rest homes with nursing supervision, home health care agencies, homemaker-home health aide agencies, and assisted living services agencies, with fifty or more full or part-time employees. "Health care employee" is defined as any individual directly or indirectly employed by, or volunteering for, a health care employer, who is either (1) involved in direct patient care, or (2) has direct contact with the patient or patient's family when collecting or processing information or escorting or directing the patient or the patient's family on the health care employer's premises.

The workplace safety committee must meet at least quarterly and be composed of representatives from the administration; physician, nursing and other direct patient care staff; security personnel; and any other staff deemed appropriate by the employer. At least half of the committee members must be non-management employees, and the committee must select a chairperson from among its membership. Meeting minutes and records must be available to all employees.

On or after October 1, 2011, and annually thereafter, each health care employer must conduct a risk assessment of the factors that put any health care employee at risk for being a victim of workplace violence. By January 1, 2012, and on or before each January thereafter, each health care employer, in collaboration with the workplace safety committee, must develop and implement a written workplace violence prevention and response plan based on the findings of the annual risk assessment. In developing the plan, an employer may take into account any guidance on workplace violence issued by government agencies, including the federal Occupational Safety and Health Administration ("OSHA"), the Centers for Medicare and Medicaid Services ("CMS"), DPH, and the Department of Labor. The Act permits a health care employer to utilize existing policies, plans or procedures to satisfy the prevention and response plan requirement if, after undertaking the risk assessment, the health care employer, in consultation with the workplace safety committee, determines that such existing policies, plans or procedures are sufficient.

The Act additionally requires a health care employer, to the extent practicable, to adjust patient care assignments so that no employee who requests such an adjustment is required to treat or

provide services to a patient who the employer knows to have intentionally physically abused or threatened the employee. However, patient behavior that is a direct manifestation of the patient's condition or disability is not considered intentional physical abuse or threatening of an employee for purposes of the Act. If it is not practicable to adjust the employee's patient care assignment, the employee may request that a second health care employee be present when treating a patient that has physically abused or threatened the requesting employee.

§ 2 –Records.
Effective Date: October 1, 2011

Health care employers must maintain records of incidents of workplace violence, to include the specific area of the premises where the incident occurred, and must report to DPH upon request the number and location of such incidents.

§ 3 – Reporting to Local Law Enforcement.
Effective Date: October 1, 2011

This section requires a health care employer to report to local law enforcement no later than twenty-four hours after the occurrence of any act which may constitute assault or a related offense against a health care employee acting in the performance of his or her duties. The report must include the names and addresses of all persons involved in the incident. The reporting requirement does not apply to acts committed by a person with a disability (limited to intellectual disability, physical disability, or mental disability, as those terms are defined in Conn. Gen. Stat. § 46a-51), whose conduct is a clear and direct manifestation of the disability.

§ 4 – Assault of Health Care Personnel.
Effective Date: October 1, 2011

This section adds health care personnel to the list of individuals the assault of whom is a Class C felony. This section also specifies that in any prosecution involving assault of a health care employee, it shall be a defense that the defendant is a person with a disability (as defined above) and the defendant's conduct was a clear and direct manifestation of the disability.

PUBLIC ACT 11-36. AN ACT PRESERVING GOOD CAUSE FOR LATE FILING OF CERTAIN UNEMPLOYMENT COMPENSATION APPEALS.
Effective Date: October 1, 2011

By law, claimants for unemployment compensation have twenty-one days to appeal a determination that they received more benefits than they were entitled to, received benefits through fraud, or made a false claim for benefits.

This Act provides for an extension of the 21-day appeal deadline if the claimant can show "good cause," as defined in Department of Labor regulations, for not filing the appeal within the 21-day timeframe. The Act further provides that an appeal filed by mail and not received within the 21-day period will nevertheless be considered timely filed if it bears a legible United States Postal

Service postmark indicating that it was placed in the possession of postal authorities for delivery within such 21-day period.

V. ACTS CONCERNING HEALTH INSURANCE

PUBLIC ACT 11-19. AN ACT CONCERNING THE LEGISLATIVE COMMISSIONER'S RECOMMENDATIONS FOR TECHNICAL REVISIONS AND MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.

§§ 41-44 – Home Health Care Services.
Effective Date: October 1, 2011

These sections broaden the applicability of various health insurance benefits required by law by requiring certain individual and group health care insurance policies amended or continued in the State to include coverage for home health care services. Under current law, this requirement applies only to policies delivered, issued for delivery, or renewed in the State.

PUBLIC ACT 11-169. AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT.
Effective Date: January 1, 2012

This Act prohibits certain individual and group health insurance policies from requiring that an insured use an alternative brand name prescription or over the counter drug prior to using the specific brand name prescription drug prescribed by a licensed physician for pain treatment. Such insurance policies may, however, require an insured to use a therapeutically equivalent generic drug prior to using the specific brand name prescription drug prescribed by a licensed physician for pain treatment.

PUBLIC ACT 11-53. AN ACT ESTABLISHING A STATE HEALTH INSURANCE EXCHANGE.
Effective Date: July 1, 2011

This Act creates the Connecticut Health Insurance Exchange, a quasi-public agency intended to meet the requirements of PPACA, and outlines the purposes and responsibilities of the Exchange, which include operating an online marketplace where individuals and small employers (those with fifty or less employees) can compare and purchase health insurance plans.

§§ 7-8 – Qualified Health Plans.

Sections seven and eight require the Exchange to make qualified health plans available to qualified individuals and employers by January 1, 2014, and prohibit the Exchange from offering non-qualified health plans. A "qualified health plan" is defined as a health benefit plan meeting the criteria of PPACA and the Act. A "qualified individual" is a Connecticut resident who is a U.S. citizen, U.S. national or lawful resident, and is not incarcerated (excluding pretrial inmates). A "qualified employer" is a small employer (with up to fifty employees) with its principal place of business in Connecticut.

PUBLIC ACT 11-58. AN ACT CONCERNING HEALTHCARE REFORM.
Effective Date: July 1, 2011

§§ 1, 2, & 4 – Opening State Employee Plan to Others.

This Act requires the Comptroller to offer coverage under the self-insured state employee health plan to employees and retirees of nonstate public employers and nonprofit employers. "Nonprofit employer" is defined as:

- A corporation exempt from federal income tax under § 501 of the Internal Revenue Code (the "Code"), that either:
    - has a purchase service contract with a state agency for the purpose of providing direct health and human services to agency clients, as defined under Conn. Gen. Stat. § 4-70b, or
    - receives fifty percent or more of its gross annual revenue from any combination of grants or funding from the State, the federal government, or a municipality, or
- An organization that is tax exempt under § 501(c)(5) of the Code (labor, agricultural, or horticultural organizations).

Under these sections, the Comptroller must begin offering such coverage to nonprofit employers no later than January 1, 2013. Thereafter, open enrollment for nonprofit employees will be for coverage periods beginning January first and July first. Nonprofit employers electing to offer this coverage must participate in the plan for not less than two-year intervals, and may apply for renewal before the expiration of each interval. The Comptroller must develop procedures for application, renewal, and withdrawal.

§ 3 – Employer Group Participation.

This section outlines two separate processes by which the Comptroller must determine whether to accept an employer's application for coverage. Which process applies depends upon whether an application covers some or all of an employer's employees.

If the application covers all employees, the Comptroller must accept the application for the next enrollment period and give the employer written notice of the date when coverage begins.

If the application covers only some employees, or indicates that the employer will provide its employees the choice of other health plans as well as the state health plan, the Comptroller must forward the application to a health care actuary within five days of receipt. The actuary must determine within sixty days of receipt thereof whether acceptance of the application would shift a disproportionate part of the employer group's medical risk to the state plan. If so, the actuary must send the Comptroller a disproportionate risk shift certification, and the Comptroller must

deny the application, giving both the employer and the Heath Care Cost Containment Committee written notice citing reasons for the denial.

§ 5 – Premiums and Fees.

Under this section, each employer must pay on a monthly basis the amount determined by the Comptroller for coverage of its employees and retirees. After at least ten days advance notice, the Comptroller may terminate a nonprofit employer's participation in the plan for nonpayment. An employer may avoid termination by paying in full before the given date of termination.

VI. ACTS CONCERNING HOUSING

PUBLIC ACT 11-168. AN ACT CONCERNING CHANGES TO CERTAIN HOUSING STATUTES.
Effective Date: July 13, 2011

This Act modifies several Department of Economic and Community Development ("DECD") housing programs. Specifically, the Act:

- makes "housing partnerships" eligible for DECD grants or loans to build and operate congregate housing and hire resident service coordinators;
- expands the use of funds from the DECD-administered Housing Trust Fund Program;
- authorizes the Housing Trust Fund to accept local, state, or federal funds if not otherwise prohibited by federal or state law and allows DECD to deposit these funds in the trust fund if the money is received for purposes that do not conflict with those of the trust fund;
- requires DECD's database of handicapped accessible and adaptable housing to contain certain information specified in existing law and the Act only when it is practicable; and
- changes various requirements for the State-Assisted Housing Sustainability Fund.

PUBLIC ACT 11-124. AN ACT CONCERNING THE STATE'S CONSOLIDATED PLAN FOR HOUSING AND COMMUNITY DEVELOPMENT.
Effective Date: October 1, 2011

This Act repeals the requirements that the (1) DECD and the Connecticut Housing Finance Authority ("CHFA") prepare a long-range state housing plan every five years and submit it to the General Assembly and (2) Commissioner of Economic and Community Development annually supplement the five-year plan with an action plan that assesses whether DECD and CHFA are meeting their goals. The Act replaces the long-range plan with the Consolidated Plan for Housing and Community Development that DECD currently prepares every five years for the U.S. Department of Housing and Urban Development ("HUD") in order to qualify for federal housing program funding. The HUD-required consolidated housing plan covers the Community

Development Block Grant Program, the Emergency Shelter Grants, the HOME Investment Partnership program, and the Housing Opportunities for Persons with AIDS program.

PUBLIC ACT 11-203. AN ACT CONCERNING THE SELECTION OF TENANT COMMISSIONERS.
Effective Date: October 1, 2011

This Act makes several changes to Conn. Gen. Stat. § 8-41 governing municipal housing authority boards of commissioners and tenant commissioners. For example, the Act:

- provides a mechanism for housing authority tenants to petition for a tenant commissioner election;

- requires a housing authority to (i) notify tenants and any existing tenant organizations no later than sixty days before a tenant commissioner's appointment, or term expiration, whichever is sooner, and (ii) include with the notice information on how tenants may petition for an election;

- expands the types of tenants eligible to participate in a tenant commissioner election or serve on the housing authority's board of commissioners; and

- allows tenant commissioners to vote to establish or revise rents.

PUBIC ACT 11-57. AN ACT AUTHORIZING BONDS OF THE STATE FOR CAPITAL IMPROVEMENTS AUTHORIZING SPECIAL TAX OBLIGATION BONDS OF THE STATE FOR TRANSPORTATION PURPOSES AND AUTHORIZING STATE GRANT COMMITMENTS FOR SCHOOL BUILDING PROJECTS.
Effective Dates: As noted

§§ 9 & 28 – Bond Authorization for Housing Development and Rehabilitation.
Effective Date: Section 9 is effective July 1, 2011. Section 28 is effective July 1, 2012.

These sections authorize state general obligation ("GO") bonding in the amount of $25 million per year for fiscal years 2012 and 2013 for housing development and rehabilitation, including (among other things) congregate and elderly housing, emergency repair assistance for senior citizens, and acquisition and related rehabilitation, including loan guaranties for private developers, of rental housing for the elderly.

§ 32 – Bond Authorization for Senior Centers.
Effective Date: July 1, 2012

This section authorizes up to $10 million per year in GO bonds for fiscal years 2012 and 2013 for grants-in-aid for senior centers.

VII. MISCELLANEOUS ACTS OF INTEREST

PUBLIC ACT 11-209. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S OVERSIGHT RESPONSIBILITIES RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS.
Effective Date: July 1, 2011

This Act establishes a process for any person or entity acting on behalf of a health care profession seeking legislative action to establish or revise a new scope of practice in the following year's legislative session, to submit a written scope of practice request to be reviewed and evaluated by a committee appointed by the Commissioner of Public Health. The Act specifies the required content of such a request, the process for requesting an exemption from the standard request process, the responsibilities of DPH on receiving such a request, the process for interested parties to submit a written impact statement, the process of establishing the practice review committee, the committee's procedures for review and evaluation of the requests it receives, and the process for the committee to present its written findings to the joint standing committee of the General Assembly.

PUBLIC ACT 11-94. AN ACT CONCERNING SECURITY DEPOSITS.
Effective Date: January 1, 2012

This Act eliminates the requirement that a landlord pay a minimum 1.5% interest rate on residential security deposits. Effective January 1, 2012, landlords are required to pay interest on each security deposit received at a rate of not less than the average savings deposit interest rate

paid by insured commercial banks published in the Federal Reserve Board Bulletin of the prior year.

PUBLIC ACT 11-26. AN ACT PERMITTING INQUIRY ACCESS TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES' ABUSE AND NEGLECT REGISTRY FOR CHARITABLE ORGANIZATIONS WHICH RECRUIT VOLUNTEERS TO WORK WITH PERSONS WITH INTELLECTUAL DISABILITIES.
Effective Date: June 3, 2011

By law, the Department of Developmental Services ("DDS") maintains a registry of individuals who have been terminated or separated from employment due to substantiated abuse or neglect of people with intellectual disabilities. Under prior law, access to the registry was limited to (1) authorized agencies, for the purpose of protective service determinations, (2) employers whose employees provide services to DDS clients, and (3) the Department of Children and Families ("DCF") and DMHAS to check whether a job applicant is listed there.

This Act requires DDS to also make information in the registry available to charitable organizations that recruit volunteers to work in support programs for persons with intellectual disability. This will allow charitable organizations to conduct background checks on such volunteers. Charitable organizations seeking access to the registry must first apply to and receive approval from DDS.

PUBIC ACT 11-102. AN ACT CONCERNING THE INVESTIGATION OF MISSING ADULT PERSONS REPORTS.
Effective Date: October 1, 2011

This Act requires state and local police to accept without delay any report of a missing adult person. "Adult person" is defined as an individual eighteen years of age or older. In addition, the police unit that investigates a missing adult person must, "with all practicable speed," enter relevant information about the case into the National Crime Information database and any other applicable federal database. The Act also requires the Police Officer Standards and Training Council to develop and implement a policy for accepting missing adult person reports.

PUBLIC ACT 11-137. AN ACT CONCERNING ADMINISTRATIVE HEARINGS UNDER THE MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM AND RETURN RECEIPTS FOR AGENCY NOTICES.
Effective Date: July 8, 2011

This Act requires the Commissioner of Social Services to (1) develop and implement a Medicaid health information technology plan in accordance with the American Recovery and Reinvestment Act of 2009 ("ARRA"), and (2) establish a Medicaid electronic health record incentive program to provide incentives for health care providers which adopt and meaningfully use electronic health records to improve patient health and healthcare delivery. "Health care providers" is broadly defined under ARRA, but right now the incentives are limited to hospitals and certain individual practitioners.

The Act also provides for health care provider appeals of adverse decisions under the Medicaid electronic health record incentive program.

PUBLIC ACT 11-34. AN ACT PERMITTING THE MAILING OF RAFFLE TICKETS AND THE USE OF COUPONS AS INCENTIVES TO PURCHASE RAFFLE TICKETS.
Effective Date: October 1, 2012

This Act allows charitable and certain other organizations conducting a raffle to promote the raffle by offering coupons to ticket buyers. "Coupon" is defined as a ticket, form, or document redeemable for merchandise, tangible personal property, services, or transportation on a common carrier, or for discounts on any of these. The Act also allows such organizations to mail raffle tickets to residents of a town that has adopted the Bazaar and Raffle Act, provided the phrase "no purchase necessary to enter the raffle" is printed on the tickets.

By law, charitable organizations may conduct raffles or bazaars only with a permit from the town in which the event will take place.

PUBLIC ACT 11-226. AN ACT ELIMINATING THE LIMIT ON TEACUP RAFFLE PRIZES AND AUTHORIZING GOLF BALL DROP RAFFLES.
Effective Date: October 1, 2011

This Act eliminates the $250 prize limit on teacup raffles, thereby allowing prizes of unlimited value. The Act also allows qualified organizations to conduct golf ball drop raffles in which cash and other prizes are awarded.