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

2012 REGULAR SESSION AND 2012 JUNE SPECIAL SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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AAA	American Arbitration Association
AAP	Aid and Attendance Pension
ADA	Americans with Disabilities Act
ADRC	Aging and Disability Resource Center
AOPO	Association of Organ Procurement Organizations
APRN	Advanced Practice Registered Nurse
ASHSP	American Society of Health-System Pharmacists
BRF	Budget Reserve Fund
BRS	Bureau of Rehabilitative Services
CCP	Child Care Provider
CDC	Centers for Disease Control and Prevention
CHCPE	Connecticut Home Care Program for Elders
CHFA	Connecticut Housing Finance Authority
CON	Certificate of Need
ConnPACE	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled
DAS	Department of Administrative Services
DCF	Department of Children and Families
DCP	Department of Consumer Protection
DDS	Department of Developmental Services
DEA	The United States Drug Enforcement Administration

DECD	Department of Economic and Community Development
DEEP	Department of Energy and Environmental Protection
DMHAS	Department of Mental Health and Addiction Services
DMV	Department of Motor Vehicles
DOA	Department on Aging
DOC	Department of Correction
DOD	United States Department of Defense
DOE	Department of Education
DOH	Department of Housing
DOJ	The United States Department of Justice
DOL	Department of Labor
DPH	Department of Public Health
DRS	Department of Rehabilitation Services
DSS	Department of Social Services
DVA	Department of Veteran's Affairs
EMT	Emergency Medical Technician
FMLA	Family and Medical Leave Act
FQHC	Federally Qualified Health Center
FOIA	Freedom of Information Act
HITE	Health Information Technology Exchange of Connecticut
LPN	Licensed Practical Nurse

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OHCA	Office of Health Care Access
OHRI	Office of Health Reform and Innovation
OPM	Office of Policy and Management
OPTN	Organ Procurement and Transplantation Network
PA	Physician Assistant
PCA	Personal Care Attendant
PURA	Public Utilities Regulatory Authority
RN	Registered Nurse
SBC	State Bond Commission
VA	The United States Department of Veterans Affairs

I. SPECIFIC ACTS OF INTEREST

1. PUBLIC ACT 12-1 (SPECIAL SESSION). AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR BEGINNING JULY 1, 2012.
   Effective June 15, 2012, except as otherwise noted

§ 2—Dental Service for Adult Medicaid Recipients
Effective July 1, 2012

By law, all non-emergency dental services provided under dental programs sponsored by DSS are subject to prior authorization, except services for diagnosis, prevention, basic restoration procedures, and nonsurgical extractions. This section applies dental benefit limitations to all clients, regardless of the number of providers serving a specific client.

§§ 7 & 15—DSS Payments to Residential Care Homes
Effective July 1, 2012

Section 7 provides that the FY 2012 rates for residential care homes, community living arrangements, and community companion homes that receive the flat rate for residential services will remain in effect until June 30, 2013.

While the biennial state budget enacted in 2011 had placed a two-year freeze on residential care home rates (as confirmed by § 7), Section 15 removes that rate freeze for FY 2013, permitting DSS to provide a rate increase, within available appropriations. However, a facility that would have been issued a lower rate due to its interim rate status must be issued that lower rate. Although Section 15 does not address rebasing, the removal of the rate freeze allows DSS to rebase all of the residential care home rates using the cost reports for the period ending September 30, 2011. This rebasing will cause some residential care home rates to be lowered; however, residential care homes may appeal the new rates if they feel that the reduction is unwarranted.

§ 8—Veterans Required to Apply for Federal Aid Benefits
Effective July 1, 2012

This section requires veterans applying for or receiving assistance under the Medicaid program to apply for benefits through the VA or DOD.

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§§ 9 & 10—Expansion of Private Assisted Living Services Pilot
Effective July 1, 2012

DSS operates two pilot programs that help pay for individuals to receive assisted living services if they reside in a residential community, are ineligible to receive assisted living services under any other program, and are eligible for services under the Medicaid waiver portion of the Connecticut home-care program for the elderly. This section expands the total number of individuals who may be enrolled in the pilot program from 75 to 125.

§ 11—Medication Administration by Unlicensed Personnel
Effective July 1, 2012

This section permits an RN to delegate the administration of medications that are not administered by injection to homemaker-home health aides ("aides") who are certified for medication administration, unless the prescribing health care provider specifies that only a nurse may administer the medication.

This section requires DPH to adopt regulations that require that each home health care agency that serves clients requiring assistance with medication administration to:

i. Adopt practices that increase and encourage client choice, dignity, and independence;
ii. Establish policies and procedures to ensure that an RN may delegate allowed nursing care tasks, including medication administration, to an aide when the RN determines that it is in the patient's best interest and the aide is deemed competent to perform the task;
iii. Designate aides to obtain certification for medication administration; and
iv. Ensure that aides receive such certification.

These regulations must establish certification requirements for medication administration and the criteria that home health care agencies will use in determining which aides will obtain certification, education, and skill training requirements, including on-going requirements for certification. Education and skill training requirements must include an initial orientation and training in client rights, medication identification, personal care, nutrition and food safety, and health and safety in general.

This Act requires each home health care agency to ensure that by January 1, 2013 delegation of nursing care tasks in home care settings is allowed within such agency and that the agency has adopted policies for employing aides to perform these tasks.

This section prohibits an RN who delegates the medication administration task to an aide from being subject to disciplinary action or to a civil action based on the

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performance of the aide to whom the tasks were delegated, unless the aide is acting pursuant to specific instructions from the RN or the RN fails to leave instructions when the RN should have done so. Such an RN will not be subject to disciplinary action provided that the RN: (i) documented in the patient's care plan that the aide could properly and safely perform the medication administration, (ii) provided initial direction to the aide, and (iii) provided ongoing supervision of the aide, including the periodic assessment and evaluation of the patient's health and safety, related to the medication administration.

This section prohibits any person from coercing an RN into compromising patient safety by requiring the RN to delegate medication administration if the RN's assessment of the patient indicates a need for an RN to administer medication and identifies why the need cannot be safely met through using medication administration by an aide. An RN who has made a reasonable determination that delegation may compromise patient safety cannot be subject to any employer reprisal or disciplinary action for refusing to delegate or refusing to provide the required training for such delegation.

§ 12—Personal Care Assistants Permitted to Administer Medication
Effective July 1, 2012

This section provides that nothing in the Nurse Practice Act can be construed to prohibit a PCA employed by a registered homemaker-companion agency from administering medications to a competent adult who directs his or her own care and makes his or her own decisions pertaining to assessment, planning, and evaluation.

§ 13—Removal of Specific Prior Authorization Requirements
Effective July 1, 2012

By law, DSS must establish prior authorization procedures under the Medicaid program for many home health services. This section changes the requirements for prior authorization procedures by eliminating the provision requiring prior authorization for skilled nursing visits that exceed two weeks per year and home health aide visits that exceed fourteen hours per week. This section also eliminates the provision allowing providers to submit only one prior authorization request a month for a home health service for the same client.

§ 14—Medicaid Personal Care Assistant Waiver
Effective July 1, 2012

The Medicaid personal care assistance program offers services to adults with severe disabilities, age eighteen and older, to help such individuals perform activities of daily living. This section requires that program participants, upon attaining sixty-five years of age, must be transitioned to the Connecticut home-care program for the

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elderly.

§ 16—Nursing Home Reimbursement
Effective, January 1, 2013

The Act provides for the limited reinstatement of fair rent by allowing DSS to provide pro rata fair rent increases in FY 2013 for facilities that have undergone material changes in circumstances related to fair rent additions placed in service in cost report year ending September 30, 2008 through September 30, 2011 and not otherwise include in their issued rates. Further, for FY 2013 (ending June 30, 2013) DSS must add fair rent increases associated with an approved CON.

§ 17—Coverage of Chiropractic Care Services for Medicaid Recipients
Effective October 1, 2012

This section allows DSS to cover chiropractic services for Medicaid recipients, provided DSS does not spend more than $250,000 annually in the aggregate for this coverage.

§ 19—Earlier Start-Date for Department of Aging
Effective July 1, 2012

Under prior law, DOA was to be established by July 1, 2013. This section moves up the start-date to January 1, 2013.

§ 21—Report on Medicaid Fraud
Effective, July 1, 2012

The Act creates a new requirement that the Chief State's Attorney submit a report to the Appropriations Committee detailing the monetary recoveries resulting from its fraud investigations of DSS medical assistance programs, including Medicaid. This report must be submitted no later than October 1, 2013 and annually thereafter.

§ 26—Waiver for Medicaid Low-Income Adults
Effective July 1, 2012

Prior law required DSS to administer coverage under the Medicaid program for low-income adults. With no asset limit for the program; only the applicant's income was included in the eligibility determination. This section requires DSS to apply for a Medicaid waiver to modify eligibility and coverage for such low-income-adults by: (i) establishing an asset limit of $10,000; (ii) including the income and assets of the parent(s) of an applicant who is under the age of twenty-six, if the applicant lives with such parent(s) or is declared as a dependent by a parent for income tax purposes; and (iii) limiting coverage of nursing facility care to ninety days.

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§ 27—Prior Authorization for Prescription Drugs
Effective July 1, 2012

By October 1, 2012, this section requires that DSS must issue a flyer to pharmacies to distribute to Medicaid recipients who only receive a one-time, fourteen-day prescription supply in lieu of a full prescription when prior authorization was required for coverage and the pharmacy was unable to obtain the prescribing physician's authorization at the time the prescription was presented to be filled. The flyer must notify the recipients that: (i) prior authorization is required for the prescription to be fully filled; (ii) only a one-time, fourteen-day supply is available; and (iii) recipients must contact the prescriber to arrange for prior authorization of a full prescription.

§§ 28–95—Bureau of Rehabilitative Services Name Changed to Department of Rehabilitation Services
Effective July 1, 2012

Under prior law, BRS, within DSS, was authorized to perform all the administrative functions of the Commission on Deaf and Hearing Impaired, and other state rehabilitation services. This Act: removes BRS from within DSS and makes it a separate entity named DRS; makes the head of DRS a commissioner, rather than an executive director; and makes the newly named DRS a successor authority to BRS. The Act also requires DSS to provide DRS with administrative support services until the earlier of either June 30, 2013 or the date DRS requests that DSS no longer provide such support.

§ 104—Inmates Released to Nursing Homes
Effective July 1, 2012

DOC may, under certain conditions, release inmates from custody to nursing homes for palliative and end-of-life care. Inmates may be released to licensed community-based nursing homes under contract with the state. Before DOC can authorize such a placement, the medical director for DOC must determine that the inmate is suffering from a terminal condition, disease, or syndrome or is so debilitated or incapacitated by such a condition as to need continuous palliative or end-of-life care or be physically incapable of presenting a danger to society. DOC is instructed that inmates convicted of a capital felony or murder with special circumstances may not be released pursuant to this Act.

§ 105—Veterans' Affairs and Department of Veterans' Affairs
Effective July 1, 2012

This section requires DAS to investigate, determine, bill, and collect all charges for services covered under Medicaid or Medicare for people aided, cared for or treated by

DVA.

§§ 112 & 113—Department of Housing

This Act establishes a DOH within DECD, which will be the lead agency for all housing matters. The head of DOH, to be appointed by the Governor, will be the Commissioner of Housing and will be responsible for developing strategies to encourage the provision of housing in the state, including housing for very low, low, and moderate income families, in addition to already established responsibilities at the state level for all aspects of policy, development, redevelopment, preservation, maintenance, and improvement of housing and neighborhoods. The Commissioner must, in consultation with the interagency council on affordable housing, review the organization and delivery of state housing programs and submit a report with recommendations to the General Assembly by January 15, 2013.

This Act also establishes an interagency council on affordable housing to advise and assist the DOH Commissioner in the planning and implementation of DOH's mission. The council shall consist of the following members: the Commissioners of DSS, DMHAS, DCF, DOC, and DECD, or their designees; the Secretary of OPM; the executive director of the Partnership for Strong Communities; the executive director of the Connecticut Housing Coalition; the executive director of the Connecticut Coalition to End Homelessness; the executive director of CHFA, or their designees; two members receiving state housing assistance; and one member who is a state resident eligible to receive state housing assistance.

By July 15, 2012, the council must convene to develop strategies and recommendations for the organization and mission of DOH by assessing housing needs of low income individuals and families, reviewing the effectiveness of existing state programs, identifying barriers to effective housing delivery systems, and developing strategies to increase the availability of safe and affordable housing.

By January 15, 2013, the council must submit a report to the Governor and the General Assembly addressing recommendations concerning:

i. Programs to be transferred to DOH and a timeline for implementation;
ii. Effective changes to the state's housing delivery systems;
iii. Prioritization of housing resources; and
iv. Enhanced coordination across housing systems.

§ 130—Disclosing Security Breaches of Computerized Data

Effective October 1, 2012

By law, anyone who conducts business in Connecticut, and who, in the ordinary course of business, owns, licenses or maintains computerized data that includes

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personal information must disclose any breach of security after the discovery of a breach to any state resident whose personal information has been, or is reasonably believed to have been, accessed by an unauthorized person.

This section replaces the general disclosure requirement with a more specific notice requirement and also requires notice to the attorney general. In practical effect, the change requires individuals and companies to alert each affected state resident of the existence of the breach. Such notice must be given to the owner or licensee of the information immediately following discovery of the breach and the notice to the Attorney General must be provided no later than when the affected residents were notified.

§ 198—Job Expansion Tax Credit
Effective July 1, 2012, and applicable to income or taxable years commencing on or after January 1, 2012

This Act extends the job expansion tax credit to include those employers hiring people receiving services from DMHAS or participating in DSS-funded or operated programs providing employment opportunities and day services. The new hires must work a minimum of twenty hours per week for at least forty-eight weeks in a calendar year in order for an employer to qualify for the credit. These credits can apply against insurance premiums or income taxes.

§ 211—DPH Vaccine Wastage Policy

This Act requires DPH to post its current policy regarding vaccine wastage on its website by October 1, 2012. In this posting DPH must articulate the factors it uses to determine the policy and update the posting as necessary to reflect the most current policy in effect. The Act requires DPH to make a form available to health care providers to report instances when the provider does not receive a full order of a requested vaccine. DPH must track, record, and investigate all such instances and post aggregate findings and reasons for these findings on its website.

§§ 218 & 219—Health Insurance Exchange Board Members and Employees
Effective July 1, 2012

The Act makes the Healthcare Advocate a voting member of the Connecticut Health Insurance Exchange board. Prior to this Act, the Advocate was an ex-officio non-voting board member. In addition, the Act:

i. Increases the number of board members that constitutes a quorum from six to seven;
ii. Expands outside employment and affiliation restrictions applicable to exchange board members and staff;

iii. Lengthens the term of the House majority leader's health care economist board appointee from one year to two years; and
iv. Allows exchange employees to enroll in the state employee health plan if the Exchange pays the enrollment costs.

2. PUBLIC ACT 12-1. AN ACT ADJUSTING INCOME ELIGIBILITY GUIDELINES FOR MEDICARE SAVINGS PROGRAMS.
Effective March 6, 2012

This Act requires DSS to annually adjust the amount of income disregarded in calculating an individual's qualification for the state Medicare Savings Program in order to align its eligibility guidelines with the ConnPACE requirements. Individuals who previously participated in the ConnPACE program but earned too much money to enroll in the Medicare Savings Program may now be eligible to do so. Annual adjustments to the Medicare Savings Program income disregards are necessary because the ConnPACE requirements are tied to Social Security's cost of living adjustment. By changing the income qualification, the General Assembly thereby reduces state ConnPACE costs by ensuring all ConnPACE recipients are also eligible for the Medicare Savings Program.

ConnPACE is a state program that helps eligible senior citizens and people with disabilities afford the cost of prescription medications. The Medicare Savings Program is a state program offering financial assistance to Medicare enrollees that helps pay Medicare Part B premiums, deductibles, and co-insurance.

3. PUBLIC ACT 12-6. AN ACT CONCERNING NOTIFICATION OF FINANCIAL STABILITY OF NURSING HOME FACILITIES AND MANAGED RESIDENTIAL COMMUNITIES TO PATIENTS AND RESIDENTS.
Effective October 1, 2012

This Act requires nursing home facilities and managed residential communities that have been placed in receivership under state law or have filed for bankruptcy under the federal Bankruptcy Code to notify current residents and those seeking admission to the facility or community of such action. This Act applies to: chronic and convalescent nursing homes, rest homes with nursing supervision, residential care homes, and managed residential communities providing assisted living services.

4. PUBLIC ACT 12-14. AN ACT CONCERNING LETTERS OF PROTECTION.
Effective October 1, 2012

This Act is a consumer protection measure requiring physicians and physical therapists to inform certain patients of certain policies in writing prior to treatment. Physicians and physical therapists must disclose to patients who have suffered personal injury whether they would be willing to provide services under a letter of

protection from the patient's attorney, which guarantees payment for medical services. Further, physicians and physical therapists shall provide to these patients an estimated cost of an opinion letter detailing the diagnosis, treatment, prognosis, and disability rating of the patient.

5. PUBLIC ACT 12-25. AN ACT CONCERNING THE APPOINTMENT OF A GUARDIAN *AD LITEM* FOR A PERSON WHO IS SUBJECT TO A CONSERVATORSHIP PROCEEDING OR A PROCEEDING CONCERNING ADMINISTRATION OF TREATMENT FOR A PSYCHIATRIC DISABILITY.
   Effective October 1, 2012

   This Act increases protections for vulnerable populations by placing limits on the discretion of a court to appoint a guardian *ad litem*. The Act delays appointments in forced medication administration cases under Conn. Gen. Stat. § 17a-543 until there is a finding that the patient is incapable of giving informed consent. Further, the Act conditions appointment of a conservator in proceedings under Conn. Gen. Stat. §§ 45a-644–45a-663 for individuals incapacitated by mental illness until the patient's or applicant's mental status is judged to meet legal standards for conservatorship.

   For a mentally conserved person, the Act prohibits superior court and probate court judges, as well as, magistrates from the Family Support Magistrate Division, from appointing a guardian *ad litem* unless the court makes a specific finding that: (i) it needs to appoint a guardian *ad litem* for a specific purpose or to answer specific questions to assist it in its decision-making or (ii) the conserved person's attorney is unable to ascertain his or her client's preferences, including those previously expressed.

   If a judge appoints a guardian *ad litem*, the order shall limit the duration and scope of the appointment and give specific direction on the actions to be taken by the guardian *ad litem*. The appointment terminates with the guardian *ad litem's* report to the court.

6. PUBLIC ACT 12-28. AN ACT CONCERNING THE USE OF TELEPHARMACY BY HOSPITALS.
   Effective July 1, 2012

   This Act permits hospitals to use telepharmacy for dispensing "sterile products," allowing hospital-based pharmacists to use electronic technology to supervise pharmacy technicians preparing sterile products at remote locations. Sterile products include any drug prepared under sterile conditions for administration to patients.

   With telepharmacy, each step involved in the dispensing of sterile products is required to be verified by a bar code tracking system and documented by digital photographs that are electronically recorded and preserved. Supervising pharmacists use electronic video and audio communication technology to monitor and verify work

performed by pharmacy technicians.

Hospitals engaging in telepharmacy must maintain a pharmacist-to-technician ratio of no more than 3:1. Pharmacy directors can petition the Pharmacy Commission to increase the ratio to 5:1 under Connecticut Agencies Regulations § 20-576-33.

If the electronic technology malfunctions, no sterile product prepared by the pharmacy technician during the malfunction period can be distributed to patients unless a licensed pharmacist can verify personally, or through the use of the restored electronic technology, that all proper steps were followed in preparing the sterile product.

Hospitals are required to perform quarterly quality assurance evaluations of the telepharmacy program. The hospital must make these evaluations available to DCP and DPH.

7. PUBLIC ACT 12-30. AN ACT CONCERNING PRESCRIPTION DRUG ADMINISTRATION IN NURSING HOME FACILITIES.
   Effective October 1, 2012

   This Act permits medical directors of chronic and convalescent nursing homes and rest homes with nursing supervision to make cost effective medication substitutions in accordance with the facility's clinical protocols and with the permission of the prescribing practitioner. The substitutions must be based on a predetermined list of prescription medications, which must meet the ASHSP guidelines and any applicable collaborative drug-therapy-management agreement.

   In establishing a prescription drug formulary system for a nursing home facility and substituting medications for patients receiving medical assistance from a program administered by DSS, the medical director must choose medications in accordance with the preferred drug list published by DSS, Medicare Part D prescription drug formularies or the patient's health insurance policy.

8. PUBLIC ACT 12-37. AN ACT CONCERNING PHYSICIAN ASSISTANTS.
   Effective October 1, 2012

   The Act permits more flexible supervision of PAs by physicians pursuant to a written delegation agreement. This Act now permits physicians to personally review PAs on a regular basis, instead of requiring a weekly review. If a PA is practicing outside of the hospital setting, the regular in-person reviews can take place at the practice location of either the physician or the PA.

   The written delegation agreement between the physician and PA establishes the role, scope, and function of the parties, and must:

1. Describe the professional relationship between the supervising physician and the PA;
2. Identify the medical services the PA may perform;
3. Describe the process of documenting the prescription of controlled substances; and
4. Describe the ongoing process used by the supervising physician to evaluate the PA, including:
    a. The frequency of personal reviews of the PA's practice and performance of delegated medical services; and
    b. How often, and in what manner, the physician intends to review the PA's prescription and administration of Schedule II or III controlled substances.

The written delegation agreement should reference applicable hospital policies, protocols, and procedures. The agreement must be reviewed annually and updated to reflect any change in the physician/PA relationship.

The law allows physicians to permit PAs to prescribe and administer Schedule II through V controlled substances. Under prior law, when a PA prescribed a Schedule II or III pharmaceutical, the supervising physician had to document his or her approval in the patient's medical record within one day of prescription issuance. The Act instead permits the supervising physician to document his or her approval in the manner set forth in the written delegation agreement.

9. PUBLIC ACT 12-55. AN ACT CONCERNING THE PALLIATIVE USE OF MARIJUANA.
Effective May 31, 2012, except as noted

This Act allows a licensed physician to prescribe marijuana for an adult patient's use after determining that the patient has a debilitating medical condition and could potentially benefit from the palliative use of marijuana. Debilitating medical conditions include, but are not limited to, cancer, AIDS or HIV, and Parkinson's disease. DCP will establish criteria for adding qualifying conditions.

The Act removes criminal or civil penalties for patients, their caregivers or doctors, dispensaries or producers for specified actions relating to use, prescription or supply of marijuana, and from being denied any right or privilege from a professional organization or licensing body.

The Act specifies that it does not require health insurers to cover the palliative use of marijuana and requires that all registration and licensure fees DCP collects under the Act be deposited in a separate, non-lapsing palliative marijuana administration account.

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It is important to note, however, that while this Act permits the use of medical marijuana in Connecticut, it does not alter federal laws prohibiting and criminalizing the use of marijuana, for any reason. The federal DEA's position on marijuana states that marijuana is properly categorized as a Schedule I Controlled Substance and that it is not safe for use even under medical supervision. The DOJ's guidelines for federal prosecutors makes clear that the focus of federal resources should not be on individuals whose actions are in compliance with existing state laws, but underscores that DOJ will continue to prosecute people who claim to be in compliance with state and local law but conceal operations inconsistent with those laws. That being said, the DEA clearly states that the DOJ guidelines do not signal the federal government's relaxation of its policy on marijuana nor provide a legal defense to a violation of federal law. In no uncertain terms, the DEA states that investigations and prosecutions of violations of state and federal law will continue.[1]

§ 4—Certification of Marijuana Use
Effective October 1, 2012

The Act requires that patients seeking to possess a one-month supply of marijuana for palliative purposes obtain a certification of endorsement from a physician. The certification must be in writing, on a DCP form, and state that, in the physician's professional opinion, the patient has a debilitating condition and the potential benefits of the palliative use of marijuana would likely outweigh its health risks.

The certification is valid for up to one year. Patients and primary caregivers are required to destroy all usable marijuana within ten days of the certification's expiration.

§§ 5 & 15—Patient and Caregiver Registration
Effective October 1, 2012

The Act requires patients and their primary caregivers to register with DCP. Upon payment of a registration fee, DCP will issue a registration certificate that is valid for the same period as the written certification from the physician.

§ 9—Dispensary Licensing and Dispensaries

The Act establishes licensing requirements for pharmacists seeking to dispense marijuana for palliative use and prohibits anyone who is not licensed by DCP from dispensing marijuana.

[1] DRUG ENFORCEMENT ADMINISTRATION, THE DEA POSITION ON MARIJUANA (JAN. 2011), *available at* http://www.justice.gov/dea/marijuana_position.pdf.

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DCP can issue dispensary licenses to licensed pharmacists who apply for a dispensary license in accordance with forthcoming regulations and are deemed qualified to acquire, possess, distribute, and dispense marijuana. Dispensary regulations will set the maximum number of dispensary licenses, limit licenses to licensed pharmacists, prevent out of state sales, set fees, require license renewals, and set zoning requirements for locations. The regulations must also establish other licensing, renewal, and operational standards that DCP deems necessary to prevent diversion and theft.

§ 10—Licensed Producers

Palliative marijuana producers are required to be licensed, and the Act prohibits anyone who is not licensed by DCP from acting as if, or representing that he or she is, a licensed producer. To qualify as a producer, the person must be organized to cultivate (plant, propagate, cultivate, grow, and harvest) marijuana for palliative use in the state. DCP must find that the applicant has appropriate agricultural expertise and is qualified to cultivate, sell, deliver, transport or distribute marijuana solely within the state. DCP will adopt regulations providing for producer licensure, cultivation standards, and locations, and will set the maximum number of licenses at between three and ten.

§§ 2–4, 6, 11, 12 & 15—Protections from Punishment Related to Palliative Marijuana Use
Effective October 1, 2012

The Act prohibits qualifying patients, their caregivers or doctors, or licensed dispensaries or producers from being arrested, prosecuted, or otherwise penalized, including being subject to civil penalties, or denied any right or privilege, including being disciplined by a professional licensing board, for taking specified actions related to the palliative use of marijuana. The Act also prohibits anyone from being arrested or prosecuted solely for being present during, or in the vicinity of, the palliative use of marijuana.

Qualifying patients can be subjected to penalties if (1) the patient fails to maintain a valid registration certificate with DCP or written certification from the patient's physician, (2) the marijuana possessed by the patient and his or her primary caregiver exceeds the usable amount reasonably necessary to ensure a one-month supply, (3) the patient has more than one primary caregiver at a time or (4) the patient otherwise fails to comply with the Act. The protections do not apply if the patient ingests marijuana:

- On a motor bus, school bus or other moving vehicle;
- At work;
- On school grounds of any public or private school;

- On college or university property;
- In any public place;
- Within the direct line of sight of anyone under age 18; or
- In a way that exposes someone under age 18 to second-hand marijuana smoke.

Physicians may be subject to penalties for issuing a certification for palliative marijuana use if they fail to do any one of the following:

- Properly identify qualifying patients with debilitating conditions;
- Explain the potential risks and benefits of using marijuana for palliative purposes to the patient and the parent, guardian, or legal custodian of a patient who lacks legal capacity;
- Base the written certification on his or her professional opinion after completing a medically reasonable assessment of the patient's medical history and current medical condition in the course of a bona fide physician-patient relationship; and
- Have no financial interest in a licensed dispensary or producer.

Primary caregivers will not be protected from the punishments or penalties for acquiring, distributing, possessing or transporting marijuana or related paraphernalia for the qualifying patient if the amount of marijuana, along with the combined usable amount the patient and caregiver possess, exceeds a reasonably necessary one-month supply. Additionally, the marijuana must be obtained from a state-licensed dispensary. The protection against punishment for distribution applies only when the drug or paraphernalia is transferred from the caregiver to the patient.

10. PUBLIC ACT 12-62. AN ACT CONCERNING THE LICENSING, INVESTIGATION AND DISCIPLINARY PROCESSES FOR PHYSICIANS AND NURSES.
Effective May 31, 2012

This Act expands the membership and alters the composition of the state Medical Examining Board and medical hearing panels. It also changes the professional qualifications for the RN members of the state Board of Examiners for Nursing. As a benefit for participating on the state Medical Examining Board or in a medical hearing panel, the DPH Commissioner is allowed to waive up to ten hours of CME. Finally, the Act requires all physicians, nurses, and dentists to renew their licenses via an online process.

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§ 1—Altering the Composition of the Medical Examining Board and Medical Hearings Panel

The Act expands the Medical Examining Board from fifteen to twenty-one members and adjusts the Board's composition is to include more specialty practitioners and public members. The pool of individuals eligible to serve on three member medical hearing panels is expanded from twenty-four to thirty-six.

§ 3—Board of Examiners for Nursing

The Act changes the required qualifications for the five RN members of the twelve-member Board of Examiners for Nursing. After October 1, 2012, instead of three, only one RN member must be affiliated with an institution for nurse education. Additionally, the Act requires one RN member to have a doctorate in nursing practice or nursing science, eliminating the requirement that one RN member must be an instructor at a school for LPNs.

11. PUBLIC ACT 12-91. AN ACT EXPANDING CONSUMER CHOICE FOR LIFE SUPPORT CARE AT HOME.
    Effective October 1, 2012

The Act requires DSS to create and operate a two-year pilot program for up to ten ventilator-dependent Medicaid recipients receiving medical care at home and living in Fairfield County. Under the pilot program, the participants have the option of directly hiring RNs and LPNs rather than having the state pay for the services through a home health agency. DSS must annually assess the participants to determine whether they can continue to manage their care.

DSS is required to set a maximum amount it reimburses the nurses and therapists for the pilot services, which must be at least 80% of the prevailing rate that DSS pays home health agencies to provide comparable care. Currently, DSS does not pay for services a respiratory therapist provides in the home. However, it will pay for respiratory care services that a nurse provides. In implementing the pilot, DSS may give respiratory therapists a greater role in long-term home care.

Nurses and therapists participating in the pilot must submit to criminal history background checks and certify, in writing, that they will not terminate a patient's care, except in an emergency, unless they provide at least two weeks written notice.

By January 1, 2015, DSS will report to the Appropriations and Human Services Committees on the pilot program, including its cost-effectiveness and care continuity. DSS is required to survey Medicaid recipients who are receiving continuous skilled care at home and report the survey results to the Human Services Committee.

12. PUBLIC ACT 12-104. AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES FOR THE FISCAL YEAR ENDING JUNE 30, 2013.
Effective July 1, 2012

The Act modifies appropriations in 2012–13 biennial state budget to adjust for changes in the 2013 fiscal year.

§1—Strategic Plan for Nursing Home Rightsizing and Long-Term Care Rebalancing

The mid-term budget adjustments and bonding package contain several elements of the state's long-term care strategic rightsizing plan. Each of the following elements were included in the Governor's budget, but not all required inclusion in the implementer bill (PA 12-1, *supra*):

- $10 million in bond funding and an additional $3 million in appropriations for grants-in-aid to nursing homes for alterations, renovations, and improvements for conversion to other uses in support of right-sizing.
- $12.5 million for the development of congregate housing to promote aging in place.
- $1 million for DECD grants-in-aid for accessibility modifications for individuals transitioning from institutions to the community under the Money Follows the Person program.
- $300,000 for DSS to develop a standardized universal long-term care assessment tool for use for all long-term care services and supports.
- $400,000 for direct-care workforce development, specifically to develop a marketing plan to attract direct-care workers to the long-term care field, to provide job assistance and retraining to nursing home direct-care workers, and to fund direct-care training programs at community colleges.
- $250,000 for the creation of an automated, web-based information system to assist the hospital discharge planning process in transitioning care from hospitals to the community.
- $500,000 to add "adult family living" as an option under the CHCPE and the Personal Care Assistance waiver. This allows individuals who provide adult family living (adult foster care) services to receive a stipend based on the client's activities of daily living and cognitive needs. This stipend would not be available to family members who have already been providing this service.
- $2.6 million in partial-year funding for the development of nursing home capacity for clients under state care through DMHAS and DOC who are difficult to place. DMHAS and DOC, in collaboration with DSS, are soliciting proposals from organizations that currently provide skilled nursing care and wish to reorganize their current business model to accommodate this population.

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§§ 8 & 27—Rate Increase for Private Providers

The Act increases per diem and other rates for private residential treatment centers licensed by DCF by 1%. To implement the increase, the Act overrides the single cost accounting system used by DCF and local educational agencies to determine reasonable expenses for room, board, and education at DCF-licensed private residential treatment facilities.

The Act also requires DDS, DMHAS, DCF, DSS, DPH, and DOC, as well as the Judicial Branch, to provide a 1% cost-of-living adjustment to private contractors with whom they contract for services. The additional funds must be used to increase provider or subcontractor employees' wages and benefits, unless a provider applies for, and OPM approves, an exception for good cause.

§ 13—Energy Assistance

The Act transfers $2 million of the funds collected through the systems benefit charge (a levy on the distribution of electricity included on customer electric bills) to DEEP in order to provide energy assistance through Operation Fuel. Operation Fuel is a private, nonprofit energy assistance program for people who need emergency help with energy bills and are not eligible for, or have exhausted, state or federal assistance. Payments are made directly to the company that supplies the household with the heating or utility services.

§ 18—Bus and Para-Transit Fares

The Act prohibits the state from increasing fares for buses or ADA para-transit services between January 1, 2013 and December 31, 2013.

§ 28—Reallocation of 2011 General Fund Surplus

The Act reallocates $222.4 million from the 2011 surplus to the BRF. Under prior law, surplus funds were supposed to be used to redeem any outstanding economic recovery notes issued to cover the state's general fund deficit in 2009 before they mature.

13. PUBLIC ACT 12-118. AN ACT CONCERNING A MORATORIUM ON CERTAIN LONG-TERM CARE BEDS.
Effective June 15, 2012

The Act extends the current moratorium on nursing home beds by prohibiting DSS from accepting or approving requests for additional nursing home beds, or modifying the capital cost of any prior approval, until June 30, 2016. The Act maintains the current moratorium, including the exemption for transfer of Medicaid beds from one

facility to another and beds associated with a continuing care facility that guarantees life care for residents.

The Act also imposes a moratorium until June 30, 2017 prohibiting the issuance or renewal of a DPH license for any hospital certified to participate in the Medicare program as a long-term care hospital, unless the hospital was so certified as of January 1, 2012.

14. PUBLIC ACT 12-130. AN ACT WAIVING ADVANCE PAYMENT RESTRICTIONS FOR CERTAIN NURSING FACILITIES.
Effective June 15, 2012

By law, DSS, upon the request of a nursing facility, is permitted to make Medicaid payments to the facility in advance of normal payment processing. The advanced payment is limited to the estimated amount due for services provided to Medicaid-eligible recipients over the most recent two months, and DDS must recover the advanced payment within ninety days. This Act allows DSS to waive both the ninety-day recovery deadline and the two month advanced payment limit for nursing facilities under receivership.

15. PUBLIC ACT 12-140. AN ACT CONCERNING REGULATIONS RELATING TO HOSPICE CARE.
Effective June 15, 2012

This Act provides that hospices licensed by DPH have authority to operate a hospice facility, including a specialized hospice residence that provides inpatient hospice services as well as hospice home care services. Additionally, this Act removes the requirement that a hospice be Medicaid certified to operate such a facility, residence or home care hospice service or to use the titles "hospice" or "hospice care program." DPH promulgated hospice regulations. *See* CONN. AGENCIES REGS. §§ 19a-495-5a & b; 19a-495-6a to 19a-495-6m (2012).

16. PUBLIC ACT 12-166. AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING ALL-PAYER CLAIMS DATABASE PROGRAM.
Effective June 15, 2012

This Act creates an all-payer claims database program for receiving and storing data regarding medical, dental, pharmacy, and other insurance claims information. Such information will be broadly available to the public for review of health care costs, use, and quality. All data disclosed for use in the database program must protect the confidentiality of individual health information.

Under the Act, insurers and "reporting entities" that administer health care claims and

payments are required to provide information for use in the database. Entities that fail to report may be charged with civil penalties of up to $1,000 per day.

The Act charges OPM, in consultation with OHRI, with adopting regulations for implementing and administering such a database program. Additionally, OHRI is required to oversee the planning, implementation, and administration of the program, including seeking federal or private funding to cover the costs of the database program. OHRI is prohibited from incurring costs for the program if funding cannot be secured.

17. PUBLIC ACT 12-170. AN ACT CONCERNING THE OFFICE OF HEALTH CARE ACCESS.
Effective October 1, 2012

The Act makes several changes in the statutes governing OHCA.

§ 1—CON Applications

The Act requires OHCA, when evaluating a CON application, to take into consideration whether the proposal is consistent with any applicable policies and standards adopted by DPH and whether the proposal is financially feasible for the applicant, in addition to, its impact on the financial strength of the state's healthcare system, instead of only considering the latter.

§ 2—CON Application Decision Deadline

The Act requires OHCA to issue a decision on a completed CON application no later than sixty days after closing the public hearing record instead of sixty days after the public hearing date.

§§ 3 & 7—Hospital Financial Audit Deadlines

The Act requires hospitals to annually file audited financial statements *not later than* February 28 instead of *by* February 28.

Additionally, upon the effective date of this Act, hospitals now must file a separate verification of the hospital's net revenue for the most recently completed fiscal year not later than March 31 of each year. The Act eliminates the requirement that hospitals file a verification of net revenue with their audited financial statements.

§ 5—Statewide Health Care Facility Utilization Study

The Act requires OHCA to update its statewide health care facilities and services plan biennially, rather than every five years, and to conduct its statewide health care

facility utilization study biennially, rather than annually. Additionally, during a statewide health care facility utilization study, this section allows, rather than requires, OHCA to assess (i) the current availability and use of care in acute care and specialty hospitals, emergency rooms, outpatient surgical centers, clinics, and primary care facilities; (ii) the geographic areas and subpopulations that may be underserved or have limited access to specific types of services; and (iii) other factors OHCA deems pertinent.

§ 6—Negotiated Discounts

The Act removes OHCA's authority to require a hospital's independent auditor to review, at the hospital's expense, the total of each payor's charges and payments after the hospital has negotiated agreements for rate discounts and reimbursement methods with insurers, HMOs, and other payors.

Now, a hospital can total each payer's charges and payments and report them to OHCA as required without the need for an independent auditor to review these figures.

§ 8—Release of Patient-Identifiable Data

Under prior law, OHCA could not release patient-identifiable data, except for medical and scientific research purposes, as provided by law, or to the Comptroller under a memorandum of understanding requiring that confidentiality be maintained. The Act allows OHCA to release patient-identifiable data to a state agency in order to improve health care service delivery, to a federal agency or the Connecticut Attorney General's Office to investigate hospital mergers and acquisitions, or to another state's health data collection agency. The release of this data is only permissible if an agency requests it and the requesting agency enters into a written agreement with OHCA that the agency will keep the information confidential and not use it as the basis of any decisions about a patient.

18. PUBLIC ACT 12-189. AN ACT AUTHORIZING AND ADJUSTING BONDS OF THE STATE FOR CAPITAL IMPROVEMENTS, TRANSPORTATION AND OTHER PURPOSES.
Effective June 15, 2012

§§ 8, 9, 14 & 15—Grants-in-Aid to Nursing Homes

The Act grants the SBC the power to authorize the issuance of state bonds, not to exceed $199,683,500, the proceeds of which are to be used for the purpose of providing grants-in-aid and other financing for programs and purposes cited in the Act. Specifically, DECD may provide grants-in-aid, not exceeding $10 million, to nursing homes for alterations, renovations, and improvements for conversion to other

uses in support of right-sizing. All financing for the grants provided by DECD will be made in accordance with the terms of a contract, which will be determined by SBC during the authorization of the funds. If the grant is made to an entity that is not a political subdivision of the state, the contract entered into must provide that if, within ten years of the grant, the premises for which the grant was made ceases to be used as a facility for which the grant was made, an amount equal to the amount of the grant, minus 10% per year for each year from the date of the grant, must be repaid to the state, and a lien will be placed on the premises in favor of the state to ensure repayment.

§§ 29 & 30—Funding for Housing Redevelopment and Rehabilitation

The Act grants SBC the power to authorize the issuance of state bonds, not to exceed $87.5 million, the proceeds of which may be used by DECD for the purpose of housing development, such as the creation of moderate cost housing, moderate rental, congregate and elderly housing, community housing development cooperation, housing for low income persons, limited equity cooperatives and mutual housing projects, and for rehabilitation, such as emergency repair assistance for senior citizens. The Act limits the total dollar amount of the bonds that DECD may issue for certain purposes. Specifically, not more than $12.5 million may be issued for development of congregate housing and not more than $1 million may be issued for grants-in-aid for accessibility modifications for persons transitioning from institutions to homes under the Money Follows the Person Program.

19. PUBLIC ACT 12-197. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTE.
    Effective October 1, 2012

§ 3—Connecticut Tumor Registry

By law, DPH maintains and operates the Connecticut Tumor Registry, which includes a report of every occurrence of a reportable tumor that is diagnosed or treated in the state. The Act expands the information that must be contained in these reports to include pathology reports.

§ 4—Interstate Tuberculosis Agreements

The Act allows DPH to enter into a reciprocal agreement with another state for the interstate transportation and medical treatment of a person afflicted with tuberculosis.

§§ 11–14—LeadingAge Name Change

The Act changes the name of the Connecticut Association of Not-For-Profit Providers for the Aging to LeadingAge Connecticut, Inc. in statutes referencing the name, most

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of which concern the various committees and councils for which LeadingAge Connecticut, Inc. or its representatives are members.

§§ 33–35—Health Certifications for Employment

This section allows handicapped persons and disabled veterans seeking to work in a variety of settings to obtain the required health certification from an APRN, as well as a physician.

§§ 36–41—Health Documentation for Part-Time Status

These sections allow an APRN to provide written documentation, consent or certification in the following instances:

- Individuals seeking to limit their availability to work to part-time employment;
- Individuals seeking to certify a qualifying event, in order to obtain accelerated benefits under a life insurance policy;
- A terminally or chronically ill owner of an insurance policy seeking to obtain a written statement that the owner is of sound mind and under no constraint or undue influence to enter into a life settlement contract; and
- Completing a standard Health Care Financing Administration 1500 health insurance claim form.

§ 44—Advisory Council on Organ and Tissue Donation Education and Awareness

The Act establishes an advisory council on organ and tissue donation education and awareness. The council will consist of: the Commissioners of DMV and DPH, the executive director of Donate Life Connecticut, and the CEO of CHA, or their designees; a representative of each of the organizations in the state that are members of the AOPO; a health care professional representing each transplant center located in the state that is a member of the federal OPTN; and five people experienced in issues involving organ and tissue donation or transplants appointed by the Governor, the House of Representatives, and the Senate, including one recipient of a donated organ or tissue, one living donor, and one family member of a deceased donor.

DMV will provide the council with data on registered organ donors on a quarterly basis. The council will analyze education on organ tissue donation in the state, determine the registration rate of donations, set goals for increasing such rate, and advise DPH and DMV on methods to increase donation rates. No later than July 1, 2013, and annually thereafter, the council will report to the General Assembly concerning actions taken by the council to increase organ and tissue donations and recommendations to increase donation rates.

§ 45—Pharmaceutical and Therapeutics Committee Expansion

The Act expands the Pharmaceutical and Therapeutics Committee within DSS from fourteen to sixteen members. One of the additional members must be a child psychiatrist and the second must be an oncologist, bringing the number of members on the Committee that must be licensed physicians from five to seven.

§ 46—Health Information Privacy Report

The Act requires the CEO of the Connecticut HITE to include in his or her annual report to the Governor and the General Assembly a report on the development of privacy practices, procedures to notify patients concerning the collection of patient health information, and the use of that information in the state-wide health information exchange.

§ 48—Licensing Requirements for an APRN

The Act expands the options to fulfill the education requirements for obtaining an APRN license. Under prior law the requirements for licensure included:

i. Maintaining a license as an RN;
ii. Holding and maintaining appropriate certification by an approved certifying body;
iii. Completing thirty hours of education in pharmacology for advanced nursing practice; and
iv. Holding a graduate degree in nursing.

The Act permits DPH to issue an APRN license to an applicant if, instead of holding a graduate degree in nursing, the applicant, on or before December 31, 2004, completed an advanced nurse practitioner program that a national certifying body recognized for certification and, at the time of application, the applicant holds a current license as an APRN in another state that requires a master's degree in nursing.

20. SPECIAL ACT 12-6. AN ACT ESTABLISHING A TASK FORCE TO STUDY "AGING IN PLACE."
Effective June 15, 2012

The Act establishes a task force to study how the state can encourage "aging in place." This study will include an examination of: (1) infrastructure and transportation improvements; (2) zoning changes to facilitate home care; (3) enhanced nutrition programs and delivery options; (4) improved fraud and abuse protections; (5) expansion of home medical care options; (6) tax incentives; and (7) incentives for private insurance. The task force will consist of executive agency

representatives, as well as chairs and ranking members of several legislative committees, and eight members who are to be appointed by the Senate, House, and Governor collectively. The task force will submit a report on its findings to the General Assembly not later than January 1, 2013 and the task force shall terminate on the date that it submits such report.

II. ACTS RELATING TO GOVERNMENT ASSISTANCE PROGRAMS

21. PUBLIC ACT 12-119. AN ACT CONCERNING CERTAIN SOCIAL SERVICES PROGRAMS.

Effective June 15, 2012, except as noted

The Act:

- Establishes the Community Choices program to assist elderly and disabled people and their caregivers in approaching long-term care decisions;
- Changes eligibility requirements, funding, and participation levels for the DSS-administered home care program for people with severe disabilities ("Katie Beckett" waiver);
- Changes who a municipality may appoint as a municipal agent for the elderly;
- Increases the information health insurers must provide to DSS in order to assist DSS in locating dual eligible individuals; and
- Channels certain third-party beneficiary payments to DSS that would otherwise have been disbursed to policyholders.

Further, the Act repeals provisions allowing:

- DAS to deposit Riverview Hospital Medicaid payments into a non-lapsing general fund account for DSS to pay Medicaid claims;
- A DSS personal care assistance home-care pilot program for the elderly made unnecessary by implementation of a statewide waiver; and
- A provision requiring DSS, when determining rates for FQHCs, to apply Medicare productivity standards and a maximum allowable per visit cost of 115% of the median cost per visit.

§ 1—Community Choices Program

The Act directs DSS to develop and administer a statewide Community Choices program, which will serve as the state's ADRC under the federal Older Americans Act. It is intended to provide a single, coordinated information and access program for individuals seeking long-term support, such as in-home, community-based or institutional services. The program must serve individuals sixty years old or older, those greater than seventeen years old with disabilities, and their caretakers.

Currently, Connecticut has three regional ADRCs that served as pilot projects. These ADRCs will be consolidated into the Community Choices program, which will expand their services statewide.

§ 3—Municipal Agents for the Elderly

The Act instructs municipalities to appoint a municipal agent for the elderly if called for by local ordinance. Such agents may be members of a municipal agency for the elderly or municipal residents with a demonstrated interest in the elderly or programs for the aged. Municipal agents may assist elders in learning about community resources and filing for state benefits. Additionally, an agent can report any needs and problems of the elderly and recommendations for action to improve their services to the chief elected official or executive officers of the municipality and DSS. Under prior law, agents were required to submit annual reports to state and local government officials, but these submissions are no longer required.

§§ 4 & 5—Investigating Medicaid Participants for Dual Coverage

The Act adds third-party administrators to the list of entities that must supply certain information on health insurance coverage policyholders who apply for aid or other support from DSS programs.

Health insurers, including self-insured plans, group plans regulated by federal law, service benefit plans, managed care organizations, health care centers, and entities that perform administrative services for them, are already required to provide DSS with information about a policyholder's health care insurance coverage.

22. PUBLIC ACT 12-208. AN ACT EXPANDING ACCESS BY VETERANS TO THE PUBLIC ASSISTANCE PROGRAMS.
    Effective July 1, 2012

    This Act directs DSS, to the extent allowed by federal law, to disregard a veteran's or surviving spouse's federal AAP benefits when calculating income eligibility for state programs such as Medicaid and the Home Care Program for the Elderly.

III. ACTS CONCERNING EMPLOYMENT AND BUSINESS RESPONSIBILITIES

23. PUBLIC ACT 12-33. AN ACT CREATING A PROCESS FOR FAMILY CHILD CARE PROVIDERS AND PERSONAL CARE ATTENDANTS TO COLLECTIVELY BARGAIN WITH THE STATE.
    Effective July 1, 2012

    This Act allows CCPs and PCAs to collectively bargain with the state as an employee organization over state reimbursement rates, benefits, payment procedures, contract

grievance arbitration, training, professional development, and other requirements and opportunities.

- CCPs are individuals paid by the state's Care-4-Kids program to provide day care in licensed private homes or their own homes for the children of low to moderate income families while a parent is working or taking classes.

- PCAs are individuals who provide in-home and community-based personal care assistance to people with disabilities and the elderly and are often paid by Medicaid waiver programs. "Personal care assistance" is defined as supportive home care, direct support services, personal care or another non-professional service provided to a person with a disability or an elderly person who needs assistance to meet daily living needs to adequately function at home or safely access the community.

§§ 2 & 6—Collective Bargaining

Under the Act, CCPs and PCAs have the right to organize into statewide bargaining units and cannot be discharged or discriminated against for organizing. The collective bargaining units are prohibited from bargaining over state employee pension or health care benefits, commencing a strike, filing grievances against parents, consumers or surrogates, and negotiating such individual's right to hire, fire, and direct a member's activities. Dues and initiation fees or non-member service fees will be deducted from the state payments.

The State Board of Labor Relations will certify the exclusive bargaining agents for the unions. The Act denies the Board jurisdiction over any complaints for unfair labor practices against parents by CCPs or against consumers and surrogates by PCAs.

The parties have 150 days once they begin negotiations to agree to a contract. If the parties have not reached an agreement within the set time frame, they must jointly agree on an arbitrator or use an arbitrator selected according to the AAA's voluntary labor arbitration rules. Any contract or arbitration award is required to be written and submitted to the General Assembly for affirmative approval.

Starting July 1, 2012, the Act requires DSS to compile monthly lists of the CCPs who have participated in the Care-4-Kids program within the previous six months and make the list available upon FOIA request.

§ 5—PCA Workforce Council

The Act establishes a thirteen member PCA Workforce Council comprised of state officials and population representatives served by PCAs. The Council is tasked with studying PCA recruitment, retention, and adequacy and developing a plan to improve

PCA quality, stability, and availability. On or after July 1, 2013, DSS and DDS must review the Council's plan. If DSS and DDS approve the plan, they must include requests for funding to implement the plan in any budgetary requests submitted to OPM.

Additionally, the Council must compile and maintain a monthly registry listing the names and addresses of all PCAs who have been paid through state-funded programs within the previous six months.

§§ 3 & 8—Liability

The Act protects the state from liability in any legal action, grievance arbitration or prohibited practice proceeding brought by any union against a parent, consumer or surrogate for a violation of the Act's provisions regarding collective bargaining, the PCA Workforce Council or federal Medicaid waivers and compliance.

24. PUBLIC ACT 12-43. AN ACT CONCERNING FAMILY AND MEDICAL LEAVE BENEFITS FOR CERTAIN MUNICIPAL EMPLOYEES.
Effective May 31, 2012

The Act expands eligibility for the FMLA by granting family and medical leave benefits to same-sex couples and to school paraprofessionals. The FMLA previously only extended benefits to couples in civil unions, as defined in Conn. Gen. Stat. § 46b-38aa.

25. PUBLIC ACT 12-125. AN ACT CONCERNING HEARINGS BEFORE THE ADMINISTRATOR AND THE EMPLOYMENT SECURITY APPEALS DIVISION UNDER THE UNEMPLOYMENT COMPENSATION ACT.
Effective October 1, 2012

§ 1—Initial Unemployment Determinations

The Act provides that if an employee or claimant requests an in-person hearing for an unemployment claim, the administrator or examiner may not unreasonably deny such a request.

§ 2—Unemployment Appeals

Under prior law, when a claimant or employer appealed a DOL unemployment administrator or examiner's determination of a claimant's eligibility for unemployment benefits, the administrator or examiner was required to hear the appeal in-person at a location reasonably convenient for the parties. The Act dictates that the telephone or other electronic means are the default methods for hearing such appeals, unless either party requests an in-person hearing, in which case, an in-person hearing

is required at locations designated by the executive head of the Employment Security Appeals Division.

26. SPECIAL ACT 12-9. AN ACT CONCERNING WORKFORCE DEVELOPMENT.
Effective July 1, 2012

The Act requires the Office of Workforce Competitiveness, in collaboration with DOE, to study model programs for the pre-employment training and employment of young adults with autism spectrum disorder and other developmental disabilities. The Office of Workforce Competitiveness must report on the findings of this study to the General Assembly no later than January 1, 2013.

IV. ACTS CONCERNING HEALTH INSURANCE

27. PUBLIC ACT 12-109. AN ACT CONCERNING COVERAGE OF TELEMEDICINE SERVICES UNDER MEDICAID.
Effective January 1, 2013

The Act allows DSS to establish a demonstration project providing "telemedicine" as a Medicaid-covered service at FQHCs. Under such a program, in-person contact is not required when deemed "clinically appropriate." The Act defines "telemedicine" as the use of interactive audio, video or data communication (other than fax or audio-only telephone) for the delivery of medical advice, diagnosis, care or treatment. The Act also defines "clinically appropriate" as care that is (i) provided in a timely manner that meets professionally recognized standards of acceptable medical care, (ii) delivered in the appropriate medical setting, and (iii) less expensive than equally effective alternative treatments or diagnostic services.

Additionally, this Act authorizes DSS to apply to the federal government to amend the state Medicaid plan, if necessary, to establish the program and to establish cost reimbursement rates for telemedicine service providers, taking into consideration reduced travel costs and other relevant factors. By an unspecified date DSS must report to the General Assembly on the services offered and cost-effectiveness of the program.

Lastly, the Act requires that the transmission, storage, and dissemination of data and records under the program must be subject to federal and state privacy, security, and confidentiality laws safeguarding individually identifiable information.

28. PUBLIC ACT 12-142. AN ACT CONCERNING FINANCIAL LIABILITY FOR AMBULANCE SERVICES, EVIDENCE OF COLLATERAL SOURCE PAYMENTS AND EVIDENCE OF BILLS FROM TREATING HEALTHCARE PROVIDERS.
Effective October 1, 2012

§ 2—Evidence of Collateral Sources

During a determination of economic damages in a personal injury or a wrongful death court case, the Act makes evidence of a specified health care provider accepting an amount from a claimant less than the total amount of any bill generated by that provider, or evidence of an insurer paying less than that total amount of any bill generated by such a provider, admissible as evidence of the total amount of collateral sources that have been paid on behalf of the claimant. The Act applies to the following state-licensed health care providers: physicians, PAs, dentists, chiropractors, naturopaths, physical therapists, podiatrists, psychologists, optometrists, APRNs, and state-certified EMTs.

§ 3—Evidence of Cost of Reasonable and Necessary Medical Care

The Act provides that, in cases in which the law allows a health care provider's signed reports and bills for treatment to be introduced as business entry evidence without such provider testifying, the total amount of any bill generated by such a provider is admissible as evidence on the issue of the cost of reasonable and necessary medical care. Additionally, the calculation of the total amount of the bill cannot be reduced because the provider accepted less than the total amount of the bill or because an insurer paid less than the total amount.

The Act further specifies that this section is not to be construed as prohibiting either party, or the court, from calling the treating health care provider as a witness to provide testimony on the reasonableness of a bill for treatment generated by such health care provider.

The Act applies to the following state-licensed health care providers: physicians, PAs, dentists, chiropractors, natureopaths, physical therapists, podiatrists, psychologists, optometrists, APRNs, and state-certified EMTs.

V. ACTS CONCERNING HOUSING

29. PUBLIC ACT 12-8. AN ACT MAKING TECHNICAL REVISIONS TO STATUTES CONCERNING THE HOUSING COMMITTEE.
Effective May 2, 2012

The Act makes technical changes to the statute, replacing "select" with "joint

standing" when referring to the General Assembly's Housing Committee. The reason for the Act is to fix incorrect references to the Housing Committee as a select committee.

30. PUBLIC ACT 12-41. AN ACT CONCERNING THE EQUAL TREATMENT OF RENTERS WITH MENTAL DISABILITIES.
Effective October 1, 2012

Under current law, tenants who are sixty-two years of age or older or who are physically disabled enjoy certain protections; this Act expands these protections to the family members who permanently reside with such tenants. Under prior law, landlords were prohibited from evicting certain tenants in a building or complex with five or more units or a mobile manufactured home park because their lease expires, in effect guaranteeing housing as long as rent payments are made. Now, the same protections extend to any immediate family member living with the tenant. The Act continues to allow eviction for other causes, such as unpaid rent, engaging in illegal activities, and material non-compliance with the landlord's rules.

Eligible individuals include those with a physical or mental disability as defined in subdivision (8) of Conn. Gen. Stat. § 46a-64b. Disabilities under subdivision (8) consist of mental retardation, mental disability and persons who have a handicap as defined by the Fair Housing Act. To qualify, the disability must be expected to result in death or to last for more than twelve months.

31. PUBLIC ACT 12-157. AN ACT CONCERNING PROPERTY TAX ASSESSMENTS BY MUNICIPALITIES.
Effective October 1, 2012; applicable to assessment years commencing on or after October 1, 2012

The Act authorizes municipalities to impose property taxes on structures that are partially completed or under construction.

32. PUBLIC ACT 12-161. AN ACT CONCERNING THE PRIVATE RENTAL INVESTMENT MORTGAGE AND EQUITY PROGRAM.
Effective July1, 2012

By law, CHFA finances multifamily housing projects subsidized by DECD under the Private Rental Investment Mortgage and Equity Program, which must include low-income affordable units for non-housing uses. In pertinent part, the Act expands the range of such non-housing uses to include retail uses. Further, the Act allows DECD to provide subsidies directly to a housing project's developer or mortgagor, instead of only through CHFA.

33. PUBLIC ACT 12-183. AN ACT CONCERNING REVISIONS TO THE STATE'S BROWNFIELD REMEDIATION AND DEVELOPMENT STATUTES.
Effective June 15, 2012

By law, DECD is required to develop a targeted Brownfield development loan program to provide low-interest loans to eligible applicants that have no direct or related liability for a site's condition and seek to develop the property for specific approved purposes. The Act expands both the definition of "eligible applicant" and the number of approved purposes for development. The definition of "eligible applicant" now includes all economic development agencies, without the requirements of being local, regional or acting on behalf of a municipality. For development, under the Act, purchasers no longer have to develop Brownfield properties only for the purposes of retaining or expanding jobs in the state or for housing for first-time home buyers. Purchasers may now receive low-interest loans to develop Brownfield properties for the additional purposes of: affordable housing units, suitable for first-time home buyers; incentive housing zones; workforce housing; and other residential purposes, as approved by DECD.

"Brownfield," as defined by the Act, means any abandoned or underutilized site where redevelopment, reuse or expansion has not occurred due to the presence, or potential presence, of pollution on the property that requires investigation or remediation for the restoration, redevelopment, and reuse of the property.

34. PUBLIC ACT 12-184. AN ACT CONCERNING SMOKE AND CARBON MONOXIDE DETECTORS AND ALARMS IN RESIDENTIAL DWELLINGS.
Effective October 1, 2012

The Act requires smoke detectors to be temporarily installed in any one or two-family dwelling that is occupied while undergoing interior alterations or additions under a building permit. Additionally, if there is a fuel-burning appliance, fireplace or attached garage present, carbon monoxide detectors are required in the area of the work while in progress. The equipment may combine smoke and carbon monoxide detection into a single device and must be tested and certified under standards issued by the American National Standards Institute and Underwriters Laboratories.

The Act also permits the Commissioner of Construction Services to establish a public awareness campaign to promote the installation of carbon monoxide and smoke detectors in all residential dwellings and educate the public about the dangers of not having such equipment installed.

VI. ACTS CONCERNING PROBATE

35. PUBLIC ACT 12-22. AN ACT CONCERNING THE CONNECTICUT UNIFORM ADULT PROTECTIVE PROCEEDINGS JURISDICTION ACT.

Effective October 1, 2012

The Act aligns Connecticut law with nationwide, uniform procedures to resolve interstate jurisdiction controversies in conservatorship proceedings involving individuals who have connections with more than one state. The Act has been adopted nationally by twenty-nine states and the District of Columbia and aims to facilitate the transfer of cases between jurisdictions and provide recognition and enforcement of a guardianship or protective proceeding order.

§§ 2 & 14—Penalizing Parties for Unjustifiable Conduct

If a probate court determines that it acquired jurisdiction by a party's unjustifiable conduct, the court can decline to exercise jurisdiction and dismiss the case or rescind any order and dismiss the case. Under these circumstances, the Act allows the court to assess that party for necessary and reasonable expenses.

§§ 4–7—Communication and Requests With Out of State Courts

Probate courts may contact the courts of any state or foreign country regarding proceedings arising out of the Act. When communicating with any state or foreign country, the probate court must do the following: (i) allow the parties to participate in such communication; (ii) make an audio recording of the communication; and (iii) give the parties access to the recording. Regarding administrative matters, however, courts may communicate without providing the parties access to such communication.

§§ 8–11—Jurisdiction

A probate court's jurisdiction to appoint a conservator of the person or estate shall be based on the following:

- The person's home state;
- If there is no home state, where the person was physically present for the past six months; or
- Where the person has a significant connection (where substantial evidence on the person is available).

In an emergency, the court may exercise special jurisdiction to appoint a temporary conservator. Should the court determine that another state is a more appropriate forum, the court may refuse to grant jurisdiction.

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§§ 15 & 16—Petitions

If a conservatorship proceeding is brought in Connecticut and Connecticut is not the person's home state, notice must be given to parties of interest in the same manner as required by Connecticut law for appointment of a conservator.

If petitions are filed in multiple states and the Connecticut probate court has jurisdiction, it can proceed unless a court in another state acquires jurisdiction before the appointment or issuance of the order.

If the Connecticut probate court does not have jurisdiction, it must stay the proceeding and communicate with the court in the other state. If the court in the other state has jurisdiction, the Connecticut probate court must dismiss the petition if the other state is a more appropriate forum consistent with the Act and constitutional law.

§§ 17 & 18—Interstate Transfers

The Act establishes conditions and procedures for the probate court to transfer a conservatorship to another state upon the petition of a party and accept a conservatorship from another state. Probate courts may grant provisional orders to ensure the welfare of the conserved person during the transfer of the case.

In order to transfer a case to another state, the court must hold a hearing on its own motion or on request of the conservator, the conserved person or his or her attorney or someone who received notice.

When determining whether to grant a petition to transfer a conservatorship of the *person*, a probate court must issue a provisional order and direct the conservator to petition for conservatorship in the other state if:

1. The court is satisfied that the conservatorship will be accepted by the court in the other state;
2. The conserved person is physically present in or is reasonably expected to move permanently to the other state;
3. No objection to the transfer is made, or anyone who does object fails to establish that the transfer would be contrary to the conserved person's interests, including the person's reasonable and informed expressed preferences;
4. Plans for the conserved person's care and services in the other state (a) are reasonable and sufficient, (b) have been made after allowing the conserved person the opportunity to participate meaningfully in decision making according to the person's abilities, (c) assist the person in removing obstacles to independence and achieving self-reliance, (d) include ascertaining the

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person's views, (e) include making decisions conforming to the person's reasonable and informed expressed preferences, and (f) make all reasonable efforts to make decisions that conform with the person's expressed health care preferences, including any health care instructions and wishes described in valid health care instructions; and

5. The requirements of Connecticut law are met regarding (a) ending the person's tenancy or lease, (b) disposing of his or her real property or household furnishings, (c) changing his or her residence or (d) placing him or her in a long-term care institution.

When determining whether to grant a petition to transfer a conservatorship of the *estate*, the court must issue a provisional order and direct the conservator to petition for conservatorship of the estate in the other state if:

1. The court is satisfied that the conservatorship will be accepted by the court of the other state;
2. The conserved person is physically present in, is reasonably expected to move permanently to or has a significant connection to the other state;
3. Either no objection to the transfer is made or anyone who does object fails to establish that the transfer would be contrary to the conserved person's interests, including the person's reasonable and informed expressed preferences;
4. Adequate arrangements will be made for managing the conserved person's property according to Connecticut law on a conservator's duties and distributions from the estate; and
5. The transfer is made according to Connecticut law regarding (a) ending the person's tenancy or lease, (b) disposing of his or her real property or household furnishings, (c) changing his or her residence or (d) placing him or her in a long-term care institution.

The Act requires the probate court to issue a final order confirming the transfer and terminating the conservatorship when it receives:

1. A provisional order from the out of state court accepting the proceeding issued under provisions similar to the Act's; and
2. The necessary documents required to terminate a conservatorship in Connecticut.

When a probate court grants a petition to accept a conservatorship from another state, the conserved person has the same rights as if the conservator was originally appointed under Connecticut law, including the right to review and terminate the conservator's appointment, and the conservator has the same responsibilities and duties as are imposed on a conservator by Connecticut law.

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§§ 19–21—Registry of Out-of-State Appointments

The Act allows a conservator appointed in another state to register the conservatorship order in Connecticut by filing certified copies of the order and letters of office as a foreign judgment in the probate court for the district where the conserved person resides, is domiciled or is located at the time of filing. Upon registration, a conservator from another state may exercise all powers authorized in the order of appointment, except those prohibited by Connecticut law.

36. PUBLIC ACT 12-66. AN ACT CONCERNING PROBATE COURT OPERATIONS.
Effective as noted

The Act revises various probate court operations provisions, including those related to costs for estates of non-domiciliary testators, transfer of proceedings, supervision of guardianships for persons with intellectual disability, and service of process on non-resident fiduciaries. This Act also codifies current practice regarding probate judges' retirement benefits. The codifications will ensure that the calculation of retirement benefits and contribution to the retirement system properly include any additional compensation received as administrative judge or special assignment probate judge.

§ 8—Estate Settlement Costs for a Non-Domiciliary
Effective May 31, 2012

The Act eliminates a provision on determining estate settlement costs for people who were not domiciled in Connecticut at the time of death and whose wills were proved according to law. For the purpose of calculating costs in a proceeding to settle the estate of someone who was not domiciled in Connecticut at death (whether the person died with a will or intestate), the person is considered to have been domiciled in Connecticut, unless the probate court determines that the in-state proceedings are ancillary to those in the person's state of domicile.

§§ 12–14—Estate Examiners
Effective January 1, 2013

The Act renames temporary administrators as "estate examiners." By law, probate courts may appoint a temporary administrator upon the application of a creditor or other party interested in a deceased person's estate to protect the property until the will is probated or an administrator is appointed.

§ 15—Guardianship and Attorneys for People With Intellectual Disabilities
Effective October 1, 2012

By law, after a guardian is appointed for someone with an intellectual disability, the

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probate court must review the guardianship at least every three years. The Act eliminates the requirement that a ward's attorney submit a report to the court on the status of the guardianship and, instead, requires the court to provide a copy of any report on the ward submitted by the guardian or DDS to the attorney for the ward. Prior law required the review to be based on written reports submitted by DDS, the guardian, and the ward's attorney.

Under the Act, within thirty days of receiving a copy of the report prepared by the guardian or DDS, the ward's attorney must meet with the ward about the report. Within this same time frame, the attorney must also give the court written notice indicating that he or she has met with the ward and whether the attorney or ward will request a hearing. The Act specifies that these provisions do not prevent the ward or his or her attorney from requesting a hearing at other times as the law allows.

§§ 16 & 17—Service of Process on Out-of-State Fiduciaries
Effective January 1, 2013

The Act provides that service of process on a non-resident fiduciary can be made by leaving an attested copy of the process with the probate court that appointed the fiduciary, in lieu of leaving it with the judge.

This includes service on probate judges as attorneys for non-resident fiduciaries. It also includes service on non-resident fiduciaries (including executors, administrators, conservators, guardians or trustees) in their representative capacities or individual capacities in cases related to their service as a fiduciary.

VII. MISCELLANEOUS ACTS OF INTEREST

37. PUBLIC ACT 12-12. AN ACT AUTHORIZING FLAVORING AGENTS FOR PRESCRIPTION PRODUCTS.
Effective July 1, 2012

The Act expands who may request the addition of flavoring agents to a prescription product, now allowing the patient or the patient's agent to make such a request, in addition to the prescribing practitioner. This new law assists the pharmacist in filling prescriptions, often for pediatric patients, in a timely manner. A pharmacist may also add flavoring agents if acting on behalf of a hospital.

38. PUBLIC ACT 12-24. AN ACT CONCERNING SECURITY DEPOSITS OF SENIOR CITIZENS AND PERSONS WITH DISABILITIES IN PUBLIC HOUSING.
Effective October 1, 2012

Beginning January 1, 2013, the Act requires housing authorities, community housing

authorities, and other corporations that receive state financial assistance and provide housing for senior citizens and disabled persons, to pay interest on security deposits at a rate indexed to the commercial bank deposit rate. Current law requires landlords to pay interest on security deposits at a rate of 5.25% per annum.

The new interest rate is determined according the provisions of Conn. Gen. Stat. § 47a-21(i), which calculates the interest rate by averaging the interest rates paid on savings deposits by insured commercial banks. This averaged rate is published in the Federal Reserve Board Bulletin in November of the prior year. For example, the interest rate on security deposits for the 2012 calendar year is 0.16%.

The Act still requires the specified landlords to return security deposits to any tenant when the tenant has resided in the specified housing for at least one year.

39. PUBLIC ACT 12-57. AN ACT CONCERNING PERMANENT ABSENTEE BALLOT STATUS FOR THE PERMANENTLY DISABLED.
Effective January 1, 2013

For voters who have permanent absentee ballot status, the Act instructs each registrar of voters to send an absentee ballot to such voters for each election, primary or referendum conducted in which the voter is eligible to vote. Previously, these voters only received an application for an absentee ballot.

Additionally, the Act requires each registrar of voters to send an annual notice in January to permanent absentee voters inquiring as to the voter's residency and eligibility status. If the notice is unable to be delivered or is not returned within thirty days, the voter will be removed from the permanent absentee ballot rolls.

An individual can qualify for permanent absentee ballot status if he or she is permanently physically disabled and unable to appear in-person at the voter's designated polling place.

40. PUBLIC ACT 12-92. AN ACT TRANSITIONING THE REGULATIONS OF CONNECTICUT AGENCIES TO AN ONLINE FORMAT.
Effective July 1, 2013, except as noted

The Act requires that state agencies publish regulations and proposed rules online on the websites of both the Office of the Secretary of the State and the agency. Currently, agency actions are published in the *Connecticut Law Journal.* A new eleven member Regulation Modernization Task Force will develop an implementation plan for publishing regulations online.

Under the Act, regulations become effective when they are published online, which must be done within five calendar days of the agency's filing. Under prior law,

regulations became effective when an agency filed them with the Secretary of the State.

§§ 6–8—Published Regulations
Effective June 8, 2012

The Act requires the Secretary of State to begin the process of posting regulations, including emergency regulations, online in a manner easily accessible to, and searchable by, the public. The regulations must be updated at least quarterly.

§§ 9–12—Agency Policies

The Act requires any state agency that has written a manual or guidance document to post it on its website. The Act also extends the online posting requirement to all agencies that adopt interim policies or procedures while the policies or procedures are in the process of being adopted in regulation form.

§ 15—Regulation Modernization Task Force

The Act establishes an eleven-member Regulation Modernization Task Force to develop a plan to make state regulations available to the public online by July 1, 2013. The Governor must make appointments to the Task Force within thirty days of the passage of the Act. The Act requires DAS to provide administrative staff support as necessary.

The Act authorizes the Task Force to request bond funds through DAS to pay a consultant for advice on the technical aspects of implementing and maintaining an online system for regulations. The Legislative Commissioners' Office and all executive branch agencies must cooperate and provide information the Task Force needs.

41. PUBLIC ACT 12-148. AN ACT ENHANCING EMERGENCY PREPAREDNESS AND RESPONSE.
 Effective July 1, 2012

 This Act requires PURA to establish performance standards for electric, gas, and telecommunication companies during emergency situations and for restoration of services after an emergency. Specifically, PURA must establish standards for acceptable performance during an emergency during which more than 10% of any utilities' customers go without service for more than forty-eight hours. PURA must further review the performance of each utility after any emergency during which more than 10% of the utility's customers went without service for more than forty-eight hours, or at PURA's discretion.

The Act requires PURA to initiate a docket to establish standards for the restoration of intrastate telecommunications services after an emergency and requires telephone companies and certified telecommunications providers to provide pro rata credits to any of their subscribers for any service outages that occur under certain circumstances.

§ 7—Electrical Services for Critical Facilities

The Act requires DEEP to establish a "microgrid" grant and loan pilot program to support local distributed energy generation for "critical facilities," which include hospitals, any commercial area of a municipality, and municipal centers, so that these critical facilities may operate in both grid-connected or island mode in the event of a service outage.

Additionally, this section charges DEEP, in consultation with the Connecticut Academy of Science, with the task of studying the methods of providing reliable electric services to critical facilities.

§ 13—Reimbursement Program for Electrical Service Outage Spoilage

The Act requires PURA to initiate a docket to study the feasibility of establishing a PURA administered program to reimburse any residential customers of an electric company for spoilage loss of food or refrigerated medications caused by an electrical service outage lasting longer than forty-eight hours. On or before February 1, 2013, PURA must submit a report to the General Assembly with its recommendations regarding the mechanisms needed for administering such a program.

42. PUBLIC ACT 12-158. AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING PUBLIC HEALTH.
Effective June 15, 2012

Under prior law, the state was charged for the cost of caring for an individual committed to a state institution after being found not guilty of a crime by reason of a mental illness. The Act authorizes the state to recover for such costs and authorizes the state to follow existing statutory collection methods.

43. PUBLIC ACT 12-159. AN ACT CONCERNING TREATMENT FOR A DRUG OVERDOSE.
Effective October 1, 2012

Under prior law, licensed health care practitioners were only permitted to prescribe, dispense or administer opioid antagonists to drug users suffering from addiction. The Act now allows practitioners to preemptively prescribe, dispense or administer opioid antagonists to anyone, including family members or other individuals, for the

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treatment or prevention of a drug overdose, without being civilly or criminally liable for prescribing such opioid antagonists or for their subsequent use. By limiting liability, this Act facilitates the availability of critical medication necessary for peers or family members of overdose victims to quickly intervene at the onset of overdose symptoms.

44. PUBLIC ACT 12-207. AN ACT CONCERNING THE ADMINISTRATION OF INJECTABLE VACCINES TO ADULTS IN PHARMACIES.
    Effective October 1, 2012

    Under prior law, pharmacists could only administer federally approved vaccines to prevent flu, pneumonia, and shingles. The Act expands the authority of licensed pharmacists to administer vaccines to adults, allowing them to administer any federally approved vaccine listed on the CDC's Adult Immunization Schedule. Pharmacists must administer these vaccines pursuant to a licensed health care provider's order and in accordance with DCP regulations, which require that pharmacists administering any adult vaccine on the CDC schedule complete an immunization training course.

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