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

2014 REGULAR SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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TABLE OF ACRONYMS

ACA	Affordable Care Act
AG	Attorney General
AIDS	Acquired Immunodeficiency Syndrome
APRN	Advanced Practice Registered Nurse
ASO	Administrative Services Organization
CCNH	Chronic and Convalescent Nursing Home
CE	Continuing Education
CEO	Chief Executive Officer
CFCA	Connecticut False Claims Act
CFR	Code of Federal Regulation
CHFA	Connecticut Housing Finance Authority
CII	Connecticut Innovations, Inc.
CMS	Centers for Medicare and Medicaid Services
COA	Commission on Aging
CRT	Complex Rehabilitation Technology
DAS	Department of Administrative Services
DCF	Department of Children and Families
DCP	Department of Consumer Protection
DDS	Department of Developmental Services

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DECD	Department of Economic and Community Development
DOA	Department on Aging
DOC	Department of Corrections
DOH	Department of Housing
DOJ	Department of Justice
DOL	Department of Labor
DORS	Department of Rehabilitation Services
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSS	Department of Social Services
DVA	Department of Veteran's Affairs
ED	Emergency Department
EMT	Emergency Medical Technician
FDA	Food and Drug Administration
FTE	Full Time Equivalent
FTC	Federal Trade Commission
FY	Fiscal Year
GA	General Assembly
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act

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HITE-CT	Health Information Technology Exchange of Connecticut
HIV	Human Immunodeficiency Virus
LTC	Long Term Care
MOLST	Medical Order for Life-sustaining Treatment
OEC	Office of Early Childhood
OHCA	Office of Health Care Access
OPM	Office of Policy and Management
PA	Physician Assistant
PCA	Personal Care Attendant
RCH	Residential Care Home
RHNS	Rest Home with Nursing Supervision
SCH	Sole Community Hospital
SEIU	Service Employees International Union
SSP	State Supplement Program
TANF	Temporary Assistance for Needy Families
TFAP	Temporary Family Assistance Program
WIC	Women, Infants, Children

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I. SPENDING BILLS AND IMPLEMENTERS

1. PUBLIC ACT 14-47. AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES AND REVENUES FOR THE FISCAL YEAR ENDING JUNE 30, 2015.
Effective July 1, 2014

This Act makes adjustments to the budget for the fiscal year ending June 30, 2015. Of relevance:

- OPM
  - Received a new appropriation in the amount of $28,409,269 for the Tax Relief for Elderly Renters Program. This was moved from DOH.
  - There was a reduction of $63,600 in the Property Tax Relief Elderly Freeze Program from $235,000 to $171,400.
- DOH
  - Elderly Rental Registry and Counselors' appropriation was increased by $138,000 from $1,058,144 to $1,196,144.
  - $875,000 from Tax Relief for Elderly Renters from FY14 was carried forward to a school readiness program for FY15.
- DSS—Overall budget reduced by $28,370,797 from $3,022,889,631 to $2,994,518.
  - Medicaid budget was reduced by $10,301,000 from $2,289,569,579 to $2,279,268,579.
  - Old Age Assistance was reduced by $1,100,000 from $39,949,252 to $38,849,252.
  - The Connecticut Home Care Program received an increase in funds of $2,440,000 from $45,584,196 to $48,024,196. This includes a 1% increase in Medicaid provider rates under this program effective January 1, 2015.
  - $400,000 from Medicaid from FY14 was carried over to the State Comptroller for FY15.
  - Medicaid budget from FY14, as appropriated from the General Fund, was decreased by $43 million. This decrease was spread among a number of departments' FY14 budgets.
- DOA—Received a total budget increase of $152,374, from $8,923,152 to $9,075,526.

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- Personal Services received an increase of $88,402.
- Programs for Senior Citizens received an increase of $20,000.

2. PUBLIC ACT 14-98. AN ACT AUTHORIZING AND ADJUSTING BONDS OF THE STATE FOR CAPITAL IMPROVEMENTS, TRANSPORTATION AND OTHER PURPOSES, AND CONCERNING MISCELLANEOUS PROGRAMS, INCLUDING THE SMART START PROGRAM, THE WATER IMPROVEMENT SYSTEM PROGRAM, SCHOOL SECURITY GRANTS, THE REGENERATIVE MEDICINE RESEARCH FUND, THE CONNECTICUT MANUFACTURING INNOVATION FUND AND THE BOARD OF REGENTS FOR HIGHER EDUCATION INFRASTRUCTURE ACT.

§§ 2 & 9—Bond Authorizations for FY15
Effective July 1, 2014

This Act authorizes the proceeds from the sale of bonds to be used for the following relevant projects:

- $1,900,000 to Office of the Healthcare Advocate for the development, acquisition, and implementation of health information technology systems and equipment in support of the state innovation model, an initiative of the Center for Medicare and Medicaid Innovation that requires the state to produce a state health care innovation plan and a model of health care delivery and payment reforms that will reach 80% of Connecticut's residents within three to five years.
- $6,000,000 to DORS for grants for home modifications and assistive technology devices related to aging in place.

§§ 22, 32–33, & 88—Regenerative Medicine Research Fund
§ 22: Effective July 1, 2015; §§ 32–33: Effective October 1, 2014; § 88: Effective July 1, 2014

This Act authorizes up to $10 million in general operating bonds for each year from FY16 to FY19. This Act shifts the responsibilities and duties of the Regenerative Medicine Research Fund (previously the Stem Cell Research Fund) to CII. Previously, these duties fell on the Commissioner of DPH.

The "Stem Cell Research Fund" name was changed to "Regenerative Medicine Research Fund" to reflect a larger scope. The Act defines "Regenerative Medicine" as the process of creating living, functional tissue to repair or replace tissue organ function lost due to aging, disease, damage, or congenital defect. Regenerative

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Medicine includes stem cell research. The Act now permits the CEO of CII to enter into agreements with other entities, including other countries to collaborate on research.

§§ 28 & 99—Bonds Affecting Social Services and Elderly Housing
Effective July 1, 2014

This Act increased the maximum amount of bonds that can be issued from $1,359,487,544 to $1,439,487,544. This increase is authorized for several projects, including: $39,100,000 to DSS for child day care projects, elderly centers, shelter for victims of domestic violence, emergency shelters and related facilities for the homeless, and multipurpose human resource centers and food distribution facilities.

Last year, pursuant to Public Act 13-268 (2)(b)(1), there was to be a grant of $500,000 to the Metropolitan Economic Development Commission to create elderly housing. That section was repealed and the bond was cancelled.

3. PUBLIC ACT 14-217. AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR ENDING JUNE 30, 2015.

§§ 1–18 & 257—Connecticut False Claims Act Expansion
Effective June 12, 2014

The CFCA prohibits a person from knowingly presenting a false or fraudulent claim for payment or approval under a state-administered health or human services program. Previously, the CFCA applied only to programs administered by DSS. Now, this Act expands the CFCA to include all state-administered health and human services programs, not simply DSS medical assistance programs. The expanded CFCA now includes programs administered by DOA, DSS, DCF, DDS, DMHAS, DPH, DORS, OEC, DAS for worker's compensation claims, and the State Comptroller for health programs administered by that office. The rest of the CFCA remains the same.

§§ 48–54 & 258—Rental Rebate and Administrative Review Process
Effective June 12, 2014 and applicable to applications made on or after April 1, 2014

These sections make certain revisions to prior legislation concerning the rental rebate program, which extends tax relief and administrative review to elderly renters who receive grants under the elderly renter tax relief program; the program provides a partial state refund of rent and utility bills paid by some renters over sixty-five years of age or those with permanent disabilities.

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This Act also replaces the Commissioner of Housing with the Secretary of OPM as the officer that runs the elderly tax relief program. Section 52 also extends the existing elderly tax relief program for homeowners to provide tax relief for elderly renters as well.

§ 74—DSS and Over the Counter Drugs
Effective June 12, 2014

This section clarifies what over-the-counter drugs DSS will pay for under Medicaid. In addition to paying for insulin and syringes, supplements and drugs for HIV/AIDS patients, nutritional supplements for patients who cannot eat food, and smoking cessation drugs, DSS will now pay for over-the-counter drugs that are covered under 42 C.F.R. 440.347, which establishes the benchmarks for "essential health benefits" under ACA, as well as drugs for preventative care that have a benefit rating of "A" or "B" by the U.S. Preventative Services Task Force.

These provisions allow DSS to comply with the requirements of ACA. For example, covered drugs under the U.S. Preventative Services Task Force rating systems include aspirin for men between the ages of forty-five and seventy-nine and women between fifty-five and seventy-nine to prevent cardiovascular disease, or folic acid for women who are pregnant or who could become pregnant.

- See Public Act 14-157, page 27, for another act with similar reference to ACA's essential health benefits regarding over-the-counter drugs.

§ 77—Facility Fees
Effective June 12, 2014

This section requires the State Comptroller to study facility fees and other fees charged by hospitals or health systems for outpatient hospital services, and report on how these fees impact state employee health insurance plans. A facility fee is any fee billed by a hospital or health system for outpatient hospital services that is intended to cover operational, and not professional, expenses. A health system includes a parent corporation of a hospital or hospitals as well as the hospital itself and any entity affiliated with the health system or hospital through ownership, governance or other means. This section now requires the State Comptroller to work with insurers and hospitals or health systems to analyze the impact of facility fees, evaluate their reasonableness, and provide a report to the Governor, the GA, and the Health Care Cost Containment Committee regarding the impact of limiting facility fees on insurance plans and enrollees.

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§ 78—Home Care Cost Analysis
Effective June 12, 2014

In addition to the 1% increase in the Connecticut Home Care Program Medicaid provider rates effective January 1, 2015, this section requires DSS to conduct an analysis of the cost of Connecticut's program for providing home care services to the elderly and those persons with disabilities under the Connecticut home-care program for the elderly and the pilot program for home-care for persons with disabilities. This analysis must include a determination of rates necessary to reimburse providers for costs and must be completed by November 1, 2014. DSS must then submit a report summarizing this analysis by January 1, 2015 to the joint standing committees on Appropriations and Human Services.

§ 135—Qualified Complex Rehabilitation Technology and Billing Codes
Effective June 12, 2014

This section requires DSS to report to the relevant GA committees by January 1, 2015 regarding four new issues related to Medicare and Medicaid reimbursement for complex rehabilitation technology. "Complex rehabilitative technology" refers to durable medical equipment that is individually configured, such as manual and power wheelchairs, adaptive seating and positioning devices and other specialized equipment and accessories including standing frames and gait trainers. This report must study the impact of 1) designating products and services as CRT for billing in HCPCS, 2) setting minimum standards for suppliers to be considered "qualified complex rehabilitation technology suppliers" and eligible for Medicaid reimbursement, 3) keeping the option for CRT to be billed and paid for as a single purchase, allowing single payments for devices that patients need for at least one year, and excluding crossover claims, and 4) requiring Medicaid recipients who are receiving a CRT wheelchair or seating component to undergo an evaluation by a qualified health care professional or a qualified CRT professional to qualify for reimbursement.

§§ 140–154—Connecticut Benefit Corporation Act
Effective October 1, 2014

These sections create a new category of business corporation called a "benefit corporation," which must have the purpose of creating a "general public benefit" or material positive impact on both society and the environment, taken as a whole, as assessed against a third party standard, from business and operations.

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§ 158—Physician and APRN Public Profiles
Effective October 1, 2014

This section authorizes DPH to prioritize collecting information on physicians and APRNs for dissemination to the public through an online profile. Under prior law, DPH was authorized to collect information on all health care providers as the budget allowed. Now, information collection on physicians and APRNs is no longer subject to budgetary restraints, although information on "other health care providers," including optometrists, dentists, and podiatrists, must be collected as appropriations allow. This section additionally requires that the profile indicate whether the physician, APRN, or other health care provider provides primary care services, and whether the APRN is practicing independently or collaboratively with a physician.

§ 159—Approval of PCA Collective Bargaining Agreement Provisions
Effective June 12, 2014

This section approves the agreement between the Personal Care Attendant Workforce Council and the New England Health Care Employees Union (SEIU, District 1199).

§ 173—Uniform Electronic Health Information Technology Standards
Effective July 1, 2014

This Act requires DSS to develop uniform electronic health information technology standards throughout DDS, DPH, DOC, DCF, and DMHAS. DSS must implement and periodically revise the state-wide health information technology plan under Conn. Gen. Stat. § 19a-25d and also establish electronic data standards so that the state may create an integrated electronic health information system for use by health care providers and institutions that receive state funding. Prior to this Act, this responsibility fell on HITE-CT, a quasi-public agency.

The standards must address the following issues: (1) security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) protect individual Social Security numbers through limitations on use and dissemination as well as requiring encryption; (3) require privacy standards no less stringent than HIPAA; (4) require security and traceability for any access to individually identifiable health care information; (5) use nationally recognized data standards to allow for information to be used in other states if necessary; (6) provide for a standard electronic format for collecting health information; and (7) ensure that any system is compatible with the definition of "electronic health information system," which is a comprehensive set of

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requirements in existing law that creates an interactive format for access to a patient's medical record by medical providers and the individual patient.

§§ 180–185—Establishing the Connecticut Retirement Security Board
Effective July 1, 2014

Together these sections define a new Board to conduct a market feasibility study and develop a comprehensive proposal for a public retirement plan. This plan would be mandatory for any employer who employs more than five people in the state of Connecticut that does not offer an employer-sponsored retirement plan.

§ 193—Electronic Prescriptions Allowed for Durable Medical Equipment Reimbursement
Effective June 14, 2014

This section requires DSS to accept electronic prescriptions for durable medical equipment, including but not limited, to wheelchairs, walkers and canes. The prescriptions must be electronically signed by a licensed health care provider with prescriptive authority.

§ 195—Residential Care Home Operating Cost Component Increase
Effective July 1, 2014

For the fiscal year ending June 30, 2015, DSS may, subject to available appropriations and at the Commissioner's discretion, make changes to RCH rate-setting. Under this section, the Commissioner may (1) increase the inflation cost limitation for reimbursements for RCHs for dietary expenses, laundry, housekeeping, and routine nursing care (excluding that provided at a nonmedical facility), up to a maximum of 5%, (2) establish a minimum rate of return of 5% for real property, inclusive of assets placed in service during cost year 2013, (3) waive the standard rate of return for (a) ownership changes or (b) health and safety improvements that are more than $100,000 pursuant to a DPH consent order, and (4) waive the rate of return adjustment in order to avoid financial hardship.

§ 220—Expanding Services under Medicaid State Plan
Effective July 1, 2014

Under this section, the Commissioner of Social Services is required to expand the Medicaid state plan to include behavioral health clinician services for all Medicaid beneficiaries over twenty-one years of age. These clinicians include psychologists, clinical social workers, alcohol and drug counselors, professional counselors, and

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marital and family therapists. These services will be designated as optional, and DSS will provide direct Medicaid reimbursement for participating providers that treat Medicaid recipients in an independent setting. In order to implement this program, DSS may adopt policies and procedures in accordance with the notice of intent to adopt the regulations provided by law.

§ 223—Sales to an Acute Care and Sole Community Hospital
Effective July 1, 2014

This section extends and restricts a sales and use tax exemption related to sales to a for-profit hospital for the next three fiscal years, (FYs ending June 30, 2015 through June 30, 2017). Under prior law, the exemption applied to any sales of tangible personal property or services to an acute care, for-profit hospital, which effectively meant that the exemption only applied to Sharon Hospital. Pursuant to this Act, the exemption now applies to sales of personal property or services to an institution that is a "sole community hospital." A sole community hospital is one that is more than thirty-five miles from similar hospitals or located in a rural area and meets one of several other conditions. At present, Sharon Hospital is the only sole community hospital in the state. Existing law, unchanged by the Act, exempts sales of personal property to and by nonprofit charitable hospitals.

§ 227—Personal Care Attendants and Union Dues
Effective June 14, 2014

This section makes a substantive change to PCAs' requirement to pay union dues. Currently, PCAs cannot have union dues deducted from wages earned from a consumer who is not participating in a waiver program—an example of a non-waiver program is the Connecticut Home Care Plan for Elders. This Act removes the word "waiver" from the statute, so that now dues may be deducted from earnings from a PCA's participation in any program covered by a collective bargaining agreement, not just those in "waiver programs."

Please note, in its recent June 30, 2014 decision, the United States Supreme Court held in *Harris v. Quinn* that personal care attendants in Illinois were partial public employees and therefore could not be required to pay union dues if they were not members of the union. It remains to be seen how this decision will impact Connecticut law.

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II. SPECIFIC ACTS OF INTEREST

4. PUBLIC ACT 14-12. AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE. (RE: APRN STATUTES)

§§ 1 & 3—Increased APRN Requirements and Responsibilities
Effective July 1, 2014

Prior law required APRNs to work in collaboration with a physician pursuant to a written collaborative practice agreement. Now, after practicing collaboratively for at least three years and 2,000 hours, this Act permits APRNs to practice independently. Once a licensed APRN has practiced with a license, in collaboration with a physician, for three years and 2,000 hours, he or she may then diagnose and treat patients as well as prescribe, dispense, and administer medical therapeutics and corrective measures and dispense professional samples of drugs independently.

APRNs practicing independently may also prescribe, dispense, and administer schedule II, III, IV, or V drugs without restrictions.

This Act was amended in the same legislative session by § 52 of Public Act 14-231 (An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes), which is summarized here and can be found at page 19:

> **§ 52—APRNs Practicing in Non-Collaborative Settings**
> *Effective July 1, 2014*
>
> APRNs who practice independently from a physician must have practiced in collaboration with a physician for not less than 2,000 hours in that time. This means that an APRN must practice collaboratively with a physician for 2,000 hours during a three year period before being able to practice independently. Any APRN who chooses to practice independently must maintain documentation that he or she has met this requirement; the documentation must be maintained for at least three years after completion. Prior to beginning independent practice, the APRN must also submit written notice of intent to practice without collaboration to the Commissioner of Public Health. DPH may request the documentation of collaborative practice at any time, and the APRN must submit the requested documents within forty-five days of any request.

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§ 4—License Renewal for APRNs
Effective May 8, 2014

APRNs applying for license renewals on and after October 1, 2014 will have to complete fifty contact hours of CE within the preceding twenty-four month period. This training must be in the APRN's practice area, help the APRN meet the health needs of the public, and include at least five hours of training in pharmacotherapeutics.

This Act was amended in the same legislative session by § 53 of Public Act 14-231 (An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes), which is summarized here and can be found at page 19:

> **§ 53—Changes to P.A. 14-12 APRN Licensing Requirements**
> *Effective June 13, 2014*
>
> This section amends the CE requirements for APRNs to include that APRNs must complete one contact hour of training or education in each of the following topics: AIDS and HIV, risk management, sexual assault, domestic violence, cultural competency, and substance abuse.

DPH may grant a waiver to an APRN for up to ten of the fifty contact hours for activities related to the Connecticut State Board of Examiners for Nursing, or assistance rendered to DPH. APRNs must retain records of earned CE for three years. If DPH requests proof of earned CE, the APRN must provide the records to DPH within forty-five days of the request. These CE requirements do not apply to an APRN applying to renew a license for the first time.

This section contains additional CE provisions concerning APRNs who are not currently engaged in professional practice and APRNs seeking waivers or extensions due to illness or disability.

§ 5—Payments to APRNs by Drug Companies
Effective October 1, 2014

Pursuant to the federal Physician Payment Sunshine Act, drug and medical device manufacturers must submit transparency information to CMS for any payment or transfer of value made to a physician or teaching hospital. This Act requires these manufacturers to report this same information to DCP regarding payments or

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transfers of value to an APRN. Such reports must be first filed on or before January 1, 2015 and quarterly thereafter.

This Act was amended in the same legislative session by § 75 of Public Act 14-217 (An Act Implementing Provisions of the State Budget for Fiscal Year Ending June 30, 2015), which is summarized here:

§ 75—Manufacturer's Disclosure Requirements for Payments to APRNs
Effective October 1, 2014

This Act requires manufacturers of covered drugs or devices to report payments or other transfers to APRNs in Connecticut to DCP, not DPH. This report must be filed quarterly. DCP, not DPH, may publish the information on the website.

Violations of this statute are subject to a civil penalty of $1,000–$4,000 per unreported payment.

5. PUBLIC ACT 14-30. AN ACT CONCERNING CAPITAL EXPENDITURES AT RESIDENTIAL CARE HOMES.
Effective July 1, 2014

This Act sets a limit of a maximum of five years over which DSS may capitalize certain costs RCHs incur. The limit applies to the capitalization of costs less than $10,000 that are related to the improvement or repair of land, buildings, or non-moveable equipment that RCHs purchased and reported to DSS in the cost year used to establish the facility's rate. Prior law required DSS to capitalize each of these costs over a time period based on useful life. Limiting the capitalization period reduces the amount of time it will take for RCHs to recover these costs from DSS.

6. PUBLIC ACT 14-55. AN ACT IMPROVING TRANSPARENCY OF NURSING HOME OPERATIONS.

§ 1—Cost Reports
Effective July 1, 2014

This Act expands the information that for-profit nursing homes must submit annually in their cost reports. Now, for-profit nursing homes must include in their annual cost reports a profit and loss statement from any related party that received at least $50,000 per year for providing goods, fees, and services. The Act defines "related party" as including any "company" ("any person, partnership, association, holding

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company, limited liability company or corporation") related to the nursing home "through family association, common ownership, and control or business association with any of the owners, operators or officials" of the nursing home.

The profit and loss statement submitted must be the most recent annual statement on profits and losses finalized by the related party before the cost report. The Act further provides that if the state does not take action based on profit and loss information required to be included in the cost reports, there is no cause of action or liability against the state, DSS, or any state official or agent.

§ 2—Nursing Home Financial Advisory Committee
Effective May 28, 2014

This section makes changes to the statute authorizing the Nursing Home Financial Advisory Committee. First, it changes the Committee membership by removing the executive director of LeadingAge Connecticut and the executive director of the Connecticut Association of Health Care Facilities. Three new voting members are added: the LTC ombudsman, and two members appointed by the Governor, one a representative of non-profit nursing homes and the other a representative of for-profit nursing homes. The DOL may also appoint one non-voting member.

Second, it modifies the Committee's duties. Prior law required that the Committee recommend appropriate actions that DSS and DPH should take in the event that a nursing home fell into financial distress. This section requires the Committee to assess the overall infrastructure and needs of nursing homes in Connecticut by evaluating information regarding quality of care, acuity, census, and staffing levels. Then, the Committee must recommend to DSS and DPH appropriate action in keeping with DSS' strategic plan for Medicaid LTC support and services.

Because this Committee has not met quarterly as required, the Act requires the Committee to meet on or before August 1, 2014. The Committee must meet with the chairpersons and ranking members of the Appropriations, Human Services, and Public Health committees by October 1, 2014.

7. PUBLIC ACT 14-95. AN ACT CONCERNING THE EXPANSION OF A SMALL HOUSE NURSING HOME PILOT PROGRAM.
Effective July 1, 2014

DSS has a pilot program to support small house nursing homes in order to have more residents in home-like facilities as opposed to institution-like settings. A "small house nursing home" is modeled as a private home with private rooms and bathrooms, and does not house more than fourteen individual units. This Act allows

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DSS to expand the pilot program from one small house nursing home to "one or more" small house nursing homes and also removes the 280-bed limit on the pilot program.

8. PUBLIC ACT 14-142. AN ACT ELIMINATING THE HOME-CARE COST CAP.
Effective July 1, 2014

DSS administers the Connecticut home-care program for the elderly which aims to prevent the institutionalization of elderly people. This Act removes the cost cap on this program. Previously, the annualized cost of community-based services could not exceed 60% of the weighted average cost of care in skilled nursing facilities and intermediate care facilities.

9. PUBLIC ACT 14-162. AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.
Effective July 1, 2014

This Act amends the procedures by which DSS, or any company with whom DSS contracts, may conduct audits of Medicaid providers and facilities that receive Medicaid, including providers paid based on fee schedules such as physicians, home health agencies, adult day centers and providers paid based on cost reports such as CCNHs, chronic disease hospitals associated with CCNHs, RHNSs, RCHs, and residential facilities for persons with intellectual disabilities which are certified to participate in Medicaid. Specifically, the Act:

- allows DSS to consider a provider's or facility's history of compliance when determining which providers or facilities should be subject to audits;
- limits the circumstances under which a finding of overpayment or underpayment to a provider is based on extrapolation;
    - Previously, if the value of the claims in the aggregate exceeded $150,000 on an annual basis, extrapolation could be used to find overpayment or underpayment. Now, the value of the claims in the aggregate must exceed $200,000.
- allows a provider or facility to present evidence at the required exit conference to refute the audit's findings in the preliminary report; and
- requires DSS and DSS-contracted auditors to have on staff or consult with, as needed, health care providers experienced in the relevant treatment, billing, and coding procedures under audit.

The Act also requires DSS to help providers and facilities avoid clerical errors by providing free training on how to enter claims and prepare cost reports. DSS must

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also post information on its website about the auditing process and ways to avoid clerical errors.

The Act requires DSS to establish audit protocols for providers and facilities. For providers, the protocols must be established by February 1, 2015 for licensed home health agencies, drug and alcohol treatment centers, durable medical equipment, hospital outpatient services, physician and nursing services, dental services, behavioral health services, pharmaceutical services, and emergency and nonemergency medical transportation services. For providers subject to cost report audits, DSS must establish and publish on the DSS website audit protocols for (1) CCNHs, (2) chronic disease hospitals associated with CCNHs, (3) RHNSs, (4) RCHs, and (5) residential facilities for persons with intellectual disabilities by April 1, 2015. Significantly, the Act amends Conn. Gen. Stat. § 17b-19a, the statute governing CCNHs, RCHs and other providers subject to cost report audits, to require that DSS adopt regulations, just as it is required to adopt regulations for other providers subject to cost report audits.

This Act requires the Commissioner of Social Services to submit a report on the audit protocols and procedures by February 15, 2015, and a report on the implementation of the audit protocols to the joint standing committee on Human Services not later than February 15, 2016.

10. PUBLIC ACT 14-164. AN ACT CONCERNING DIRECT PAYMENT OF RESIDENTIAL CARE FACILITIES.

§§ 1–3—Calculating Direct Payments
Effective June 11, 2014

Current law requires that the aid granted under the State Supplement and Temporary Family Assistance Programs ("SSP" and "TFAP") be paid directly to the participants of each program. This Act permits aid granted under these programs to be paid directly to a licensed RCH or a rated housing facility where the individual receiving such aid resides. A rated housing facility is (1) a boarding facility or home licensed by DDS, DMHAS, or DCF, or (2) the facility established by New Horizons, Inc., provided that DSS has approved the home or facility to receive SSP payments for residents.

DSS calculates a person's monthly needs and subtracts it from his or her income. The difference becomes the amount of that person's SSP benefit. The Act requires DSS to pay the home or facility at a *per diem* or monthly rate less any applied income due from a resident of an RCH or rated housing facility who is deemed eligible for SSP. If a retroactive rate adjustment results in a current resident becoming eligible for SSP,

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and the resident applies for it, the start date of eligibility for those residents can be the later of the resident's admission date or the date that is ninety days prior to the date DSS received the application.

§ 4—RCH Cost Reports

This Act requires that DSS notify an RCH for failure to submit a complete annual cost report to DSS. If the RCH does not complete an accurate report within thirty days, DSS may withhold a retroactive rate increase.

§ 5—Rate Increases
Effective July 1, 2014

Beginning with the fiscal year ending June 30, 2014, DSS must give rate increases to an RCH for any capital improvement made during that fiscal year for the health and safety of its residents, provided such increase is within available appropriations. The capital improvement must have been approved by DSS.

11. PUBLIC ACT 14-194. AN ACT CONCERNING THE ALZHEIMER'S DISEASE AND DEMENTIA TASK FORCE'S RECOMMENDATIONS ON TRAINING.

§ 1—Nursing and Rest Home Dementia Training
Effective October 1, 2014

This section adds new requirements for staff training for CCNHs and RHNSs. In addition to the regular in-service training already required, these institutions must now provide training on Alzheimer's disease and dementia symptoms and care to all employees annually and when a new employee is hired. One designated staff member must also undertake a review of the care of all dementia residents, and use that information to make recommendations to the nursing home administrator about dementia care, including the factors affecting person-centered care, wellness indicators, and staff training programs regarding dementia care capability. This staff person will also monitor implementation of any recommendations that are approved by the nursing home administrator.

§ 2—Home Health Agency, Residential Care, Assisted Living, and Hospice Dementia Training
Effective October 1, 2014

Every home health agency, RCH, assisted living services agency, and licensed hospice care organization must provide training and education on Alzheimer's disease

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and dementia symptoms and care to all employees annually and when a new employee is hired.

§ 3—Training for Residential Facilities Serving Down Syndrome Residents
Effective October 1, 2014

This section requires DDS to include within DDS regulations the requirement that all residential facilities serving residents that have Down syndrome and are over fifty years of age must have a least one staff member who is trained in Alzheimer's disease and dementia symptoms and care.

§ 4—Timing of Training of Staff in Alzheimer's Special Care Units
Effective October 1, 2014

Under current law, licensed and registered staff and nurse's aides who provide direct patient care in Alzheimer's special care units or programs must complete eight hours of Alzheimer's and dementia specific training. This section requires that the initial training be completed not later than six months after the date of employment or if the date of employment is on or after October 1, 2014, then within 120 days after the date of employment. Current law also requires that unlicensed and unregistered staff (except for nurse's aides) who work at an Alzheimer's special care unit or program, who provide services and care to the residents, must complete at least one hour of such training annually.

§§ 5–6—Nursing Home Administrator Licensing Requirements
Effective November 1, 2014

Under these sections, an applicant for a Nursing Home Administrator license who is applying for licensure by examination must now also complete training in Alzheimer's disease and dementia symptoms and care as a requirement of licensure. In addition, this section requires that applicants for license by endorsement must now have training or education in long-term care, including Alzheimer's and dementia symptoms and care, or certify that they will get training no later than 120 days after being licensed.

§ 7—Nursing Home Administrator License Renewal
Effective October 1, 2014

This section requires all licensed nursing home administrators to complete training in Alzheimer's disease and dementia symptoms and care as part of their mandatory minimum of forty hours of CE every two years. This section adds the Alzheimer's

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Association to the list of organizations authorized to provide qualified CE programs and activities.

§ 8—Health Care Institution Training
Effective October 1, 2014

The Commissioner of Public Health must now include training on Alzheimer's disease and dementia in his or her regularly adopted regulations addressing the standards of higher education, licensing requirements, residency training programs, and reinstatement of expired nursing home administrator licenses.

§ 9—Long Term Care Ombudsman
Effective October 1, 2014

Under this section, the LTC Ombudsman must now provide training in Alzheimer's and dementia symptoms and care to regional ombudsmen residents' advocates and employees of the LTC Ombudsman's Office who are individually designated by the LTC Ombudsman.

§ 10—Probate Court
Effective October 1, 2014

The Probate Court Administrator must now develop a plan to offer training on diseases that can affect a person's judgment, such as Alzheimer's and dementia, to probate judges, paid conservators, and other persons who may act as fiduciaries.

§ 11—Department of Social Services Training
Effective October 1, 2014

DSS must ensure that all employees who work in DSS's protective services for the elderly program and who work directly with elderly persons, receive annual training in Alzheimer's disease and dementia symptoms and care.

§ 12—Emergency Medical Technician Training
Effective October 1, 2014

This section now requires that the thirty hours of EMT recertification refresher training that EMTs must take every three years contain training in Alzheimer's disease and dementia symptoms and care.

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12. PUBLIC ACT 14-203. AN ACT CONCERNING HEPATITIS C TESTING.
Effective October 1, 2014

This Act requires that all primary care providers (including physicians, APRNs, and PAs) offer to provide every patient born between 1945 and 1965 a Hepatitis C screening or a Hepatitis C diagnostic test. A primary care provider is not required to offer the screening or diagnostic test if the patient is being treated for a life-threatening emergency, if the patient has already been offered or received the test, or if the patient is unable to give consent to the test.

13. PUBLIC ACT 14-224. AN ACT CONCERNING THE PHARMACY PRACTICE ACT AND COUNTERFEIT DRUGS OR DEVICES.
Effective July 1, 2014

§ 1—How Prescribers Must Specify "Brand Medically Necessary" Prescription Drugs

This section changes the existing requirements for a prescribing practitioner to specify a non-generic drug in a prescription for a Medicaid beneficiary. Prior to this revision, a practitioner would write the phrase "brand medically necessary" on a handwritten form or include a statement of "brand medically necessary" in a telephone or electronic communication to a pharmacy regarding the Medicaid beneficiary's prescription. For telephonic or electronic orders, the practitioner was then required to send written certification in the practitioner's handwriting within ten days of the request to confirm the brand-specific order.

Now, the prescriber may indicate on the prescription form that the drug is "brand medically necessary" or "no substitution." For written prescriptions, this may be on the prescription form. For telephonic orders, the pharmacist should write either of the phrases on the prescription form, in the pharmacist's handwriting, or record the request on the electronic prescription record. The pharmacist must also record on the prescription form the time that the telephone authorization was received and who called in the order. For other forms of electronic prescription ordering, the practitioner must select the "dispensed as written" code on the certified electronic prescription form. At no time may any prescription form, whether written or electronic, default to "brand medically necessary." The requirement that a practitioner send written confirmation for a telephonic or electronic order is removed.

- See Public Act 14-158, page 27, for another act with similar changes to the designation of a drug as "brand medically necessary."

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14. PUBLIC ACT 14-231. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

§ 7—Nursing Facility Management Services
Effective October 1, 2014

This Act permits DPH to require that a nursing facility license holder and the nursing facility management service certificate holder jointly submit a plan of correction when DPH finds that there has been a substantial failure to comply with statutes and regulations governing nursing homes.

§ 10—Nursing Home Medical Records
Effective October 1, 2014

This section permits CCNHs and RHNSs to use electronic signatures for medical records as long as the facility maintains written policies to maintain the privacy and security of the electronic signatures.

§ 13—Eliminating Certain Requirements from the Nursing Home Resident Medical Examination
Effective October 1, 2014

This section eliminates the requirement that CCNHs and RHNSs include urinalysis, including protein and glucose qualitative determination and microscopic examinations, in the comprehensive medical history and examination that must be completed for each resident upon admission and annually thereafter.

§ 15—Waiver of Regulation for Health Care Institutions
Effective October 1, 2014

This section expands the scope of waivers that DPH may grant to include any regulations affecting an "institution," rather than only for the physical plant requirements for RCHs. An institution is any hospital, RCH, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or

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treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for the mentally retarded licensed and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded.

§ 27—Nursing Home Requirement for Oral Health and Hygiene Training
Effective October 1, 2014

This section adds to the training requirement for any nursing home that is not an RCH or an Alzheimer's special care unit. Now, in addition to two hours of training in pain recognition and management, this Act requires that nursing homes must provide a minimum of one hour of training in oral health and hygiene for all direct care staff and nurse's aides who provide patient care. This training must be conducted annually for existing staff and for new employees within one year of the date of hire.

§ 36—Licensed Clinical Social Workers
Effective October 1, 2014

Applicants for Clinical Social Work licensure who are licensed or certified in another state or territory may substitute three years of licensed or certified work experience for Connecticut's 3,000 hour post-master's work requirement as long as the out of state work experience equals or exceeds the Connecticut post-master's experience requirements.

§ 52—APRNs Practicing in Non-Collaborative Settings
Effective July 1, 2014

In addition to the new requirements for APRNs discussed at P.A. 14-12 on page 9, APRNs who practice independently from a physician must have practiced in collaboration with a physician for not less than 2,000 hours in that time. This means that an APRN must practice collaboratively with a physician for 2,000 hours during a three year period before being able to practice independently. Any APRN who chooses to practice independently must maintain documentation that he or she has met this requirement; the documentation must be maintained for at least three years after completion. Prior to beginning independent practice, the APRN must also submit written notice of intent to practice without collaboration to the Commissioner of Public Health. DPH may request the documentation of collaborative practice at any time, and the APRN must submit the requested documents within forty-five days of any request.

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§ 53—Changes to P.A. 14-12 APRN Licensing Requirements
Effective June 13, 2014

This section requires that APRNs complete one contact hour of training or education in each of the following topics: AIDS and HIV, risk management, sexual assault, domestic violence, cultural competency, and substance abuse.

This section modifies § 4 of Public Act 14-12 (An Act Concerning the Governor's Recommendations for Improving Access to Health Care), which is summarized here or can be found at page 9:

> **§ 4—License Renewal for APRNs**
> *Effective May 8, 2014*
>
> APRNs applying for license renewals on and after October 1, 2014 will have to complete fifty contact hours of CE within the preceding twenty-four month period. This training must be in the APRN's practice area, help the APRN meet the health needs of the public, and include at least five hours of training in pharmacotherapeutics.

§ 67—Change to Section One of Special Act 14-5

Please see summary for Special Act 14-5 below.

§ 70—Requirement Removed from Physician Assistant Written Orders
Effective October 1, 2014

This section removes the requirement that PAs include the printed name of their supervising physician on written orders.

15. SPECIAL ACT 14-5. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST).
Effective May 28, 2014

The Commissioner of Public Health may establish a pilot program in one or more geographic areas of the state to begin the use of "medical orders for life-sustaining treatment" (MOLST) by health care providers. A MOLST is a written medical order made by a physician, APRN, or PA to effectuate a patient's request for life-sustaining treatment in the end stages of terminal illness or advanced frailty. The Commissioner may also establish an advisory group to help establish the pilot program and make recommendations. This advisory group may be made up of physicians, APRNs, PAs,

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emergency medical service providers, patient advocates, including advocates for persons with disabilities, hospital representatives, and long-term care facility representatives. Prior to establishing the pilot program, the Commissioner may contact health care institutions as well as individual doctors, APRNs, and PAs in the pilot's geographic area, to request their participation. Such participation is voluntary. Likewise, patient participation in the pilot program is voluntary. Patients must sign an agreement to participate in the pilot program and the health care institution or practitioner requesting the patient's participation must maintain the written agreement.

If a pilot program is established and later terminated, the Commissioner shall submit a report to the Governor and the joint committee on Public Health. Any pilot program will terminate before October 1, 2016.

The Commissioner must create policies and procedures for the pilot program to ensure that (1) the medical orders for life-sustaining treatment can be transferred to and recognized by different types of health care providers, (2) any forms and procedures used in creating the MOLST will require the signature of the patient or legally-authorized representative and a witness (per P.A. 14-231 § 67), and that the patient/representative then receives a copy of the signed order, (3) prior to offering any form for signature, a provider will discuss the patient's goals for care and treatment and the benefits and risks of various methods of documenting the patient's end of life wishes, including MOLST, and (4) any provider who intends to write a MOLST will receive training regarding patient counseling, presenting end-of-life care information in a neutral fashion, obtaining informed consent about the effects of a MOLST, factors that may affect the use of MOLST, and procedures for properly completing and implementing MOLSTs.

This Act was modified by § 67 of Public Act 14-231 (An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes), which is summarized here:

> **§ 67—Legally Authorized Representatives and Physician Orders**
> *Effective June 13, 2014*
>
> This Act modifies S.A. 14-5 to define "legally-authorized representative" as used in S.A. 14-5 as "a patient's parent, guardian, or health care representative" appointed under the health care representative statutes that define the process for naming a health care representative who is authorized to make medical decisions for a patient over eighteen years of age. This Act also requires that any procedures and forms that are

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developed for recording MOLST documents under this pilot program must consider the physician orders for the life-sustaining treatment paradigm, and adds the requirement that a witness sign the MOLST along with the patient or the patient's legally authorized representative.

Prior to this Act, S.A. 14-5 did not contain this definition of "legally authorized representative" nor did it require a witness signature or consideration of physician orders.

16. SPECIAL ACT 14-20. AN ACT CONCERNING SENIOR SAFETY ZONES.
Effective June 13, 2014

This Act establishes a task force regarding "senior safety zones," which are areas where senior citizens live or congregate that need special observation to protect seniors from registered sex offenders. This task force is charged with examining (1) best practices nationwide for protecting seniors from interaction with sexual offenders at the senior's home, at senior centers, or at long-term nursing facilities; (2) legal considerations related to identifying sexual offenders as well as preventing them from entering public facilities where seniors may live or congregate; (3) data on sexual offenders who abuse the elderly; and (4) how to identify sexual offenders and limit their presence in these safety zones without affecting their constitutional rights. The task force's administrative staff will be the administrative staff of COA, and the task force must issue a report by January 1, 2015. Upon submission of this report, the task force shall terminate.

The Act requires that the task force appointments be made within thirty days of June 13, 2014 and include the following members:

- Two appointed by the speaker of the House of Representatives, one of whom shall be a manager of a senior center and one of whom shall be a representative of a long-term care facility that provides skilled nursing care to residents
- Two appointed by the president pro tempore of the Senate, one of whom shall be a resident of housing for elderly persons financed pursuant to section 8-114a of the general statutes and one of whom shall be a resident of congregate housing for the elderly financed pursuant to section 8-119h of the general statutes
- One appointed by the majority leader of the House of Representatives, who shall be an attorney with experience in constitutional law

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- One appointed by the majority leader of the Senate, who shall be a chairperson or vice-chairperson of the joint standing committee of the GA having cognizance of matters relating to aging
- One appointed by the minority leader of the House of Representatives, who shall be a ranking member of the joint standing committee of the GA having cognizance of matters relating to aging
- One appointed by the minority leader of the Senate, who shall be a probation officer experienced with sexual offenders
- The executive director of the Commission on Aging or the executive director's designee
- The State Long-Term Care Ombudsman or the ombudsman's designee

III. ACTS CONCERNING HEALTH INSURANCE

17. PUBLIC ACT 14-62. AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.
Effective July 1, 2016

DSS, DCF, and DMHAS contract with ASOs to provide care and administer services to Medicaid beneficiaries. This Act changes the requirements of ASO contracts with respect to the provision of hospital ED services for Medicaid recipients. It authorizes the use of a cost-sharing requirement in state contracts with the ASO to reduce inappropriate use of hospital ED services and requires that the ASO provide intensive case management, which includes: (1) the identification by ASOs of hospital EDs which may benefit from intensive case management based on the number of Medicaid clients; (2) the creation of regional intensive case management teams to work with ED physicians to (a) identify Medicaid beneficiaries who would benefit from intensive case management, (b) create care plans for such beneficiaries, and (c) monitor progress of such beneficiaries; (3) the assignment of at least one staff member from a regional intensive case management team to the ED during hours when Medicaid beneficiaries who are frequent users (those that have ten or more ED visits per year) visit the ED the most.

ASO contracts must also require that the ASO assess primary care physicians and specialists, and reach out to Medicaid beneficiaries to (1) inform them of the advantages of seeing a primary care physician, (2) help those beneficiaries connect

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with primary care providers, and (3) help arrange visits to primary care providers for Medicaid beneficiaries after ED visits.

ASOs are required to report annually on Medicaid beneficiaries' use of ED services, such as the number of visits, the reason for such visits, and whether the beneficiary has an appointment with a primary care physician after the ED visit. DSS then uses this report to measure whether the ASOs are helping frequent users.

Finally, state-issued Medicaid cards must contain the name and contact information of the beneficiary's primary care provider.

18. PUBLIC ACT 14-118. AN ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY.
Effective January 1, 2015

This Act expands the prohibition on insurers requiring insureds to obtain prescription medicine from a mail order pharmacy in order to obtain drug benefits to include all types of insurance entities covering prescription drugs, and insurance contracts as well as policies, whether such contracts and policies are delivered, renewed, amended, or continued. In addition, the Act creates an additional prohibition related to step therapy.

Step therapy is a protocol or program that establishes the specific sequence for prescribing drugs for a specified medical condition. An entity delivering, issuing for delivery, renewing, amending, or continuing an individual health insurance policy or contract that provides coverage for prescription drugs can no longer require the use of step therapy for longer than sixty days. After sixty days, the insured's health care provider can deem the step therapy program ineffective, in which case, the insurer must authorize coverage of a drug prescribed by the health care provider. If the health care provider does not deem the step therapy ineffective, the insurer may continue with it.

In addition to the sixty-day limitation, the insurer must notify its health care providers of the override process, which process must permit override if the health care provider demonstrates that the step therapy (a) has been ineffective in the past, (b) is expected to be ineffective based on the known characteristics of the insured, (c) will cause or likely will cause an adverse reaction or physical harm, or (d) is not in the best interest of the insured, based on medical necessity.

This Act does not affect a provider's or a covered person's right to request a review of a claims denial or affect the law requiring coverage of pain management treatments.

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19. PUBLIC ACT 14-145. AN ACT CONCERNING THE FEES CHARGED FOR SERVICES PROVIDED AT HOSPITAL-BASED FACILITIES.
Effective October 1, 2014

This Act requires that hospital-based facilities provide patients written notice that the facility charges both a facility fee and a professional fee. A facility fee is a fee intended to compensate the hospital or health system for the operational expenses of the hospital or health system separate from a professional fee, and a professional fee is a fee charged for professional medical services of the provider.

This notice must discuss the patient's potential liability and instruct the patient to call his or her insurer for more information.

Additionally, all hospital-based facilities must prominently display written notice in locations that are readily accessible and visible to patients, stating that (1) they are part of a hospital or health system, and (2) if the hospital-based facility charges a facility fee, that the patient may be charged more than if the facility was not hospital-based. The facility must also hold itself out to the public and payors as being hospital-based and must state the name of the hospital or health system in its signage.

Hospital-based facilities are facilities owned or operated by a hospital or health system where hospital or professional medical services are provided.

The requirements under this Act to provide written notice to the patient do not apply if the patient is insured by Medicare or Medicaid or is receiving services under a workers compensation plan. We note that Medicare requires similar notices for all hospital outpatient "provider-based" locations.

20. PUBLIC ACT 14-150. AN ACT CONCERNING WAIVERS FOR MEDICAID-FINANCED, HOME AND COMMUNITY-BASED PROGRAMS FOR INDIVIDUALS WITH ACQUIRED BRAIN INJURY.
Effective July 1, 2014

Since 1999, DSS has offered home and community based programs for adults with acquired brain injuries who are under sixty-five years of age. Currently, DSS has one waiver from federal law to establish a Medicaid-financed, home and community-based program for individuals with acquired brain injury. This Act permits DSS to seek a second waiver in addition to the first, and establishes an advisory committee for the second waiver program.

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21. PUBLIC ACT 14-157. AN ACT CONCERNING COVERAGE UNDER STATE MEDICAL ASSISTANCE PROGRAMS FOR CERTAIN OVER-THE-COUNTER DRUGS.
Effective June 11, 2014

This Act expands the parameters under which DSS may pay for over-the-counter drugs to now include the over-the-counter drugs that are required to be covered under the federal essential health benefits plan.

- See § 74 of Public Act 14-217, page 3, for another act with similar reference to ACA's essential health benefits regarding over-the-counter drugs.

22. PUBLIC ACT 14-158. AN ACT CONCERNING BRAND NAME DRUG PRESCRIPTIONS FOR STATE MEDICAL ASSISTANCE RECIPIENTS.
Effective July 1, 2014

Under prior law, pharmacies were permitted to bill Medicaid for a brand name drug only when it is specified as "medically necessary" by a physician. This Act now allows physicians to submit a prescription stating that a brand name drug is "medically necessary" by electronic means, when previously, such statement had to be hand-written. The Act still requires pharmacists to provide a cheaper generic drug if available, unless the physician specifies that there shall be no substitution.

- See § 1 of Public Act 14-224, page 18, for another act with similar changes to the designation of a drug as "brand medically necessary."

23. PUBLIC ACT 14-180. AN ACT CONCERNING NOTICE OF A PATIENT'S OBSERVATION STATUS.
Effective October 1, 2014

This Act requires that each hospital provide oral and written notice to each patient if the hospital decides to place the patient on "observation status" within twenty-four hours of such decision being made, unless the patient has already been discharged or left the hospital. Both the oral and written notice must include the following information: (1) a statement that the patient is not admitted to the hospital, but rather under observation status; (2) that this observation status may affect Medicare/Medicaid/private insurance coverage for hospital services including medications and pharmaceutical supplies, home or community-based care, or care at a skilled nursing facility upon the patient's discharge; and (3) a recommendation that the patient contact his or her insurance company or the Office of Health Care Advocate to understand the consequences of being placed on "observation status."

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The written notice provided by the hospital pursuant to this Act must be signed and dated by the patient or his or her legal representative.

24. PUBLIC ACT 14-206. AN ACT CONCERNING MEDICAID COST SAVINGS. *Effective June 13, 2014*

Currently, the Council on Medical Assistance Program Oversight advises the Commissioner of Social Services about the planning and implementation of state health care programs, including those for the elderly and beneficiaries dually eligible for Medicaid and Medicare.

This Act modifies the makeup of the Council by creating a standing subcommittee of six newly appointed members, one each appointed by the six legislative leaders. These members must only work on the new subcommittee of the Council. Their task is to study and make recommendations to the Council regarding evidence-based best practices concerning Medicaid cost savings. The subcommittee chooses its chairpersons from among its members. Its first report must be filed with the Council by January 1, 2015.

The Act adds the following members to the Council to serve on the subcommittee:

- A member of the Connecticut Hospital Association, appointed by the House speaker
- A representative of the business community with experience in cost efficiency management, appointed by the Senate president pro tempore
- A representative from the for-profit nursing home industry, appointed by the House majority leader
- A physician who serves Medicaid beneficiaries, appointed by the Senate majority leader
- A representative of the not-for-profit nursing home industry, appointed by the House minority leader
- A representative of the business community with experience in cost efficiency management, appointed by the Senate minority leader

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IV. ACTS CONCERNING EMPLOYMENT AND BUSINESS RESPONSIBILITIES

25. PUBLIC ACT NO. 14-1. AN ACT CONCERNING WORKING FAMILIES' WAGES.
Effective July 1, 2014; first increase in minimum wage effective January 1, 2015; second increase in minimum wage effective January 1, 2016; third increase in minimum wage effective January 1, 2017

The Act increases the hourly minimum wage from $8.70 to $9.15, beginning January 1, 2015. The hourly minimum wage increases again from $9.15 to $9.60, beginning January 1, 2016. It then increases from $9.60 to $10.10, beginning January 1, 2017.

Learners, beginners, and people under age 18 may be paid 85% of the minimum wage for the first 200 hours of their employment. Thus, the minimum wage for this category of workers will change from $7.40 to $7.78 in 2015; from $7.78 to $8.16 in 2016; and from $8.16 to $8.59 in 2017.

26. PUBLIC ACT 14-128. AN ACT CREATING PARITY BETWEEN PAID SICK LEAVE BENEFITS AND OTHER EMPLOYER-PROVIDED BENEFITS.
Effective January 1, 2015

This Act amends the state's paid sick leave statutes. Certain employers with fifty or more employees in Connecticut must provide up to forty hours of paid sick leave per year to service workers. A service worker is defined as an hourly, non-exempt employee primarily engaged in one of the many occupations listed at § 31-57r.

This Act changes (1) the method for determining if an employer is exempt from providing paid sick leave and (2) the timeframe for accruing paid sick leave. Under prior law the determination of whether a business employed fifty or more employees was made January 1st, annually, and was based on whether the entity employed fifty or more in any one quarter in the previous year. Now, pursuant to this Act, the determination is based on the entity's payroll for the week of October 1st annually. Thus, now, if an entity employs fifty or more on its payroll containing the week of October 1st, the entity is subject to the requirement to provide sick leave.

Additionally, the Act amends current law to provide that no employer may terminate an employee, dismiss an employee, or transfer an employee solely in order to avoid having fifty or more employees, thus triggering the paid sick leave requirement.

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For the purposes of this Act, a year is defined as any 365 day period used by an employer to calculate employee benefits. Previously, all employers had to use the calendar year regardless of the employer's fiscal year.

27. PUBLIC ACT 14-154. AN ACT CONCERNING THE INTEGRITY OF THE BUSINESS REGISTRY.
Effective July 1, 2015, except fee provisions are effective January 1, 2015

This Act amends statutes related to corporate documents filed with the Secretary of State's Office by eliminating fees for certain filings, including a certificate of dissolution of a nonstock corporation.

The Act also authorizes the Secretary of State to prepare and file a certificate of administrative dissolution whenever corporations fail to file their annual reports. Timeframes for administrative dissolution vary by type of business entity. The Act also requires business entities to include an email address on certain documents that they file with the secretary.

28. PUBLIC ACT 14-159. AN ACT CONCERNING EMPLOYERS AND HOME CARE WORKERS.
Act Effective January 1, 2015, but ability to exclude eight hours takes effect on or after the effective date of the U.S. Department of Labor's Final Rule on fair labor standards for domestic workers

This Act allows employers and employees to agree in writing to exclude up to eight hours of sleep time from the overtime hours worked by employees working in "companionship services," who must remain at the worksite for at least twenty-four consecutive hours. In order to exclude the sleep time from overtime pay, the employer must provide adequate on-site sleeping facilities, and the employee must receive at least five hours of sleep time. If the employee's sleep is interrupted, the interruption counts as hours worked, and if the employee gets less than five hours of sleep, all hours slept count as hours worked.

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V. ACTS CONCERNING HOUSING AND REAL PROPERTY

29. PUBLIC ACT 14-26. AN ACT MAKING TECHNICAL CORRECTIONS TO STATUTES CONCERNING HOUSING.
Effective October 1, 2014

In 2013, the administration of certain housing-related matters was transferred from DECD to DOH. This Act eliminates the requirement that DECD provide an annual report to the Governor and GA summarizing its housing development efforts. DOH has assumed authority over housing development efforts and must, by law, report on them.

This Act also makes the DOH Commissioner responsible for ensuring that residential anti-displacement and relocation assistance plans are properly implemented in connection with housing and community development projects that receive state assistance. The DECD Commissioner is still responsible for ensuring that the plans are properly implemented in connection with similarly financed economic development projects.

30. PUBLIC ACT 14-35. AN ACT TRANSFERRING CERTAIN POWERS AND FUNCTIONS OF THE DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT TO THE DEPARTMENT OF HOUSING.
Effective October 1, 2014; provisions concerning grants to nonprofit housing organizations effective July 1, 2014

This Act transfers various housing-related powers from the DECD Commissioner to the DOH Commissioner, including the ability to award grants to nonprofit housing assistance or nonprofit housing development organizations to support technical assistance planning, predevelopment, development, construction and management of housing developments.

31. PUBLIC ACT 14-45. AN ACT TRANSFERRING FUNDS DEPOSITED IN THE COMMUNITY INVESTMENT ACCOUNT TO THE DEPARTMENT OF HOUSING.
Effective May 28, 2014

This Act redirects to DOH all Community Investment Account funds that CHFA received under prior law. The Community Investment Account is a separate, non-lapsing account in the General Fund that provides funding for open space, farmland preservation, historic preservation, affordable housing, and promoting agriculture.

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32. PUBLIC ACT 14-46. AN ACT CONCERNING THE DEPARTMENT OF HOUSING'S RECOMMENDATIONS FOR REVISIONS TO THE SUPPORTIVE HOUSING INITIATIVE STATUTE.
Effective July 1, 2014

This Act makes changes to the supportive housing statute. It adds the Commissioners of DDS and DVA to the Commissioners who work with the Commissioner of DMHAS to establish permanent supportive housing services for the homeless and those at risk of homelessness. Most importantly, the Act removes the specific eligibility requirements from the prior statute, which required that individuals meet one of the following criteria: (1) affected by psychiatric disabilities or substance abuse; (2) eligible for TANF; (3) being an adult aged 18–23 transitioning out of foster care; or (4) being a community-supervised offender with serious mental health needs.

33. PUBLIC ACT 14-88. AN ACT CONCERNING BROWNFIELD REMEDIATION AND DEVELOPMENT.
Effective June 3, 2014

By law, a property owner may begin to investigate and remediate a site under DEEP's voluntary cleanup program before it is required to under the Transfer Act, which requires the party transferring the property to certify the site's investigation and remediation. This Act gives property owners who do not participate in the voluntary cleanup program more latitude under the Transfer Act by allowing the property owners to submit an interim verification in lieu of a complete verification. An interim verification is an opinion, written by a licensed environmental professional that: (1) says an investigation has been performed according to law; (2) states that the remediation has been completed and is in accordance with standards, except that the remediation for ground water has not been achieved; (3) identifies the long-term remedy being implemented to achieve groundwater standards; and (4) states that there are not exposure pathways to the groundwater area. The complete verification is a written opinion indicating the whole investigation and remediation is finished.

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VI. ACTS CONCERNING PROBATE

34. PUBLIC ACT 14-103. AN ACT CONCERNING PROBATE COURT OPERATIONS.
Effective July 1, 2014

When appointing a conservator to an estate, this Act allows probate courts to also appoint a successor conservator. If the conservator resigns, dies, or is adjudicated incapable, the successor conservator acts as the conservator. This Act also allows an adult to designate a successor conservator when he or she is designating a conservator and amends the statutory form of advanced directive to include the designation of a successor conservator.

35. PUBLIC ACT 14-121. AN ACT CONCERNING THE APPOINTMENT OF A CONSERVATOR FOR A PERSON WITH INTELLECTUAL DISABILITY.
Effective October 1, 2014

§ 1—Evidence of Respondent's Condition

When determining whether a person with an intellectual disability requires a conservator, the court must receive evidence regarding the individual's condition. In lieu of medical evidence from physicians, now, pursuant to this Act, the court may receive psychological evidence from a psychologist who has examined the individual within the forty-five days prior to the hearing. Likewise, when the court reviews the conservatorship of an individual with an intellectual disability, a psychologist's report may be submitted in lieu of a physician's report.

36. PUBLIC ACT 14-204. AN ACT CONCERNING THE DUTIES OF A CONSERVATOR AND OTHER PERSONS AUTHORIZED TO MAKE DECISIONS RELATING TO THE CARE AND DISPOSITION OF A DECEASED PERSON'S BODY.
Effective October 1, 2014

§§ 1–3—Documentation Relating to the Disposition of a Body

This Act amends the statute setting forth the form of power of attorney appointment to include the ability to execute a written document in advance of the principal's death directing the disposition of the body upon death or designating an individual to have custody and control the disposition of the principal's body upon death.

The Act also permits a conservator to execute a written document before the principal dies directing the disposition of the body, or designating someone to have custody

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and control of the disposition of the body. In this document, the conservator may also name another individual responsible for disposition and an alternate to that individual. This written document must be signed by the conservator and witnessed by two witnesses. Such a document must also contain clauses indicating that the document is (1) valid if the principal is under conservatorship at the time of his or her death and (2) terminates if the conservatorship ends before the death of the conserved person. Any person responsible for the disposition of the body will provide for disposition in accordance with the written document, unless otherwise approved by the Probate Court.

As before, if there is no written document designating the disposition of the body, or if a person responsible for making such a designation (or his or her alternate) cannot be located within forty-eight hours of the death or the discovery of the body, then the following persons, in the order listed, have the right to control disposition: (1) spouse (2) adult children (3) parents (4) siblings (5) next adult in the legal order of inheritance greater than the third degree of kinship (6) other adult appointed by the Probate Court. Now, pursuant to this Act, if there is more than one person in any category in (2) through (5), the control shall be given to the majority of the members of the class who can be located and agree to participate in making the arrangements within ten days after the identification of the deceased. This decision among class members will be made in writing.

§ 4—Conservators and Advanced Health Care Directives

In addition, this Act provides that a conservator must comply with a principal's directive regarding the disposition of his or her body issued while competent. Prior to this Act, conservators were required comply with the conserved person's health care instructions and other wishes as expressed when the conserved person had capacity and if the conservator had knowledge of such wishes. In addition, advance directives statutes also provide that, absent a court order to the contrary, certain decisions of an appointed health care representative take precedence over that of a conservator, except in certain defined circumstances.

This Act provides that the decision of a health care representative concerning health care or the disposition of the body of a deceased person also trumps a conservator's decision in those two areas, absent a contrary court order or one of the exceptions set forth in the statute.

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VII. ACTS CONCERNING GOVERNMENT STUDIES AND TASK FORCES

37. PUBLIC ACT 14-148. AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE.
Effective October 1, 2014

Pursuant to this Act, the Commissioner of Public Health must develop and implement a plan that reduces the incidence of chronic disease, improves chronic disease care coordination, and reduces the effects of chronic disease. No later than January 15, 2015, and biannually thereafter, the Commissioner must submit a report to the GA's joint standing committee on Public Health concerning the implementation of the plan. The report must also be posted on the DPH website.

The report must include: (1) a description of the chronic diseases that are most likely to cause a person's death or disability; (2) a description and assessment of programs and actions that have been implemented by DPH and health care providers; (3) the sources and amounts of funding to treat people with multiple chronic diseases; (4) a description of chronic disease care coordination between DPH and health care providers; and (5) recommendations to reduce the incidence and effects of chronic disease.

38. PUBLIC ACT 14-214. AN ACT CONCERNING A TASK FORCE TO STUDY STROKE AND REPORTING ON HEALTH CARE-ASSOCIATED INFECTIONS.
Effective June 13, 2014

This Act establishes a task force to study stroke, including (1) Connecticut's adoption of a stroke assessment tool; (2) care protocols for emergency medical organizations regarding stroke victims; (3) creating a plan for improving the quality of stroke care and emergency response; and (4) the potential creation of a state-wide, hospital stroke program administered by DPH.

This task force will be made up of the following members:

- Two representatives of the American Academy of Neurology, one of whom shall also be a representative of a hospital that is not certified as a stroke center, appointed by the speaker of the House of Representatives
- Two representatives of the Stroke Coordinators of Connecticut, one of whom shall also be a representative of a hospital that is not certified as a stroke center, appointed by the president pro tempore of the Senate

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- Two representatives of the Connecticut College of Emergency Physicians, one of whom shall also be a representative of a hospital that is not certified as a stroke center, one each appointed by the majority leader of the House of Representatives and the majority leader of the Senate
- One representative of the American Heart Association, appointed by the minority leader of the House of Representatives
- One representative of the Connecticut Hospital Association, appointed by the minority leader of the Senate
- The Commissioner of Public Health, or the Commissioner's designee
- Two members appointed by the Commissioner of Public Health
- One member representing the Emergency Medical Services Advisory Board, appointed by the Governor.

All appointments to this task force must occur within thirty days after the passage of this Act and the task force must meet within sixty days of passage.

39. SPECIAL ACT 14-6. AN ACT CONCERNING A STUDY OF FUNDING AND SUPPORT FOR HOME AND COMMUNITY-BASED CARE FOR ELDERLY PERSONS AND PERSONS WITH ALZHEIMER'S DISEASE.
Effective May 28, 2014

This Act provides for the COA to conduct a study regarding private sources of funding and public state programs for the elderly and those with Alzheimer's disease who need home or community-based care. The study must address the availability and cost effectiveness of the programs run by the state. The COA must submit a report by January 1, 2015 to the joint standing committee on Aging.

40. SPECIAL ACT 14-17. AN ACT CONCERNING THE TASK FORCE ON DOMESTIC WORKERS.
Effective October 1, 2014

This Act establishes a task force on domestic workers which will study the issues surrounding domestic workers and make recommendations as to legislation that can help with outreach and education efforts to both domestic workers and their employers. The task force is made up of fourteen members, including domestic workers, government officials or their designees and a representative from an organization that advocates for the rights of domestic workers in Connecticut.

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By October 1, 2015, this task force will submit a report on its findings to the Governor and the joint committees on Legislative Management and Labor and Public Employees. The task force dissolves upon the submission of this report, or October 1, 2015.

VIII. MISCELLANEOUS ACTS OF INTEREST

41. SPECIAL ACT 14-1. AN ACT CONCERNING A STUDY OF THE RENEWAL TIMES FOR OCCUPATIONAL LICENSES.
Effective May 12, 2014

This Act requires DPH and DCP to review the license renewal times for all categories of health care and pharmacy professionals and to submit a report by July 1, 2015 with their recommendations on which professionals' license renewal times may be extended without jeopardizing public health and safety and at the same time achieving a cost savings for those professionals.

42. PUBLIC ACT 14-61. AN ACT PROVIDING IMMUNITY TO A PERSON WHO ADMINISTERS AN OPIOID ANTAGONIST TO ANOTHER PERSON EXPERIENCING AN OPIOID-RELATED DRUG OVERDOSE.
Effective October 1, 2014

This Act authorizes anyone to administer an opioid antagonist, such as Narcan, or any other similarly acting FDA-approved drug, to a person he or she believes, in good faith, is experiencing an opioid-related drug overdose. A person, other than a health care professional, receives civil and criminal immunity if he or she acts with reasonable care in administering the opioid antagonist.

Existing law permits a licensed health care professional, who is permitted by law to prescribe an opioid antagonist, if acting with reasonable care, to prescribe, dispense or administer an opioid antagonist to treat or prevent a drug overdose without being civilly or criminally liable for his or her conduct or for any subsequent use of the opioid antagonist.

By law, an "opioid antagonist" means naloxone hydrochloride (Narcan) or any other similarly acting and equally safe drug approved by the FDA for the treatment of a drug overdose.

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43. PUBLIC ACT 14-73. AN ACT CONCERNING LIVABLE COMMUNITIES AND ELDERLY NUTRITION.
Effective July 1, 2014

By January 1, 2015, this Act requires the COA, as part of its "Livable Communities" initiative, to recognize communities that have implemented initiatives that allow people to age in place and remain in a home setting of their choosing. The initiatives must include, but are not limited to: (1) affordable and accessible housing, (2) community and social services, (3) planning and zoning regulations, (4) walkability, and (5) transportation-related infrastructure.

The Act also requires DOA and DSS to hold quarterly meetings with nutrition service stakeholders to:

1. develop recommendations to address complexities in the administrative process of nutrition services;
2. establish quality control benchmarks; and
3. help move toward greater quality, efficiency and transparency in the elderly nutrition program.

Nutrition service stakeholders must include, but are not limited to, area agencies on aging, access agencies, the COA, nutrition providers, representatives of food security programs and contractors, and nutrition host site representatives and consumers.

44. PUBLIC ACT 14-126. AN ACT CONCERNING BAKERIES, FOOD MANUFACTURING ESTABLISHMENTS AND FOOD WAREHOUSES.
Effective June 6, 2014

This Act requires that a bakery be designed and operated pursuant to the directions of the Commissioner of DCP. Under current law, a bakery is defined as a building or part of a building where bread, cakes, cookies, doughnuts, crullers, spaghetti, macaroni and other food products are made either wholly, or in part, from flour or meal. The Act clarifies that a "bakery" may include but is not limited to, any restaurant, hotel, private institution, home bakery, establishment operating doughnut-frying equipment, or other similar place that offers such food products for sale.

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45. PUBLIC ACT 14-138. AN ACT CONCERNING VARIOUS REVISIONS TO THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES' STATUTES.
Effective October 1, 2014

This Act, among other things, mandates that DMHAS specify uniform methods of keeping statistical information for public and private agencies that provide care or treatment for psychiatric disabilities and alcohol or drug dependence. The agencies must report the information to the Commissioner at his request. The Act also permits the Commissioner to give housing subsidies to persons receiving services from DMHAS. The Act also allows, with permission from the Commissioner, an agency that distributes housing subsidies on behalf of DMHAS to distribute any remaining housing subsidies from the department to cover housing subsidies for eligible persons in the following year. Finally, it allows persons receiving services from DMHAS to receive services outside of the region in which he or she lives and permits DMHAS to disclose whether somebody had received services from DMHAS when he or she is clinically assessed upon an arrest.

46. PUBLIC ACT 14-165. AN ACT CONCERNING MANDATORY REPORTING OF ABUSE AND NEGLECT OF INDIVIDUALS WITH AUTISM SPECTRUM DISORDER, THE DEFINITION OF ABUSE, AND THE DEPARTMENT OF DEVELOPMENTAL SERVICES ABUSE AND NEGLECT REGISTRY.
Effective October 1, 2014

Under current law, DDS has an obligation to conduct investigations into allegations of abuse and neglect of a person with an intellectual disability. This Act expands the definition of abuse and specifically grants authority to the department to investigate reports of abuse of individuals between the ages of eighteen and sixty with autism spectrum disorder. The Act now includes financial exploitation, psychological abuse, verbal abuse, and sexual abuse as part of the definition of "abuse." The definition of "authorized agency" is amended to include agencies authorized to investigate abuse and neglect or carry out protective services concerning "individuals receiving services or funding from the department's Division of Autism Spectrum Disorder Services."

This Act permits DDS to investigate reports alleging abuse or neglect of an individual who receives services from the department's Division of Autism Spectrum Disorder Services. All state, local, and private agencies have a duty to cooperate with investigations. DDS must make written findings as to whether abuse or neglect has occurred and recommendations for protective services as appropriate. The Commissioner must keep the findings from the investigation confidential, and any records given to DDS as part of its investigation must be kept confidential.

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Section 3 of the Act amends provisions concerning individuals terminated or separated due to "substantial abuse or neglect" such that the registry now applies to "former employees" and not generally "individuals." Information from the registry is made available only to employers with employees who provide services to DDS clients.

Finally, this Act provides the steps that the Office of Protection and Advocacy for Persons with Disabilities must take upon receiving a report of alleged abuse of an individual who receives autism spectrum disorder services. The Office of Protection and Advocacy for Persons with Disabilities must make an initial determination of whether the individual who is allegedly being abused receives funding or services from DDS's Division of Autism Spectrum Disorder Services, whether the report warrants an investigation, and if it does, perform an investigation.

47. PUBLIC ACT 14-168. AN ACT CONCERNING NOTICE OF ACQUISITIONS, JOINT VENTURES, AFFILIATIONS OF GROUP MEDICAL PRACTICES AND HOSPITAL ADMISSIONS, MEDICAL FOUNDATIONS AND CERTIFICATES OF NEED.

§ 1—Notifications and Reports to the Attorney General
Effective October 1, 2014

This section requires that when a hospital, hospital system, or other health care provider is party to a merger or acquisition and must file information with FTC or DOJ in compliance with federal law, it must also provide written notice to the AG.

It furthers requires that the parties to any transaction that results in a "material change" to the business or corporate structure of a group practice, defined as two or more physicians, must submit written notice to the AG at least thirty days prior to the effective date of the transaction. A "material change" includes mergers, consolidations, affiliations, and acquisitions of a group practice with or by another group practice comprised of eight or more physicians, hospital, hospital system, captive professional entity, medical foundation, or other entity organized or controlled by hospital or hospital system.

Hospital systems must file a report with the AG and DPH detailing the activities of the group practices owned or affiliated with the hospital or hospital system. This report must be filed no later than December 31, 2014 and annually thereafter. Similarly, physician groups of thirty or more that are not included in the hospital or hospital system report described above, must submit a report to the AG and DPH

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concerning the practice group. The first report must be filed no later than December 31, 2014 and annually thereafter.

§ 3—Board of Directors for Medical Foundations
Effective June 3, 2014

By law, any hospital, health system, or medical school can organize and become a member of a medical foundation. Section 3 limits who can serve on the board of directors for a medical foundation. No employee or representative of a for-profit health system, hospital, or medical school can serve on the board of directors of a medical foundation organized by a nonprofit hospital, health system, or medical school. No employee or representative of a nonprofit health system, hospital, or medical school can serve on the board of directors of a medical foundation organized by a for-profit hospital, health system, or medical school. No person can serve on a board of directors of a medical foundation organized by a for-profit health system, hospital, or medical school at the same time as he or she is serving on the board of directors of a medical foundation organized by a nonprofit hospital, health system, or medical school.

This Act also prohibits a hospital, health system, or medical school to organize or be a member of more than one medical foundation.

§ 4—Notice to Primary Care Doctors
Effective October 1, 2014

This section requires that upon admission of a patient to a hospital, hospital personnel must ask whether the patient would like the hospital to notify his or her personal physician. If the patient desires physician notification, hospital personnel must make reasonable efforts to notify the physician as soon as practicable but no later than twenty-four hours after the request.

§§ 5–8—Certificates of Need
Effective July 1, 2014

These sections expand the instances when a CON is required from OHCA. A CON is now required for the transfer of ownership of a group practice, defined as eight or more FTE physicians, to any entity other than a physician or group of physicians, except when the parties have signed a sale agreement to transfer ownership before September 1, 2014.

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Section 7 expands the factors that OHCA must consider when reviewing a CON application. The additions include (a) whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region, and (b) whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

Under sections 7 and 8, when an offer for the group practice in an acquisition is made in response to a request for proposal or similar voluntary offer for sale, there is a presumption in favor of approving the CON, and the review period is limited to sixty days from the date of OHCA's web notice. In addition, a public hearing is held only when twenty-five or more individuals request it.

§ 9—Hearing on the Contents of the CON
Effective June 3, 2014

Not later than thirty days after the receipt of a CON determination letter by DPH and the AG, the purchaser of a nonprofit hospital and the nonprofit hospital must hold a hearing on the contents of the CON determination letter in the municipality in which the newly owned hospital is to be located. The nonprofit hospital must give at least two weeks' notice for such hearing in a newspaper with substantial circulation in the community. The notice must have substantially the same information as the CON determination letter. The hearing must be recorded or transcribed and be publicly available.

48. PUBLIC ACT 14-182. AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS TO THE GOVERNMENT ADMINISTRATION AND ELECTIONS STATUTES.
Effective June 12, 2014

This Act makes a number of minor changes to statutes relating to state agency administration. Of relevance, the COA is removed from the Legislative Department.

49. PUBLIC ACT 14-187. AN ACT ELIMINATING UNNECESSARY GOVERNMENT REGULATION.

§§ 2 & 8—eRegulations System
Effective October 1, 2014; § 2 is applicable to regulations noticed on and after that date

Section 2 amends the process by which an agency must notify the public of proposed regulations through the eRegulations system. Prior to this Act, state agencies could

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post either a statement of the terms or of the substance of the proposed regulation or a sufficiently detailed description such that persons who were likely to be affected by the regulation would be apprised. The notice also was required to include a statement of purpose for the regulation, a reference for the statutory authority for the regulation, and information about both the public hearing and how persons can obtain the small business impact and regulatory flexibility analysis. The state agency was also required to (1) give electronic notice to each joint standing committee of the GA that was responsible for the regulation's subject matter; (2) give notice electronically or by paper, if requested, to all persons who have requested advance notice of its regulation-making proceedings; and (3) prepare a fiscal note that includes an estimate of the cost or revenue impact on the state, municipalities, and small businesses. The agency did not need to post a copy of the regulation on the eRegulations site, and could charge persons for paper copies of the notice.

Now, pursuant to this Act, state agencies are required to post a notice of the intended action on the eRegulations system. The notice which must include both a specified public comment period of no less than thirty days and a detailed description of the regulation so that persons who are likely to be affected by the regulation will be apprised. The requirement of the statement of terms has been removed, but the required statement of purpose, statutory authority, small business impact and regulatory flexibility analysis and the public comment process remain the same. Notice must still be given to the joint standing committees and persons who have requested advance notice, and the fiscal note must still be prepared. State agencies must post a copy of the proposed regulation on the eRegulations System, and they may not charge for paper copies of notices.

This Act also makes the notice and comment process requirements more clear by changing the language (but not the substance) of § 4-168(b), although it does now require that each agency create and maintain a publically available regulation-making record for each regulation proposed by the agency.

After the public comment period has closed but before the regulation is submitted to the AG, each agency must now provide electronic notice of whether the agency will move forward with the regulation to every person who submitted oral or written comment, and provide a paper notice to all persons who submitted comments in a nonelectronic format. The requirement to post on the eRegulations system the final wording of the regulation, the statement of principal reasons in support, and the statement of principal considerations in opposition remains. The Secretary of State must now compile Connecticut state agency regulations and update such regulations at least monthly on the eRegulations System.

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§ 22—Department on Aging Policy Adoption and Publication of Regulations
Effective June 11, 2014 through September 30, 2014

This section requires DOA to adopt regulations to provide programs and services under the federal Older Americans Act of 1965. While in the process of adopting the necessary regulations, DOA may alter its policies to conform with federal program requirements, as long as any change in policy is posted on the website and submitted to the Secretary of State for posting online within twenty days after the policy's adoption. These temporary policies will remain valid until final regulations are adopted.

50. PUBLIC ACT 14-226. AN ACT CONCERNING ESSENTIAL PUBLIC HEALTH SERVICES AND THE EUTHANIZATION OF ANIMALS IN A FACILITY SUBJECT TO REGULATION BY THE UNITED STATES DEPARTMENT OF AGRICULTURE WAGES.

§§ 1–3—Basic Health Program Required for District and Municipal Health Departments
Effective October 1, 2014

This Act adds a new required program to be provided by each district department of health and municipal health department. This program, known as a basic health program, must provide the following services to residents: (1) monitoring community health problems; (2) investigating and diagnosing community health hazards and problems; (3) educating the community about health; (4) encouraging community partnerships to improve health; (5) developing policies and plans to support these efforts; (6) enforcing health and safety laws; (7) connecting residents to health care services; (8) supporting a quality health care workforce; (9) evaluating health services in the community; and (10) researching new solutions for health problems. Funding for municipal and district departments of health is now contingent on meeting the requirements of this basic health program.

51. SPECIAL ACT 14-3. AN ACT CONCERNING PARTICIPATION IN WIC AND SENIOR NUTRITION FARMERS' MARKET PROGRAMS BY CERTAIN NONPROFIT FARMERS.
Effective May 16, 2014

This Act requires the Commissioner of Agriculture to start a pilot program in which three not-for-profit farmers will sell to the Connecticut Farmer's Market/Senior Nutrition Program. This program will last for two years. The Commissioner will then submit a report to the joint standing committee on Agriculture with his or her

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recommendations as to whether the program should continue as a permanent program.

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