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

2015 REGULAR SESSION AND 2015 JUNE SPECIAL SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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TABLE OF ACRONYMS

AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
APRN	Advanced Practice Registered Nurse
CCRC	Continuing Care Retirement Community
CDN	Certified Dietician-Nutritionists
CE	Continuing Education
CHA	Connecticut Hospital Association
CHCPE	Connecticut Home Care Program for Elders
CHOICES	Connecticut's program for Health insurance assistance, Outreach, Information and referral, Counseling, Eligibility Screening
CHRO	Commission on Human Rights and Opportunities
CIGA	Connecticut Insurance Guaranty Association
COA	Commission on Aging
CON	Certificate of Need
COPD	Chronic Obstructive Pulmonary Disease
CUTPA	Connecticut Unfair Trade Practices Act
DAS	Department of Administrative Services
DCF	Department of Children and Families
DCP	Department of Consumer Protection
DECD	Department of Economic and Community Development

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DMHAS	Department of Mental Health and Addiction Services
DMV	Department of Motor Vehicles
DOA	Department on Aging
DOH	Department of Housing
DOI	Department of Insurance
DOL	Department of Labor
DPH	Department of Public Health
DRS	Department of Revenue Services
DSS	Department of Social Services
ED	Emergency Department
EMS	Emergency Medical Services
ERISA	Employee Retirement Income Security Act of 1974
FDA	Food and Drug Administration
FY	Fiscal Year
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITE-CT	Health Information Technology Exchange of Connecticut
ICF-IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
LLC	Limited Liability Company
LP	Limited Partnership
LPN	Licensed Practical Nurse

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LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
NLRA	National Labor Relations Act
OHCA	Office of Health Care Access
OPM	Office of Policy and Management
PA	Physician Assistant
PCA	Personal Care Attendant
PHI	Protected Health Information
POA	Powers of Attorney
RCH	Residential Care Home
RN	Registered Nurse
SPP	State Supplemental Program

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I. SPENDING BILLS AND IMPLEMENTERS

1. PUBLIC ACT 15-244. AN ACT CONCERNING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 217, AND MAKING APPROPRIATIONS THEREFOR, AND OTHER PROVISIONS RELATED TO REVENUE, DEFICIENCY APPROPRIATIONS AND TAX FAIRNESS AND ECONOMIC DEVELOPMENT.

   § 1—Appropriations from the General Fund

   The following relevant sums are appropriated from the General Fund:

   - Commission on Aging
     - Total budget in each of FY16 and FY17 – $454,629
   - OPM
     - Tax relief for elderly renters FY16 – $26,700,000 and FY17 – $28,900,000
     - Property tax relief elderly circuit breaker in each of FY16 and FY17 – $20,505,900
     - Property tax relief for elderly freeze program in each of FY16 and FY17 – $120,000
   - DOH
     - Elderly rental registry and counselors in each of FY16 and FY17 – $1,196,144
     - Subsidized assisted living demonstration FY16 – $2,255,625 and FY17 – $2,332,250
     - Congregate facilities operation costs FY16 – $7,783,636 and FY17 – $8,054,279
     - Elderly congregate rent subsidy in each of FY16 and FY 17 – $2,162,504
   - DSS
     - Medicaid FY16 – $2,469,915,500 and FY17 – $2,544,288,000
     - Old age assistance FY16 – $37,944,440 and FY17 – $38,347,320
     - Connecticut home care program FY16 – $43,430,000 and FY17 – $40,590,000
     - Protective services to the elderly FY16 – $476,599 and FY17 – $478,300
   - Department on Aging
     - Total budget FY16 – $8,797,409 and FY17 – $8,823,625

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§ 6—Appropriations from the Insurance Fund

The following relevant sums are appropriated from the Insurance Fund:

- Department on Aging
    - Fall prevention in each of FY16 and FY17 – $475,000

§ 52—Appropriation from the General Fund

For FY15, $82,000,000 is appropriated to the DSS Medicaid account.

§ 56—Revenue Estimates for the General Fund

The appropriations from the general fund in section 1 are supported by estimated revenue generated from taxes. The estimated state revenue from the health provider tax is $676,900,000 in FY16 and $683,900,000 in FY17.

§§ 112–137—Fee Increase for DPH License Renewals

These sections increase the fee for all DPH-issued licenses by five dollars. The revenue resulting from the fee increase will be transferred to the "professional assistance program account," also known as HAVEN, which is a rehabilitation program for health professionals who have a chemical dependence, emotional or behavioral disorder, or physical or mental illness.

2. JUNE 2015 SPECIAL SESSION PUBLIC ACT 15-5. AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017, CONCERNING CENTRAL GOVERNMENT, EDUCATION, HEALTH AND HUMAN SERVICES AND BONDS OF THE STATE.

§ 52—Workers' Compensation Approved Provider Lists
Effective July 1, 2015

If an employer utilizes an approved providers list for work-related injuries, the employer must provide an employee such list within two business days of the employee's report of a work-related injury.

§ 57—Notice of Fire Sprinkler Systems in Leases
Effective October 1, 2015

This section requires landlords to include notices in leases disclosing whether dwelling units they rent have working fire sprinkler systems. If a unit has a working

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system, the lease must also include a notice indicating the date of its last maintenance and inspection. Both notices must be printed in at least 12-point, boldface, uniform font.

§§ 73–75, 77, 79, 81 & 84—CHRO
Effective October 1, 2015

Under current law, it is a discriminatory practice to deprive someone of rights, privileges, or immunities guaranteed by state or federal laws and constitutions based on religion, national origin, alienage, color, race, sex, gender identity or expression, sexual orientation, blindness or physical disability. These sections add mental disability to that list.

In addition, these sections eliminate the notarization requirement for discriminatory practice complaints alleging housing discrimination. Further, these sections clarify that if CHRO fails to meet the time requirements for processing complaints, an action does not lose jurisdictional standing before either CHRO or superior court.

Under current law, after a complaint is certified, CHRO must initiate proceedings to hear the complaint or conduct settlement negotiations. These sections require CHRO to appoint different individuals to hear the complaint and conduct settlement negotiations. Further, current law requires proceedings to take place at CHRO offices or an alternative location CHRO chooses. This section requires proceedings to take place at CHRO's Hartford office, but can be moved if all parties agree on a different location.

In addition, these sections allow CHRO to withdraw the certification of a complaint if it believes that additional investigation is warranted. The investigator must complete such additional investigation within ninety days. Further, respondents are now required, as opposed to allowed to, file a written answer and appear at a hearing.

In addition, discrimination claims can be brought in Hartford Superior Court, regardless of where the respondent resides or the alleged discrimination occurred. An individual granted a release from CHRO jurisdiction may bring a court case in the district where he or she resides, in addition to where the alleged discrimination occurred.

Finally, these sections prohibit a complainant from applying to reopen a case if the complainant (1) has been granted a release from CHRO jurisdiction or (2) has not been granted a release, but has filed a court case.

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§ 92—Funds Carried Forward
Effective July 1, 2015

Up to $1,100,000 of the amount appropriated to OPM for Tax Relief for Elderly Renters, pursuant to Public Act 14-47, shall not lapse and shall be transferred to the litigation and settlement account.

§ 112—Civil Actions to Collect Past Due Payments to Employee Welfare Funds
Effective October 1, 2015

This section clarifies that any payment to an employee welfare fund that is past due under the terms of a written contract or rules and regulations adopted by the trustees of such a fund are to be considered wages. This determination allows an employee, a labor organization representing the employee, or DOL to recover, in a civil lawsuit, twice the amount of the wages, plus costs and reasonable attorney's fees.

In addition, this section creates personal liability for any sole proprietor or general partner, officer, director, or member of a corporation or LLC who fails to make such a payment when due. This section also creates personal liability for any employee of a corporation or LLC who is supposed to and fails to make such a payment.

While the terms of this section are drafted broadly, its application to private employers may be preempted by ERISA. The U.S. Supreme Court has generally held that state laws providing additional enforcement mechanisms are preempted by ERISA because they tend to undermine Congress's intent to create a uniform body of law and regulation.

§ 126—Submitting Federal W-2 Forms to DRS
Effective June 30, 2015

Under current law, every employer that is required to deduct and withhold taxes from employees' wages must provide a written statement to DRS showing the amount of wages paid by the employer to the employee and the amount deducted and withheld as a tax (i.e., federal form W-2). This section requires employers to submit this written statement by January 31, annually.

§ 135—Sales and Use Tax on Employer-Provided Parking
Effective July 1, 2015, and applicable to sales occurring on or after said date

This section repeals § 75 of Public Act 15-244 which, beginning July 1, 2015, purported to eliminate the sales and use tax exemption for non-metered motor vehicle parking in an employer-operated lot with thirty or more spaces if (1) owned or leased

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for at least ten years and (2) operated for the exclusive use of its employees. This section ensures that this exemption remains intact.

§ 137—Sales Tax Remittance Deadline
Effective October 1, 2015, and applicable to periods ending on or after December 31, 2015

This section delays the deadline, from the 20th of the month to the last day of the month, for remitting monthly sales and use taxes and filing sales tax returns from the twentieth day of the following month to the last day of the following month.

§§ 155–156—Budget Adjustments
Effective July 1, 2015

These sections amend DSS's Medicaid budget by $1,500,000 in each FY16 and FY17. These sections also permit OPM to make the following reductions in funds to relevant agencies:

- DOA: $573 in FY16 and FY17
- OPM: $33,683 in FY 17, $49,047 in FY 16
- DOH: $17,942 in FY 16 and FY 17, relating to Elderly Rental Registry and Counselors
- DSS: $2,228,186 overall in FY 16, $2,335,977 overall in FY 17

§§ 238–240—Tax on Health System Acquisition of Property
§ 238: Effective June 30, 2015 and applicable to assessment years commencing on and after October 1, 2015; §§ 239–240: Effective June 30, 2015

These sections allow municipalities to tax real property acquired by a health system (i.e., (1) a parent company of one or more hospitals and any entity affiliated with the corporation through ownership, governance, membership, or otherwise or (2) a hospital and any affiliated entity) on or after October 1, 2015 if the real property was subject to taxation immediately prior to its sale. To be liable for the tax, the health system must have generated patient revenues of $1,500,000,000 or greater for the FY ending September 30, 2013. These sections also allow municipalities to tax any personal property incident to such an acquisition. This tax liability does not apply to any property acquired within a health system's "campus" (the area immediately adjacent to a hospital's main campus but not associated with the main buildings, typically two hundred fifty yards surrounding the main buildings). These sections

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also specify that the tax must be paid by the health system itself, not its individual member hospitals.

Finally, these sections expand the existing laws allowing a municipality to fix the real property tax assessment increase based on an entity's improvements made to the real property by now including property used by a health system.

§ 354—Prescription Drug Monitoring Program
Effective October 1, 2015

Under current law, every pharmacy, nonresident pharmacy, outpatient pharmacy in a hospital or institution, and dispenser must report to DCP at least weekly certain information regarding dispensing controlled substances. Effective July 1, 2016, these institutions must report such information immediately upon, but in no case more than twenty-four hours after, dispensing the controlled substance.

§ 356—Psychiatric Services Study
Effective July 1, 2015

This section requires DMHAS, along with DCF and DSS, to study the status of psychiatric services, including (1) the number of short-term, intermediate, and long-term psychiatric beds needed in each region of the state, (2) the average wait time for these beds, (3) the impact of this wait time, (4) funding sources to meet the bed need, (5) access to outpatient services, including wait times for initial appointments, (6) housing options, and (7) access to alternatives to hospitalization.

By January 1, 2017, DMHAS, DCF, and DSS must submit to the joint committees on Appropriations, Public Health, and Human Services a report discussing the results of the study above. In addition, the report must include recommendations on (1) expanding the utilization criteria to increase access to acute, inpatient psychiatric services, (2) increasing the number of long-term, inpatient hospitalization beds, (3) funding for these increases, (4) placing additional beds in health care facilities, and (5) funding to increase alternatives to hospitalization.

§ 359—Study of Community-Based Health Care Services
Effective June 30, 2015

This section requires DSS and DPH to study the effectiveness of community-based health care services, including reviews of (1) the health care needs of people who utilize the 9-1-1 emergency system when not appropriate, (2) the feasibility of providing follow-up home visits for people recently discharged from hospitals, (3) the need for EMS to provide home visits for frequent and repeat users of the 9-1-1

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emergency system, (4) the need for additional primary care services for areas with high use of the 9-1-1 emergency system in the absence of an emergency, (5) the best practices in mobile integrated health care, (6) the scope of practice for EMS, (7) practice guidelines for community-based health care services, and (8) Medicaid authority to cover these types of services.

§ 368—Ombudsman Pilot Program
Effective July 1, 2015

Under current law, the state ombudsman must implement and administer a pilot program that serves Hartford County's home and community-based care recipients. This section limits that program to available appropriations.

§ 376—Supplemental Security Income Program
Effective July 1, 2015

Under current law, DSS annually increases the unearned income disregarded for the purpose of determining eligibility and benefits for the State Supplemental Program. This section freezes any such increase for the next two fiscal years.

§ 377—Medicaid Reimbursement to Nursing Homes
Effective July 1, 2015

This section freezes the Medicaid reimbursement rate at 2015 levels for the next two FYs. As usual, the rate can be lower for any facility that would have been issued a lower rate due to interim rate status, a change in allowable fair rent, or agreement with DSS.

This section also allows DSS to provide pro rata fair rent increases if appropriations allow. Those increases may include increases for facilities that have undergone a material change in circumstances relate to fair rent additions or movable equipment placed in service in the 2014 and 2015 cost report years and was not otherwise included in rates issued.

This section also authorizes DSS, within available appropriations, to adjust facility rates, effective July 1, 2015, for wage enhancements. The rate adjustments must provide a pro rata increase based on direct and indirect employee salaries reported in the facility's 2014 cost report and adjusted to reflect subsequent salary increases, to reflect reasonable costs mandated by employee collective bargaining agreements, or otherwise provided by the facility to its employees. For the purpose of this provision "employee" does not include:

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1. A facility's manager or chief administrator;
2. A person required to be licensed as a nursing home administrator; or
3. Anyone who is not directly employed by the facility, but instead receives compensation for services under a contract

When adjusting rates based on employee salary, DSS can establish an upper limit for reasonable costs, beyond which the adjustment does not apply. Facilities that receive an adjustment but do not provide salary increases on or before July 31, 2015, may be subject to a rate decrease in the amount of the adjustment. Finally, no more than $9 million of the amount appropriated for this purpose can go to increases mandated by collective bargaining agreements, and the section states that DSS shall not be required to distribute the adjustment in a way that jeopardizes anticipated federal reimbursement.

§ 380—Medicaid and Fair Rent Reimbursement to Residential Care Homes
Effective July 1, 2015

This section requires DSS to provide reimbursement to RCHs at the greater of (1) the allowable accumulated fair rent reimbursement associated with real property additions and land as calculated on a per day basis, or (2) $3.10 per day.

This section also caps RCH reimbursement rates at 2015 levels. The rate can be lower, however, for any facility that would have been issued a lower rate due to interim rate status or some other agreement with DSS. Finally, rates can be higher than 2015 levels, within available appropriations, for facilities that have documented fair rent additions that were placed in service during the 2014 or 2015 cost report years, and that are not otherwise included in rates issued.

§§ 381 & 399—DSS Prescription Reimbursements
§ 381: Effective July 1, 2015; § 399: Effective August 1, 2015

Under current law, DSS reimburses pharmacies for drugs provided under medical assistance programs, like Medicaid. DSS does so at the lower of (1) the rate established by CMS, (2) the average wholesale price, minus a discounted percent, or (3) an equivalent percentage established under the state's Medicaid plan. These sections increase the discounted percent, from 16% to 16.5%, that is taken off of the average wholesale price. They also reduce, from $1.70 to $1.40, the professional fee that DSS pays for each prescription that is filled for beneficiaries of medical assistance programs.

They also provide that DSS will pay for an original prescription and as many refills as ordered by the practitioner within twelve months. However, this provision does not

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apply to prescription drugs that are (1) schedule III or IV controlled substances and (2) have not been dispensed directly by a practitioner who is not a pharmacy.

§ 383—Connecticut Home Care Program for Elders
Effective July 1, 2015

Under current law, the state-funded portion of the Connecticut Home Care Program for Elders (CHCPE) provides services to (1) individuals at risk of hospitalization or short-term nursing placement if they do not receive a moderate amount of home care or (2) individuals who require nursing home level care. This section limits that eligibility to (1) individuals who require nursing home level care or (2) individuals who live in affordable housing under the state's assisted living demonstration projects and are otherwise eligible.

This section also increases, from 7% of the cost of care to 9%, the copayment required from participants in the state-funded portion of the Connecticut Home Care Program for Elders. As under current law, the copayment does not apply to those who live in affordable housing under the state's assisted living demonstration projects.

§§ 384–385—Burial Expenses
Effective July 1, 2015

These sections reduce, from $1,800 to $1,400, the maximum amount DSS will pay toward funeral and burial expenses for people who are on public assistance or who are otherwise indigent. They also increase, from $2,800 to $3,200, the amount outside persons, groups, or other agencies can contribute toward funeral and burial expenses without reducing the state's obligation to pay.

§ 386—Medicare Part D Copayment
Effective July 1, 2015

Under current law, a full benefit dually eligible Medicare Part D beneficiary is responsible for prescription drug copayments of up to $15 per month, with DSS paying any amount in excess of $15. This section removes the $15 cap that beneficiaries must pay, along with DSS's obligation to pay. This section, however, does not apply to nursing home residents or those receiving Medicaid waiver services.

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§ 387—Medication Administration – Home Health Care
Effective July 1, 2015

Under current law, an RN can delegate the administration of non-injectable medication to homemaker-home health aides who obtain certification. This section requires DSS to monitor the savings that have been achieved since the law was implemented three years ago. If the savings is less than adequate to meet the amount assumed for the 2016-2017 biennial budget, DSS can reduce rates for medication administration as necessary to achieve budget savings.

Before any such reduction, DSS must report to the Appropriations and Human Services committees. The report must contain provider-specific cost and utilization trend data for patients receiving medication administration. If DSS determines it is necessary to reduce medication administration rates, it must examine the possibility of establishing a separate Medicaid supplemental rate or a pay-for-performance program for those providers for have established successful nurse delegation programs.

§ 391—Nursing Home Bed Moratorium
Effective July 1, 2015

This section indefinitely extends DSS' moratorium on accepting or approving any requests for additional nursing home beds. It also modifies several of the exemptions to the moratorium. The section removes the exemption from beds restricted to use by patients with AIDS or traumatic brain injuries, but adds an exemption for beds restricted to use by patients requiring neurological rehabilitation.

The section also adds an exemption for Medicaid beds relocated from a licensed facility or facilities to a new licensed facility, provided at least one currently licensed facility is closed in the transaction, and the new facility's bed total is not less than 10% lower than the total number of beds relocated. The relocation must be in accordance with the state's strategic plan to rebalance Medicaid long-term care supports and services.

Finally, the section eliminates the following exemptions:

1. Medicaid-certified beds relocated from a licensed nursing facility to a small house nursing home;
2. Requests for no more than twenty (20) beds from certain facilities that do not participate in Medicaid or Medicare;
3. Requests for no more than twenty (20) beds from certain freestanding facilities that provide hospice care service; and

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4. Requests for no more than sixty (60) new or existing Medicaid-certified beds relocated from a licensed nursing facility in a municipality with a 2004 estimated population of 125,000 to another location within that city.

§ 392—Nursing Home Closure Rate
Effective July 1, 2015

This section provides the Commissioner of DSS may, within his discretion, revise the rate of a facility that is closing. If an interim rate is established for the closure period, it must be based on (1) a review of the facility costs, (2) the expected duration of the close-down period, (3) the anticipated impact on Medicaid costs, (4) available appropriations, and (5) the relationship of the rate requested by the facility to the average Medicaid rate for a close-down period.

§ 393—Rate Provision for Chronic Disease Hospitals
Effective July 1, 2015

This section specifies that, when DSS sets rates for freestanding chronic disease hospitals, it must do so within available appropriations.

§ 394—Acuity-Based Medicaid Reimbursement
Effective June 30, 2015

DSS can also choose to implement an acuity-based methodology for Medicaid reimbursement of nursing home services. The development of such a system would be based on recommendations from the nursing home industry, as well as the Medicare prospective payment system, and other methodologies used nationally.

§ 400—Medicaid Provider Audits
Effective July 1, 2015

This section makes several changes in the statute governing the DSS Medicaid provider audit process for fee for service providers. It does not amend the separate statute governing the Medicaid audit process for nursing homes, RCHs and ICF-IID facilities. Specifically, it amends definitions, extrapolation provisions, notice requirements, the process for contesting an audit decision, and protocols.

This section adds definitions for the following four terms:

1. "Clerical error" mean an unintentional typographical, scrivener's, or computer error;

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2. "Ninety-five percent confidence level" means there is a probability of at least ninety-five percent that the result is reliable;
3. "Stratified sampling" means a method of sampling that involves the division of a population into smaller groups known as strata based on shared attributes, characteristics, or similar paid claim amounts;
4. "Statistically valid sampling and extrapolation methodology" means a methodology that is
    a. Validated by a statistician who has completed graduate work in statistics and has significant experience developing statistically valid samples on behalf on government entities;
    b. Provides for the exclusion of highly unusual claims that are not representative of the universe of paid claims;
    c. Has a ninety-five percent confidence level or greater; and
    d. Includes stratified sampling when applicable.

In regard to extrapolation, this section prohibits DSS from finding that an overpayment or underpayment was made to a provider based on extrapolated projections unless the total net amount of the extrapolated overpayment calculated from a statistically valid sampling and extrapolation methodology exceeds 1.75% of total claims paid to the provider for the audit period. The section also prohibits DSS from extrapolating an overpayment or attempting to recover an extrapolated overpayment if the provider presents credible evidence that DSS or a DSS contractor caused the overpayment, provided DSS can recover the amount of the original overpayment.

This section adds that at the start of an audit, DSS or a DSS-contracted auditor must disclose the following:

1. The name and contact information of the assigned auditor(s);
2. The audit location, including notice of whether such audit shall be conducted on-site or through record submission; and
3. The manner by which information requested shall be submitted.

No audit can include claims paid more than thirty-six (36) months from the date claims are selected to be audited. A scanned copy of documents supporting a claim must be acceptable when original documents are unavailable.

Within thirty days after receipt of the final audit report, any provider aggrieved by the decision can request a contested case hearing. If a provider does so, and is contesting an overpayment amount based on extrapolation, DSS cannot recoup the payment at issue until a final decision is issued. During the hearing, a provider is permitted to argue that the negative finding was due to the provider's compliance with a state or

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federal law or regulation. A final decision must be issued within ninety (90) days following the close of evidence, or the date on which final briefs are files, whichever occurs later.

The Commissioner of DSS is no longer required to, but may, adopt implementing regulations. Finally, by January 1, 2016, DSS must establish audit protocols for homemaker companion services.

§ 404—Notification Requirements for Medicaid-Eligible Residents
Effective July 1, 2015

This section requires nursing facilities with reason to know that a resident is likely to become financially eligible for Medicaid benefits within 180 days to notify the resident or the resident's representative and DSS. DSS may (1) assess the resident to see if the resident would prefer (and is able to) live at home or some other community-based setting and (2) develop a care plan to assist the resident in his or her transition to the community.

§ 413—Paid Family and Medical Leave Implementation
Effective June 30, 2015

This section requires DOL, the State Treasurer, the State Comptroller, and DAS to establish procedures to implement a paid family and medical leave program. By October 1, 2015, DOL must contract to create an implementation report which must include (but is not limited to): (1) mechanisms by which employees will pay a portion of their salary or wages to family and medical leave program, (2) mechanisms for accepting and processing of claims, (3) mechanisms for distributing employee compensation, and (4) funding opportunities to assist with the start-up costs of the program. DOL and the State Treasurer must complete an actuarial analysis to report the level of employee contributions necessary to sustain the program.

DOL must submit this implementation report and actuarial analysis to the joint committee on Labor no later than February 1, 2016.

§§ 447–458—Probate Fees
§§ 447, 448 & 452–454: Effective July 1, 2015; §§ 449–451 & 455–458: Effective January 1, 2016

Effective for all deaths on or after January 1, 2015, these sections remove the cap on the fee assessed by the probate court for the settlement of the decedent's estate (currently capped at $12,500).

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In addition, these sections introduce filing fees for a number of filings made in Probate Court (e.g., $250 fee for filings pertaining to conservatorship, adults with intellectual disabilities, individuals with psychiatric disabilities). For a complete list of the fees, please see Sections 449-450 of this Act. These sections also modified a number of fees for filings made in Probate Court. For a complete list of the fees, please see Sections 451-452 of this Act.

§ 459—Workers' Compensation Hospital Charges
Effective June 30, 2015

Public Act 14-167 instructed the Workers' Compensation Commission to establish a fee schedule for all workers' compensation-related hospital services. That Act also required charges incurred before the schedule became effective on April 1, 2015, to be the hospital's actual costs of treating the injured worker. This section clarifies that these pre-schedule charges are to be determined exclusively under the requirement of Public Act 14-167, not under OHCA statutes.

In addition, this section provides that all disputes for hospital services in workers' compensation cases must be filed within a year from the date of the initial payment for the services, no matter when the services were provided.

§§ 469–470—Off-Label Prescription Drugs
Effective January 1, 2016

This section expands coverage under certain individual and group health insurance policies for off-label drugs (i.e., when a drug is prescribed to treat a condition other than the one it has been approved for by the FDA). This section expands coverage by (1) including peer-reviewed medical literature in the list of sources to recognize an off-label drug, (2) requiring coverage for medically necessary services associated with the administration of the drug, and (3) prohibiting denial based on medical necessity, except for reasons unrelated to the legal status of the drug.

This section does not require coverage for a drug used in a research trial or for any drug in a research trial if the trial sponsor gives the drug free of charge.

§ 473—PCA Training Contract
Effective July 1, 2015

This section allows the state and the union representing state-funded PCAs to contract with a non-profit labor management trust to provide PCA training and other services to the PCAs, at cost, so long as the collective bargaining agreement authorizes the

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training contract and the trust is eligible to receive payments from an employer under federal labor law.

§§ 474–478—DPH License Renewal Fees
Effective June 30, 2015

These sections specify that the rate application renewal fee increases imposed by Public Act 15-244 will take effect October 1, 2015 and apply to licenses that expire on or after that date.

§ 480—Reporting of Impaired Health Care Professionals
Effective October 1, 2015

This section requires health care professionals, including RNs and LPNs, and hospitals to file a petition with DPH when they have information that appears to show that a health care professional cannot perform his or her duties with the requisite skill, as a result of impairment. This petition must be filed within thirty days of obtaining such information to support the petition. No person who files a petition shall be liable for damage or injury to the person who is the subject of the petition, absent a showing of malice.

A health care professional must notify DPH within thirty days of being arrested in connection with the possession, use, prescription for use, or distribution of a controlled substance or alcohol. In addition, a health care professional must notify DPH with thirty days of being diagnosed with a mental illness or behavioral or emotional disorder.

This section requires DPH to investigate such petitions, within eighteen months from the filing date, to determine if probable cause exists to issue a statement of charges against the health care professional. Unless otherwise specified, the investigation shall be deemed to be a public record at the conclusion of the investigation. If DPH makes a finding of no probable cause, the investigation shall remain confidential unless the health care professional wishes that the petition and subsequent record be open.

In conducting the investigation, DPH may order the health care professional to complete a physical or mental examination performed by a physician chosen from a list supplied by DPH. If the health care professional does not obey an order submit to such an examination, DPH may petition the superior court to order the examination.

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Finally, this section mandates that a health care professional's license cannot be revoked until the health care professional has been given notice and an opportunity for a hearing.

§ 493—DPH Approval of Board and Commission Decisions
Effective June 30, 2015

The United States Supreme Court recently issued an opinion holding that state occupational licensing boards and commissions that are comprised predominantly of active market participants are at antitrust risk if such boards issue regulations, declaratory rulings or adjudicatory decisions, unless the board's actions are subject to review by another state official that is not an active market participant before such action becomes final.

This section addresses this problem, on a going forward basis, by requiring boards or commissions housed within DPH to notify the DPH Commissioner of the issuance of a complaint, the filing of a petition for declaratory ruling or the initiation of a proceeding for declaratory ruling. Within fifteen days of such notification, the Commissioner or her designee may notify the board or commission that its decision in such matter shall be a proposed decision and that the Commissioner or her designee shall make a final determination on the matter which can include approval, modification or rejection of the proposed decision or remand for further review or the taking of additional evidence. Notably, this section does not address the issue with regard to the boards and commissions housed within DCP, which is where the pharmacists' board is located.

II. SPECIFIC ACTS OF INTEREST

3. PUBLIC ACT 15-19. AN ACT CONCERNING THE STATE AGING AND DISABILITY RESOURCE CENTER PROGRAM.
Effective July 1, 2015

Pursuant to this Act, the state's Aging and Disability Resource Center Program shall be administered in connection with DOA's CHOICES program.

4. PUBLIC ACT 15-32. AN ACT CONCERNING PATIENT-DESIGNATED CAREGIVERS.
Effective October 1, 2015

This Act amends the statute governing hospital discharges.

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§ 1(a)—Definitions

This section provides definitions for "caregiver," "home," "hospital," and "post-discharge assistance" as they are to be used in this Act.

- Caregiver – a caregiver is anyone who is designated to provide post-discharge assistance to a patient at the patient's home. Such individuals could include, but are not limited to, relatives, spouses, partners, friends, or neighbors. The term does not include anyone who receives compensation for providing post-discharge assistant to the patient.

- Home – a home is the place the patient considers to be his or her home. It does not include rehabilitation facilities, hospitals, nursing homes, assisted living facilities, or group homes unless the patient was living in such a facility immediately prior to his or her inpatient admission.

- Hospital – a hospital is any establishment that lodges, cares for, and treats individuals suffering from disease or other physical or mental conditions. "Hospital" includes "chronic disease hospitals," but does not include "residential care home," "nursing home," or "rest home."

- Post-discharge assistance – post-discharge assistance is any care provided by a nonprofessional that that is in accordance with a written discharge plan of care.

§ 1(d)—Patient's Choice of Caregiver

This section permits a patient to choose a caregiver when discharged from a hospital to his or her home, although the chosen caregiver is not required to assist the patient post-discharge.

§ 1(e)—Hospital Instruction to Caregivers

Hospitals must record basic information (name, relationship to patient, telephone number, address) of the designated caregiver in the discharge plan. Once a patient designates a caregiver, hospitals are required to contact the designated caregiver as soon as practicable, but the inability to contact the designated caregiver shall not delay appropriate discharge.

In addition, prior to discharge, hospitals must provide caregivers with instruction for all post-discharge activities. At a minimum, (1) such instruction must be given in person or via video technology by a hospital representative that is authorized to

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provide the training; (2) hospitals must allow caregivers to ask questions; and (3) hospitals must answer the questions in a culturally competent manner. Hospitals must also adhere to federal and state law regarding access to language interpretation services for this instruction. Finally, hospitals must record in the patient's medical records the date, time, and contents of such instruction.

§ 2—No Liability for Hospitals for Caregiver Conduct

This section states that it should not be construed as creating a private right of action against a hospital, its employees, or contractors. It also excludes hospitals, hospital employees, and any consultants or contractors of hospitals from liability resulting from the actions of a caregiver subsequent to discharge of a patient.

This exclusion from liability does not limit or obviate the obligations of entities issuing health benefit plans to provide coverage that is required under a health benefit plan.

In addition, caregivers will not be reimbursed by any governmental or commercial payer for any post-discharge services they provide.

Finally, this Act does not take precedence over a patient's directive, conservatorship, or other proxy health care rights delegated by the patient or by law.

5. PUBLIC ACT 15-34. AN ACT CONCERNING LANGUAGE INTERPRETERS IN HOSPITALS.
Effective October 1, 2015

   This Act requires acute care hospitals to ensure that interpreter services are available to patients whose primary language is spoken by at least 5% of the population in the geographic area surrounding the hospital. Under current law, acute care hospitals were only required to provide these services to the extent possible.

6. PUBLIC ACT 15-36. AN ACT EXTENDING COST REPORTING DEADLINES FOR LONG-TERM CARE FACILITIES.
Effective July 1, 2015

   The deadline by which LTC facilities (including nursing homes and RCHs) must submit their annual cost reports has been extended from December 31 to February 15 annually, giving providers an additional forty-five days to complete their cost reports. In addition, this Act extends DSS's deadline for reporting cost report data to the joint committee on Appropriations from February 15 to April 1, annually.

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7. PUBLIC ACT 15-50. AN ACT CONCERNING REQUIREMENTS FOR FACILITIES THAT COMPLETE MEDICARE OR MEDICAID APPLICATIONS FOR PATIENTS.
Effective July 1, 2015

This Act amends the patient's bill of rights for residents of nursing homes, RCHs, and chronic disease hospitals to include the right to receive a copy of any Medicare or Medicaid application completed on behalf of the resident or to designate a family member to receive the copy of the application.

8. PUBLIC ACT 15-91. AN ACT CONCERNING REPORTS OF NURSE STAFFING LEVELS.

§ 1—Hospital Nurse Staffing Plans
Effective July 1, 2015

Under prior law, hospitals (including chronic disease hospitals) had to make available to DPH, upon request, their prospective nurse staffing plans. Hospitals are now required to report their prospective nurse staffing plan annually to DPH.

For nurse staffing plans developed and implemented after January 1, 2016, this Act expands the information that must be included in a hospital's nurse staffing plan to include:

- the number of RNs providing direct patient care and the ratio of patients to such RNs, by patient care unit;
- the number of LPNs providing direct patient care and the ratio of patients to such LPNs, by patient care unit;
- the number of assistive personnel providing direct patient care and the ratio of patients to such assistive personnel, by patient care unit;
- the method used by the hospital to determine and adjust appropriate direct patient care staffing levels; and
- a description of the supporting personnel assisting on each patient care unit.

For nurse staffing plans developed and implemented after January 1, 2017, each hospital must also include (1) descriptions of differences between the staffing levels

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described in their plan and actual staffing levels and (2) any actions the hospital intends to take to address such differences in future staffing plans.

Finally, no later than January 1, 2016, and annually thereafter, DPH must report to General Assembly's Public Health Committee on hospital compliance with these reporting regulations and provide recommendations for any additional reporting regulations.

§ 2—Workplace Violence
Effective October 1, 2015

All health care employers (including chronic disease hospitals, RCHs, and nursing homes) are required to maintain records that detail incidents of workplace violence, including the specific area and department where the incident occurred. Under current law, health care employers must provide these records to DPH, upon request. This Act requires health care employers to report to DPH the number of workplace violence incidents from the preceding calendar year not later than January 1, 2016, and annually thereafter.

For purposes of this section, a health care employer is any DPH-licensed institution with at least fifty full- or part-time employees.

9. PUBLIC ACT 15-102. AN ACT CONCERNING STATE PAYMENT TO CERTAIN FACILITIES FOR RESERVED BEDS.
Effective July 1, 2015

This Act amends the statute concerning state payments made as part of SPP on behalf of residents of licensed RCHs and rated housing facilities. Before, the law required DSS to pay the facility when the resident was absent from the home or facility, provided that the resident could reasonably be expected to return by the end of the following month. Now, there is an added condition to DSS payment, that the recipient's bed would otherwise be available during his or her absence. "Rated housing facilities" are homes that DSS approved to receive state supplement payments and that are licensed by DDS, DMHAS, DCF, or New Horizons.

10. PUBLIC ACT 15-115. AN ACT ESTABLISHING A BILL OF RIGHTS FOR RESIDENTS OF CONTINUING-CARE RETIREMENT COMMUNITIES.
Effective October 1, 2015

This Act establishes a bill of rights for CCRC residents and it makes several revisions to update and streamline the statutes governing CCRC.

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For more information on this Act, please see Wiggin and Dana's Advisory: New Law Establishes a Bill of Rights for CCRC Residents and Streamlines Several Statutory Requirements for CCRCs.

11. PUBLIC ACT 15-116. AN ACT AUTHORIZING PHARMACISTS TO DISPENSE DRUGS IN NINETY-DAY QUANTITIES.
Effective July 1, 2015

This Act allows a pharmacist discretion in refilling a prescription for a quantity greater than the initial quantity authorized by the prescribing practitioner, provided that (1) the refill is made after the patient's initial prescription has been dispensed; (2) it does not exceed a ninety day supply and does not exceed the total quantity authorized by the prescriber; (3) the prescriber has not specified that the initial or refill quantities are fixed and unchangeable; (4) the drug is not a controlled drug (i.e., designated as (i) subject to the federal Controlled Substances Act, (ii) a depressant or stimulant per federal food and drug laws, or (iii) having a stimulant, depressant, or hallucinogenic effect on higher functions of the central nervous system and a tendency to promote abuse or dependence; (5) the pharmacist informs the prescriber about the refill within forty-eight hours after it has been made; and (6) the patient's health insurance policy will cover the refill quantity without any additional out-of-pocket expense from the patient.

12. PUBLIC ACT 15-129. AN ACT CONCERNING HOSPITAL TRAINING AND PROCEDURES FOR PATIENTS WITH SUSPECTED DEMENTIA.
Effective July 1, 2015

This Act requires each hospital to include training on the symptoms of dementia as part of their regularly provided training to staff members who provide direct care to patients.

13. PUBLIC ACT 15-130. AN ACT CONCERNING THE SAFEGUARDING OF FUNDS FOR RESIDENTS OF CERTAIN LONG-TERM CARE FACILITIES.
Effective July 1, 2015

This Act extends the statutes (19a-551 and 19a-552) that govern LTC facility residual funds to RCHs. As a result, RCHs must comply with all specific statutory regulations for safe guarding residents' funds. The Act also extends to RCHs the same penalties that apply to nursing homes for failure to comply with the residual fund requirements:

1. Criminal liability (Class A misdemeanor)
2. Civil liability based on a private right of action by the resident or his or her representative.

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14. PUBLIC ACT 15-146. AN ACT CONCERNING HOSPITALS, INSURERS AND HEALTH CARE CONSUMERS.
Effective October 1, 2015, except as otherwise noted

§§ 1–2—Exchange Website

The HITE-CT is required to establish and maintain, by July 1, 2016, a consumer health information website to help consumers make informed decisions concerning their health care and informed choices among health care providers (defined as any individual, corporation, facility, or institution licensed by the state to provide health care services). The website is to be designed to allow comparisons between prices paid by various health carriers to health care providers and will contain:

- information comparing the quality, price and cost of health care services including, comparative price and cost information for certain primary diagnoses and procedures categorized by payer and listed by health care provider;
- links to the websites for The Joint Commission and Medicare hospital compare tool where consumers may obtain comparative quality information;
- definitions of common health insurance and medical terms so consumers may compare health coverage and understand the terms of their coverage;
- factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost-sharing, covered services and tier information; and
- patient decision aids.

§ 2—Most Frequent Procedures

This section requires DOI and DPH to publish by July 1, 2016, and annually thereafter, a list of the most frequent inpatient primary diagnoses and procedures, outpatient procedures, surgical procedures, and imaging procedures occurring within the state.

Health carriers must submit to the HITE-CT by January 1, 2017, and annually thereafter, a report that lists the amounts paid to health care providers and other out-of-pocket expenses for the most frequent procedures as listed above.

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§§ 2, 3, 13 & 15—Patient Notices

On and after January 1, 2017, every time a hospital[1] schedules certain nonemergency diagnoses or procedures, the hospital, which includes chronic disease hospitals, must notify the patient of his/her right to make a request for cost and quality information. Within three business days after scheduling such a diagnosis or procedure, the hospital must also provide the patient with written notice, including the following information:

- if the patient is uninsured, the amount that the patient will be charged for the procedure, including the amount of any facility fee, or if the hospital is unable to provide a specific amount, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee;

- the Medicare reimbursement amount;

- if the patient is insured, the allowed amount, toll-free telephone number, and Internet website address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs. If the hospital is out-of-network under the patient's health insurance policy, a statement that the diagnosis or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply;

- the Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and

- the website addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

Effective January 1, 2016, every health care provider[2], which includes nursing homes, home health care agencies, assisted living services agencies and chronic disease hospitals, must determine, prior to any scheduled admission, procedure or service for nonemergency care, whether the patient is covered under a health insurance policy. If the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, the health care provider must notify the patient:

[1] For purposes of this Act, the term "hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals.

[2] For purposes of this Act, unless otherwise noted, a "health care provider" means any individual, corporation, facility, or institution licensed by the state to provide health care services.

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- of the charges for the admission, procedure or service;

- that the patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission, procedure or service; and

- if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply.

On and after January 1, 2016, if a transaction between a hospital and physician group practice materially changes the business or corporate structure of a physician group practice and results in the establishment of a hospital-based facility at which facility fees will likely be billed, the hospital or health system purchasing the practice must provide a written notice specifying certain information set forth within the Act.

Effective October 1, 2015, each health care provider, which includes nursing homes, home health care agencies, assisted living services agencies and chronic disease hospitals, that refers a patient to another health care provider who is not a member of the same partnership, professional corporation or limited liability company, but is affiliated with the referring health care provider, must notify the patient, in writing, that the health care providers are affiliated. The notice must inform the patient that the patient is not required to see the provider to whom he or she is referred and that the patient has a right to seek care from the health care provider chosen by the patient, and must provide the patient with the website and toll-free telephone number of the patient's health carrier to obtain information regarding in-network health care providers and estimated out-of-pocket costs for the referred service. Although health care providers that are members of the same partnership, professional corporation, or limited liability company are not required to comply with this notice requirement, medical foundations are not similarly exempted and must provide patients with this notice every time a referral is made to providers within the medical foundation.

§ 4—Prohibited Provisions in Contracts between Health Care Provider and Health Carrier

On and after January 1, 2016, no contract between a health care provider and a health carrier may prohibit disclosure of (1) billed or allowed amounts, reimbursement rates, or out-of-pocket costs and (2) any data to the all-payer claims database program which assists consumers in making informed health care choices.

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§ 6—Updates to No Longer Accepted Health Carriers

This section requires health care providers to notify, in writing, a health carrier within thirty days of the provider's decision to no longer accept patients enrolled in an the carrier's insurance plan. It also requires each health care carrier to update its health care provider directories not less than monthly.

§§ 11, 13, & 20—Unfair Trade Practices
§§ 13 & 20: Effective October 1, 2015; § 11: Effective July 1, 2016

This Act expands the practices that are considered unfair trade practices under CUTPA to include:

- any health care provider (defined as an individual licensed by DPH to provide health care services, including APRNs, RNs, and LPNs) requesting payment from a patient, other than a coinsurance or other out-of-pocket expense, for (1) health care services or a facility fee covered under a health care plan, (2) emergency services covered under a health care plan and rendered by an out-of-network health care provider, or (3) a surprise bill, defined as a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider;

- any health care provider (defined as an individual licensed by DPH to provide health care services, including APRNs, RNs, and LPNs) reporting to a credit reporting agency a patient's failure to pay a bill for the facility fee or surprise bill, when a health carrier has primary responsibility for payment of such services, fees or bills;

- a hospital, health system or hospital-based facility collecting a facility fee for services provided at a hospital-based facility from the date of the transaction that resulted in the change from a physician practice to a hospital-based facility, earlier than the thirty day time period after the required written notice to patients, as described above, is mailed to the patient or a copy of such notice is filed with OHCA;

- a hospital, health system, or hospital-based facility collecting a facility fee for outpatient services that use a current procedural terminology evaluation and

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management code and are provided at a facility, other than a hospital ED, that is not on a hospital campus;

- a hospital, health system, or hospital-based facility collecting a facility fee for outpatient services from uninsured patients, other than those provided in off-site EDs, that exceeds the Medicare facility fee rate;

- health information blocking, meaning (A) knowingly interfering with or knowingly engaging in business practices or other conduct that is reasonably likely to interfere with the ability of patients, health care providers or other authorized persons to access, exchange or use electronic health records, or (B) knowingly using an electronic health record system to both (i) steer patient referrals to affiliated providers, and (ii) prevent or unreasonably interfere with patient referrals to health care providers who are not affiliated providers; and

- a seller making a false, misleading or deceptive representation that an electronic health record system is a certified electronic health record system.

CUTPA generally permits enforcement by DCP, the AG and/or private litigants. The AG may seek injunctive relief, restitution, and civil penalties of up to $5,000 for each willful violation in the Superior Court, while DCP possesses investigative authority and may seek administrative relief in the form of a cease and desist order as well as restitution of up to $5,000. Private litigants may seek injunctive relief as well as compensatory and punitive damages in the Superior Court as well.

§ 13—Facility Fees

Hospitals, including chronic disease hospitals, are already required to provide patients with notifications regarding any charged facility fee, defined as, "any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and separate and distinct from a professional fee."

The new law requires, effective January 1, 2016, that each billing statement that includes a facility fee also must:

- clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider;

- provide the Medicare facility fee reimbursement rate for the same service as a comparison;

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- include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses;

- inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and

- include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction.

Moreover, the actual facility fees collected are now subject to certain limitations. As stated above, if a transaction materially changes the business or corporate structure of a physician group practice and results in the establishment of a hospital-based facility at which facility fees will likely be billed, the hospital, health system or hospital-based facility may not collect a facility fee for services provided at a hospital-based facility from the date of the transaction until at least thirty days after the required written notice to patients, as described above, is mailed to the patient or a copy of such notice is filed with OHCA, whichever is later.

In addition, on and after January 1, 2017, no hospital, health system or hospital-based facility is permitted to collect a facility fee for outpatient health care services provided off-site from a hospital campus, other than a hospital ED, if a current procedural terminology evaluation and management code is used. And, even when such a code is not used, if the services are provided to a patient who is uninsured, then the collected facility fee may not be more than the Medicare rate.

In circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for these types of facility fees, a hospital or health system is permitted to continue to collect reimbursement from the health insurer for the facility fees until the date of expiration of such contract.

Beginning on July 1, 2016, and annually thereafter, each hospital and health system must report to DPH concerning facility fees charged or billed during the preceding calendar year and the information reported will be published on the website of the OHCA.

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§§ 20 & 24—Electronic Health Records

Electronic health records must, to the fullest extent practicable, (1) follow the patient, (2) be made accessible to the patient, and (3) be shared and exchanged with the health care provider of the patient's choice in a timely manner.

Each hospital, including chronic disease hospitals, must, to the fullest extent practicable, use its electronic health records system to enable bidirectional connectivity and the secure exchange of patient electronic health records between the hospital and any other health care provider who (1) maintains an electronic health records system capable of exchanging such records, and (2) provides health care services to a patient whose records are the subject of the exchange. Each hospital must also implement the use of any hardware, software, bandwidth or program functions or settings already purchased or available to it to support the secure exchange of electronic health records and information.

§§ 27, 28, 30 & 35—Affiliations and Acquisitions

There were a number of significant changes made to the regulatory process for approval of affiliations and acquisitions between hospitals and physician practices and the transfer of ownership of a hospital, including additional filings to the AG and DPH, changes to the CON process and new post-transaction requirements. For an in depth analysis of these changes, please see Wiggin and Dana's Advisory: Connecticut Passes New Controversial Health law Affecting Hospitals.

§ 40—Annual Reporting for Health Systems
Effective July 1, 2015

Under current law, hospitals must annually submit copies of the hospital's audited financial statements. This section allows health systems (i.e., (1) a parent corporation of one or more hospitals or (2) a hospital and any entity affiliated with such hospital) to submit only set of documents that covers all of its hospitals.

15. PUBLIC ACT 15-150. AN ACT REQUIRING NOTICE OF ABUSE REPORTS CONCERNING RESIDENTS OF LONG-TERM CARE FACILITIES.
Effective October 1, 2015

In response to abuse reports concerning residents of LTC facilities, DSS must now notify the resident's guardian, conservator, legally liable relative or other responsible party within twenty-four hours, or as soon as possible after receiving such a report. DSS will do so by obtaining the relevant contact information from the LTC facility.

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The notification is not required, however, when it is the guardian, conservator, legally liable relative or other responsible party who is suspected of perpetrating the abuse.

16. PUBLIC ACT 15-154. AN ACT CONCERNING NOTIFICATION OF MEDICAID WAIVER AND MEDICAID STATE PLAN AMENDMENT PROPOSALS.
Effective July 1, 2015

    Under prior law, before submitting an application for a federal waiver of any assistance program to the federal government, DSS had to submit such application to the joint committees on Human Services and Appropriations. This Act extends this application process to renewals of federal waivers. Further, this Act specifies that notice for all applications for waiver, renewal of waiver, or amendment must be published thirty days prior to submission to the joint committees on the DSS website. Finally, this Act extends the comment period from fifteen to thirty days.

17. PUBLIC ACT 15-165. AN ACT CONCERNING MEDICAID COVERAGE FOR OVER-THE-COUNTER DRUGS AND PRODUCTS AND REQUIREMENTS FOR MEDICAID BENEFIT CARDS AND NOTICE OF REGULATIONS.
Effective July 1, 2015

    This Act expands the types of medications that DSS may pay for through its medical assistance programs by allowing coverage for over-the-counter medications and products that DSS deems appropriate based on their clinical efficacy, safety, and cost effectiveness.

    The Act also changes the location where the Commissioner must print notice of intent to adopt regulations from the Connecticut Law Journal to both DSS's website and the eRegulations System. Unchanged is that such notice must be published at least twenty days prior to implementation.

18. PUBLIC ACT 15-230. AN ACT CONCERNING NEW CAR DEALERS AND INFORMATION REGARDING THE MAGNUSON-MOSS WARRANTY ACT, WRITTEN NOTICE FOR HOMEMAKER OR COMPANION SERVICE REGISTRIES AND TELEPHONE SOLICITORS WHO MAKE UNSOLICITED AND INTENTIONALLY MISLEADING TELEPHONE CALLS TO CONSUMERS.
Effective October 1, 2015

    § 2—Homemaker or Companion Service Registries

    Under current law, a homemaker or companion service registry, defined as a person or entity engaged in the business of supplying or referring an individual to or placing

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an individual with a consumer to provide homemaker or companion services, must provide to the consumer a written notice specifying the legal liabilities of the registry to the individual supplied, referred, or placed with a consumer no later than seven days following the date on which a registry supplied, referred, or placed an individual with a consumer. Effective October 1, 2015, this Act reduces this time period to just four days. If the registry maintains a website, a sample notice must be posted on the website.

19. PUBLIC ACT 15-233. AN ACT CONCERNING PROTECTIVE SERVICES FOR SUSPECTED ELDERLY ABUSE VICTIMS.
Effective July 1, 2015, except as otherwise noted

This Act amends the elderly protective services statutes.

§ 1—Definitions
Effective October 1, 2015

This section amends the definition of "services which are necessary to maintain the physical and mental health" of individuals over the age of sixty to include protection from abuse, neglect, exploitation, and abandonment. It also revises the definition of "neglect" to include "the failure to provide or arrange for the provision of services necessary to maintain physical or mental health." Finally, it defines "legal representative" as the guardian, conservator, or power of attorney appointed to act on an elderly person's behalf.

§ 2—DSS Investigations of Abuse, Neglect, Exploitation, and Abandonment

This section clarifies that when DSS investigates a report that an individual over the age of sixty is being, or has been, abused, neglected, exploited, or abandoned, DSS must conduct an in-person visit with the person. This section also removes an exception providing that DSS did not have to interview the person if a physician provides a letter stating that the physician examined the person within either thirty days before or after DSS receives the report and that, in the physician's opinion, the person alone is medically contraindicated.

This section also clarifies that DSS can disclose the investigation file and records to an individual, agency, corporation, or organization only with the elderly person's written consent, or the consent of the elderly person's legal representative. However, DSS, however, may disclose the investigation file and records (1) to teams formed to assist DSS in investigation, evaluation, or treatment of elderly abuse and neglect cases, (2) to law enforcement, and (3) in proceedings which DSS believes necessary to assure the health, safety, and welfare of the elderly person. DSS cannot disclose

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the name of the person who reported the suspected abuse without that person's permission, or unless the disclosure is to law enforcement.

The elderly person or his or her legal representative has a right of access to the records made by DSS except: (1) if PHI was obtained by DSS from someone other than a health care provider under the promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information; (2) that information identifying the person who reported the abuse shall not be released unless the Superior Court determines that there is reasonable cause to believe that the reporter knowingly made a false report or other interests of justice require it; (3) if it is determined by a licensed health care professional that access to the information is reasonably likely to endanger the safety of the elderly person or someone else; (4) if the PHI references another person; or (5) the request for access is made by the legal representative and a health professional determines that such access is likely to cause harm to the elderly person or someone else.

§ 4—Requirement to Disclose Information to DSS

This section requires covered entities (entities that must comply with the federal HIPAA requirements) to disclose to DSS all relevant PHI and other information about an elderly person that DSS needs to investigate an allegation of abuse, neglect, exploitation, or abandonment. Covered entities must provide notice to the elderly person, in accordance with HIPAA regulations, that they are providing such information to DSS.

§ 9—Petition to Enter Person's Premises

If DSS has reasonable cause to believe that an elderly person needs protective services, but the elderly person refuses access, DSS may petition the Probate Court for an order to enter the elderly person's premises. DSS must include in the petition (1) the name and address of the elderly person, (2) reason for the belief that the person may be in need of protective services, (3) the name and address of those who are preventing access to the elderly person, (4) previous efforts made to enter the premises of the elderly person, (5) the names of individuals who will assess whether the elderly person is in need of protective services, (6) the manner in which the assessment will be conducted, and (7) whether a similar petition has already been filed.

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20. PUBLIC ACT 15-236. AN ACT PROTECTING ELDERLY CONSUMERS FROM EXPLOITATION.
Effective October 1, 2015

This Act also revises sections of the elderly protective services statutes.

§ 2—Mandatory Reporters

This section reorganizes the statute listing those who are mandated to report within seventy-two hours to DSS when they have reasonable cause to suspect or believe that an elderly person has been abused, neglected, exploited, or abandoned. The Act formalizes a definition of "mandatory reporter" and also expands that definition to include EMS providers. The following are all mandatory reporters:

- any physician or surgeon,
- any resident physician or intern in any hospital in this state,
- any registered nurse,
- any nursing home administrator,
- any person paid for caring for a patient in a nursing home facility or residential care facility,
- any staff employed by a nursing home or residential care facility,
- any patient's advocate,
- any licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, social worker, clergyman, police officer, pharmacist, psychologist, or physical therapist,
- any person paid for caring for an elderly person by any institution, organization, agency or facility, and
- any EMS provider.

The mandatory training that facilities, institutions, organizations, or agencies caring for those over sixty years of age must provide has been expanded to include training on detecting exploitation and abandonment in addition to abuse and neglect.

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§ 3—Private Cause of Action

Pursuant to this section, any elderly person who has been the victim of abuse, neglect, exploitation, or abandonment may file a civil lawsuit against any perpetrator, and may recover actual and punitive damages, costs, and reasonable attorney's fees. In addition to recovering damages due to exploitation, the Superior Court may enter an order prohibiting the defendant from transferring or depleting any funds, assets, or property. However, no cause of action for neglect or abandonment can be brought against an individual who did not have a contractual duty to care for the elderly person.

§ 6—Training for Financial Agents

Financial agents, defined as officers or employees of a financial institution (e.g., trust company, bank, savings bank, credit union, savings and loan association, insurance company, investment company, mortgage banker, trustee, executor, pension fund, retirement fund) who have direct contact with elderly persons or prepare documents for elderly persons, must now participate in mandatory training to detect potential fraud, exploitation, and financial abuse of elderly persons. Training may be accomplished using resources on COA's web portal.

This mandatory training must be completed within six months of availability of training resources from COA or within the first six months of employment.

21. PUBLIC ACT 15-242. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Effective October 1, 2015

§ 1—Technical Assistance Fee

This section provides that the technical assistance fee charged by DPH for construction, renovation, building alteration, sale, or change of ownership is taxed on total construction costs rather than project costs ($565 when total construction costs are $1,000,000 or less, and 0.25% of total construction costs when more than $1,000,000).

§ 2—Chronic Disease Hospitals

This section requires a chronic disease hospital to:

1. Maintain its medical records on-site in an accessible manner;

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2. Keep a patient's records on-site for at least 10 years after the patient's discharge unless a copy of those records is preserved by a process consistent with current hospital standards; and[3]
3. Complete a patient's medical records within 30 days of the patient's discharge, except in unusual circumstances specified by the hospital's rules and regulations.

Chronic disease hospitals must also provide to DPH a list of the process it uses for preserving a copy of medical records.

§ 3—Physician Assistant's Signature

This section specifies that all orders written by a PA must be followed by his or her signature and printed name.

§ 6—Nurses from Other States

Under current law, a qualified RN or qualified LPN from another state may temporarily care for a patient in Connecticut if he or she receives a temporary permit from DPH. This section allows for temporary care of up to seventy-two hours without a permit. Beyond seventy-two hours, the nurse must obtain a DPH permit and must not represent himself or herself as a practitioner of this State.

§ 7—Massage Therapists

This section allows DPH to take disciplinary action against a licensed massage therapist for fraud or deceit in obtaining the license.

§ 9—Mandated Reporters of Elder Abuse
See also § 2 of Public Act 15-236

The list of mandated reporters of elder abuse has been expanded to include EMS providers.

§ 13—OHCA Release of Data

This section makes technical changes to clarify that OHCA may release patient-identifiable data for medical and scientific research purposes, in accordance with existing regulations.

[3] The statute says "or" but we believe the intent was to put "and."

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§ 16—Disciplinary Action

Under current law, DPH can take disciplinary action against a practitioner's license or permit as a result of the practitioner being subject to disciplinary action by other states, the District of Columbia, a United States possession or territory or a foreign jurisdiction. This section adds that DPH can also do so as a result of disciplinary action by a federal agency.

§ 17—Voluntary Surrender of a License

DPH may deny an application if an applicant for a medical professional permit or license voluntarily surrendered or agreed not to renew or reinstate his or her license.

§ 18—Advance Notice of Health Care Institution Inspections and Investigations

Current law prohibits DPH employees, DSS employees, or regional LTC ombudsmen from providing advance notice of an investigation or inspection to nursing homes or RCHs. This section extends the prohibition to cover all licensed health care institutions, while clarifying that the prohibition does not apply to inspections related to an institution's initial licensure inspection.

§ 27—Certificate of Need

Under current law, if a health care facility proposes to terminate all of its services, and those services were originally authorized by a CON, it must (i) notify OHCA at least sixty days before and (2) surrender its CON thirty days prior to the termination. This section specifies that a health care facility must comply with those requirements only if it is not otherwise required to file a CON pursuant to § 19a-638, which requires a CON to terminate certain services and facilities.

Similarly, if a health care facility proposes to terminate the operation of a facility or service for which a CON was not obtained, it must notify OHCA at least sixty days prior to the termination. This section specifies that a health care facility must comply with that requirement only if it is not otherwise required to file a CON.

§ 51—Infectious Diseases

This section changes the definition of "infectious disease," "airborne infectious disease," and "exposed" to the definitions developed by HHS. It also requires each hospital (including chronic disease hospitals) to designate one employee to act as the hospital contact person. The hospital contact person is responsible for communicating with emergency services representatives about patients with infectious diseases.

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By January 1, 2016, each hospital must notify DPH of its contact person including that person's contact information and subsequently must keep DPH updated if any of that information changes.

§§ 54–56—Certified Dietician-Nutritionists

Certified dietician-nutritionists ("CDN") may directly order diet or nutritional support, including therapeutic diets, for patients in health care institutions. The CDN must document the order in the patient's medical record and a physician must countersign it within seventy-two hours unless otherwise provided by state or federal law or regulations. Any order that a CDN conveys can be acted on by the institution's nurses with the same authority as if the order was received directly from a physician.

§§ 60–67—Continuing Education for Practitioners

These sections amend the CE requirements for the following providers: (i) licensed and certified alcohol and drug counselors, (ii) chiropractors, (iii) psychologists, (iv) licensed marital and family therapists, (v) professional counselors, (vi) social workers, (vii) physicians, and (vii) nurses to require them to obtain CE on the topic of mental health conditions common to veterans and family members of veterans. The requirement calls for a minimum of two contact hours during the first renewal period and not less than once every six years thereafter.

§ 70—Uncompensated Care
See also § 40 of Public Act 15-146

Under current law, a hospital is required to file its audited financial statements to OHCA each year. This section amends the law to allow a health system to only file one such statement that includes the audited financial statements for each hospital within the health system.

III. ACTS CONCERNING HEALTH INSURANCE

22. PUBLIC ACT 15-69. AN ACT CONCERNING HUSKY PROGRAMS.
Effective June 19, 2015

This Act provides a definition for "HUSKY C" and "HUSKY D" participants. A HUSKY C participant is anyone who receives Medicaid that is (1) aged sixty-five or older, (2) blind, or (3) has a disability. A HUSKY D participant is any non-pregnant low income individual who is covered by Medicaid and is between eighteen and sixty-four years of age.

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It also requires DSS to use the modified adjusted gross income ("MAGI") financial eligibility rules from the Social Security Act and its regulations in determining eligibility for HUSKY D applicants.

DSS must provide Medicaid to an individual who is determined by a hospital to presumptively qualify for a HUSKY designation. Hospitals must also assist individuals in completing applications for full Medicaid benefits.

This section instructs DSS to publish notice of intention to adopt regulations on DSS's website and the eRegulations System, instead of in the Connecticut Law Journal.

23. PUBLIC ACT 15-139. AN ACT CONCERNING CONFERENCES BETWEEN HEALTH CARRIERS' CLINICAL PEERS AND HEALTH CARE PROFESSIONALS.
Effective October 1, 2015

When a health carrier notifies a covered person, his or her authorized representative, or his or her health care professional of a denial of coverage that was based, at least in part, on medical necessity, the health carrier must notify the health care professional of the opportunity for a conference with the clinical peer of the health care professional. The conference is not considered a grievance of the denial of coverage. The health carrier must offer the conference at the request of the health care professional.

24. PUBLIC ACT 15-171. AN ACT CONCERNING THE CONNECTICUT INSURANCE GUARANTY ASSOCIATIONS.
Effective October 1, 2015

This Act makes changes to the laws that govern Connecticut insurance guarantors, which pay certain insurance claims when an insurer becomes insolvent.

The Act specifies that claims arising from a direct obligation assumed through a merger or acquisition are "covered claims." It clarifies, however, that CIGA is not responsible for claims originally issued by surplus lines carriers, risk retention groups, self-insurers, or group self-insurers, claims that arise after the commencement of delinquency proceedings, or claims for which the original insurer remains separately liable.

The Act also changes the point at which payments are triggered, from the determination of insolvency to the final order of liquidation. It further increases the

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coverage limit, from $400,000 to $500,000, for claims arising under policies from insurers placed into liquidation with a finding of insolvency on or after October 1, 2015.

Finally, claims arising from policies or contracts that provide hospital, medical, prescription drugs, or other health care benefits pursuant to Medicare Parts C and D are not covered.

25. PUBLIC ACT 15-226. AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR MENTAL OR NERVOUS CONDITIONS.
Effective January 1, 2016, except as otherwise noted

§§ 1–2—Mental or Nervous Conditions and Health Insurance Policies

Under current law, individual and group health insurance policies are required to cover procedures relating to relating to mental or nervous conditions (as defined by the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"). These sections specify that the following procedures must be covered:

- General hospital inpatient hospitalization
- Medically necessary twenty-four hour medically supervised treatment for a substance use disorder
- General hospital outpatient services
- Psychiatric inpatient hospitalization
- Psychiatric outpatient hospital services
- Intensive outpatient services
- Partial hospitalization
- Maternal, infant, and early childhood home visitation services
- Home-based services designed to address family challenges
- Inpatient services at psychiatric treatment facilities
- Extended day treatment programs
- Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals, or psychiatric facilities
- Observation beds in acute hospital settings
- Psychological and neuropsychological testing conducted by an appropriately licensed health care provider
- Trauma screening conducted by a licensed behavioral health professional

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- Family-based and community-based treatment programs addressing juvenile offenders
- Nonhospital patient detoxification
- Medically monitored detoxification
- Ambulatory detoxification
- Depression screening conducted by a licensed behavioral health professional
- Substance use screening conducted by a licensed behavioral health professional

In addition, an insurer cannot deny an individual coverage for multiple screening services as part of a single-day visit to a health care provider. Finally, APRNs are added to the list of medical providers that must be covered by group and individual policies when providing of any of the above-listed services.

Special Session Act 15-5 delays the implementation of the following services until January 1, 2017:

- Family-focused therapy specializing in juvenile substance abuse
- Short-term family therapy to address adolescent behavior issues, conduct disorders, substance abuse disorders, and delinquency
- Home-based therapeutic interventions for children
- Chemical maintenance treatment

§ 3—Working Group to Develop Policies for Inpatient Mental Health Services
Effective June 30, 2015

This section requires the Insurance Commissioner and the Healthcare Advocate to study and make recommendations by January 1, 2016 for the development and implementation of policies relating to health insurance coverage for inpatient mental health services and substance use disorder services.

IV. ACTS CONCERNING EMPLOYMENT AND BUSINESS RESPONSIBILITIES

26. PUBLIC ACT 15-6. AN ACT CONCERNING EMPLOYEE ONLINE PRIVACY.
Effective October 1, 2015

The Act forbids employers from requesting that an applicant or employee (i) provide usernames or passwords for personal online accounts, (ii) access a personal online account in the presence of the employer, or (iii) invite the employer or accept an invitation from the employer to join a group on the employee's personal account. In addition, employers are prohibited from discharging, disciplining, discriminating

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against, retaliating against, or otherwise penalizing employees who refuse to do any of the above or files a complaint concerning an employer's violation of the above. Finally, an employer may not fail or refuse to hire applicants who refuse to do any of the above.

Employers are permitted to ask for usernames and passwords for individual employee or applicant accounts that an employee uses for the benefit of the employer and electronic devices supplied by or paid for, at least in part, by the employer. Employers are permitted to discipline employees (including discharge) who transfer an employer's proprietary information, without permission, via a personal online account. The Act allows employers to monitor, review, access, and block certain electronic data stored on electronic devices for which the employer pays or that travels through an employer's network.

If an employer receives specific information about activity on an employee's personal account, the employer is permitted to conduct investigations to ensure compliance with state and federal laws, regulatory requirements, and prohibitions against work-related employee misconduct. An employer is also allowed to conduct an investigation, pursuant to the receipt of specific information, to inquire if an employee or applicant is misappropriating the employer's proprietary information. If an employer is conducting a lawful investigation, it may require an employee or applicant to allow the employer access to personal accounts. However, an employer may not ask for personal account names or passwords.

If an employee believes that an employer has violated the Act, the employee or applicant may file a complaint with DOL. If DOL finds that the employer violated the Act with regards to an applicant, DOL may (1) fine the employer up to $25 for the first offense and up to $500 for each subsequent offense. If DOL finds that the employer violated the Act with regards to an employee, DOL may (1) fine the employer up to $500 for the first offense and up to $1,000 for each subsequent offense and (2) award the employee relief including rehiring or reinstatement, back wages, employee benefits, or other appropriate remedies.

All parties that are aggrieved by DOL's decision may appeal the decision to Superior Court.

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27. PUBLIC ACT 15-53. AN ACT CONCERNING MORTGAGE CORRESPONDENT LENDERS, THE SMALL LOAN ACT, VIRTUAL CURRENCIES AND SECURITY FREEZES ON CONSUMER CREDIT REPORTS.
Effective June 19, 2015

§ 9—No Credit Freeze Fee for Elderly Individuals

This section forbids credit rating agencies from charging any person over the age of sixty-two a fee for a credit freeze (i.e., when a credit rating agency restricts access to an individual's credit report because of potential or suspected identity theft).

28. PUBLIC ACT 15-56. AN ACT PROTECTING INTERNS FROM WORKPLACE HARASSMENT AND DISCRIMINATION.
Effective October 1, 2015

An employer, or its agent, is prohibited from refusing to hire an individual seeking an internship, bar an intern from providing internship services, or discriminate against an intern in terms, conditions, or privileges of service to the employer on the basis of the intern's race, color, sex, gender identity, sexual orientation, marital status, national origin, ancestry, present or past history of mental disability, intellectual disability, or learning disability. Further, no employer can advertise an internship opportunity in such a manner that would restrict it to or discriminate against individuals with the aforementioned designations. The Act also prohibits an employer from discharging an intern because he or she opposed any discriminatory employment practice or filed a complaint about discriminatory practices. Finally, an employer may not engage in sexual harassment toward an intern or an individual seeking an internship.

29. PUBLIC ACT 15-86. AN ACT CONCERNING AN EMPLOYER'S FAILURE TO PAY WAGES.
Effective October 1, 2015

Prior to this Act, a court had to award double damages plus court costs and attorney's fees if it found that an employer had failed to (1) pay an employee's wages, accrued fringe benefits, or arbitration award, or (2) meet the law's requirements for an employee's minimum wage or overtime rates. This Act establishes an exception to that recovery requirement. Now, if an employer establishes a good-faith belief that its underpayments were legal, it is only responsible for paying the difference between the amount actually paid and the full amount required by law, plus costs and reasonable attorney's fees.

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30. PUBLIC ACT 15-158. AN ACT CONCERNING THE LOSS OF AN OPERATOR LICENSE DUE TO A DRUG OR ALCOHOL TESTING PROGRAM AND UNEMPLOYMENT BENEFITS.
Effective October 1, 2015

    This Act states that an employer's base period account (in connection with unemployment tax payments) shall not be charged with respect to benefits paid to an employee who was discharged because, as a result of a failed drug or alcohol test, he or she lost an operator's license and therefore, can no longer perform the work he or she was hired to perform.

31. PUBLIC ACT 15-167. AN ACT EXTENDING CREDITOR PROTECTION TO AMOUNTS PAYABLE TO A PARTICIPANT OF OR BENEFICIARY UNDER AN ANNUITY PURCHASED TO FUND EMPLOYEE OR RETIREE RETIREMENT BENEFITS.
Effective October 1, 2015

    Under current law, employers may enter into group annuity contracts to fund employee retirement benefits or otherwise decrease the risk associated with managing a retirement plan. This Act exempts from creditors' claims interests in, or amounts payable to, participants and beneficiaries of certain allocated or unallocated group annuity contracts. The group annuity contracts that qualify for the exemption are ones that fund benefits which, prior to the contract, were protected by ERISA or PBGC, but lost that protection on or after the effective date of the group annuity contract.

32. PUBLIC ACT 15-196. AN ACT CONCERNING PAY EQUITY AND FAIRNESS.
Effective July 1, 2015

    Employers may not prohibit employees from disclosing and discussing their wages, the wages of employees who have disclosed their wages, or inquiring about the wages of other employees. The Act does not require an employer or employee to disclose any wage information.

    Employers cannot require employees to sign a waiver or other document that would waive any of the employee's above-named rights. This Act also forbids employers from discharging, disciplining, discriminating against, retaliating against or otherwise penalizing employees for exercising any of these rights.

    Employers who violate this Act may be held liable for compensatory damages, attorney's fees and costs, punitive damages, and other relief that the court deems proper. There is a two year statute of limitations from the date of the alleged violation in which a court action must be brought.

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These additional restrictions on employers largely mirror those already in place by the operation of the NLRA. However, some small employers may not be covered by the NLRA. In addition, Connecticut labor law defines "employee" more broadly than the NLRA by extending protections to managerial and supervisory personnel, positions that are beyond the scope of the NLRA.

33. PUBLIC ACT 15-249. AN ACT CONCERNING DOMESTIC SERVICE AND THE COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES.
Effective October 1, 2015

§ 2—Procedural Requirements for Discrimination Actions

This section reduces the number of days, from twenty to fifteen, that CHRO has to serve a respondent after receiving a discriminatory practice complaint. Respondents must either (1) file an answer to the complaint within thirty days or (2) within ten days of receipt of the complaint, elect to participate in pre-answer conciliation. If so selected, pre-answer conciliation must be conducted no later than thirty days after respondent's request is received. If pre-answer conciliation is unsuccessful, respondents then have thirty days to file an answer. As before, respondents still may ask for a one-time extension of up to fifteen days to file an answer. Answers to any amendment of the complaint must be filed within twenty days.

Not later than sixty days after the respondent files its answer, CHRO must complete a case assessment to evaluate if (1) the claim is frivolous or fails to state a claim, (2) the respondent is exempt, or (3) there is no reasonable possibility that the claim is meritorious. Under current law, CHRO has ninety days after the filing of an answer to complete this review; however, this section reduces this to sixty days.

If, as a result of the case assessment, CHRO decides to proceed with the case, it must hold a mandatory mediation conference within sixty days after notifying the parties that the action is going forward. A mediation conference is not necessary, however, if the parties had conducted a pre-answer conciliation conference. Further, the investigator or counsel assigned by CHRO to conduct mediation shall not also be assigned to investigate the complaint. If the mandatory mediation conference does not resolve the dispute, CHRO must assign an investigator to the case within fifteen days. In the course of its investigation, CHRO is allowed to subpoena witnesses to testify.

Under current law, CHRO can issue an order of default against any respondent who fails to (1) answer the complaint within the appropriate time, (2) answer interrogatories or answer a subpoena, (3) attend a fact-finding conference, and (4)

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attend a mediation session. The Act now allows respondents to challenge a CHRO order of default.

Finally, CHRO may dismiss an action if a complainant (1) fails to attend a fact-finding conference, (2) fails to attend a mandatory mediation conference, or (3) refuses a settlement offer in which the respondent (i) offered full relief, (ii) eliminated the discriminatory practice, and (iii) has taken steps to ensure similar instances do not occur in the future.

V. ACTS CONCERNING HOUSING AND REAL PROPERTY

34. PUBLIC ACT 15-29. AN ACT CONCERNING ADMINISTRATIVE HEARINGS CONDUCTED BY THE DEPARTMENT OF HOUSING.
Effective October 1, 2015

This Act establishes the same hearing and appeals process for DOH as is current law for hearings and appeals in front of DSS. Individuals may request a hearing before DOH if they are a part of the (1) rental assistance program, (2) transitionary rental assistance program, and (3) security deposit guarantee program.

35. PUBLIC ACT 15-119. AN ACT CONCERNING FREEDOM OF ASSOCIATION IN PUBLIC HOUSING.
Effective October 1, 2015

This Act forbids housing authorities, nonprofit corporations, municipalities, and municipal developers from prohibiting tenants of public housing (state or federally subsidized multifamily housing) to utilize common rooms located within the public housing for political activity. Political activity includes an event organized for a political party or candidate, initiating or signing petitions, campaigning a referendum question, legislation, constitutional amendments, or municipal ordinances, or expressing opinions about candidates and political or social issues.

VI. ACTS CONCERNING PROBATE

36. PUBLIC ACT 15-217. AN ACT CONCERNING PROBATE COURT OPERATIONS.
Effective January 1, 2016, except as otherwise noted

The Act makes revisions to certain probate statutes, including several changes that affect conservatorships.

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§ 6—Petitions Challenging Involuntary Conservatorship
Effective October 1, 2015

A petition for a writ of habeas corpus challenging an involuntary conservatorship can be brought in front of a three-judge panel in Probate Court. If a conserved person wishes to appeal the panel's decision, such appeal must be filed in the Superior Court in the judicial district where the probate court that appointed the conservator is located. This section clarifies that, if the probate district extends into multiple judicial districts, the appeal can be brought in any judicial district with part of the probate district in it.

§ 21—Petitions for Voluntary Conservatorship

This section specifies that a voluntary petition for conservatorship can be filed in the Probate Court district where the petitioner currently resides, or where the petitioner is domiciled or located at the time of the petition.

§ 22—Notice of Proceeding

Probate courts must notify certain people of hearings to appoint a guardian of an adult with an intellectual disability. This section clarifies that notice by first class mail must be sent to the applicant, the parents of the respondent, the spouse of the respondent, children of the respondent, siblings of the respondent or their representatives, and if the respondent has no living parents, the person in charge of the hospital, nursing home, residential facility or other institution in which the respondent may reside must also be notified.

VII. ACTS CONCERNING GOVERNMENT STUDIES AND TASK FORCES

37. PUBLIC ACT 15-203. AN ACT CONCERNING A STUDY OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE.
Effective July 2, 2015

By February 1, 2016, DPH, in consultation with DSS, CHA, and other national patient organization representatives, must study COPD and report the results to the joint committee on Public Health.

The report must include: (1) hospitalization and rates of hospital readmission within thirty days for persons with COPD, (2) a description of current activities by state agencies to promote awareness and education by health care providers and the general public on COPD, (3) an assessment of the need for community-based services for persons with COPD, and (4) recommendations concerning (a) the necessity and

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feasibility of a needs assessment, (b) hosting an annual summit, (c) development of a pilot program to determine best practices and outcomes to lower hospital readmission rates, and (d) identification of the amount of funding and potential funding sources for the pilot program.

In addition to the study, DPH must post information relating to COPD on its website.

38. PUBLIC ACT 15-40. AN ACT CONCERNING A STUDY OF ALTERNATIVE FUNDING SOURCES FOR NUTRITIONAL SERVICES FOR SENIOR CITIZENS.
Effective July 1, 2015

The Act requires DOA and DSS to study alternative funding for nutrition services programs for senior citizens. DOA and DSS must submit their findings and recommendations to the General Assembly's Aging Committee by July 1, 2016.

39. SPECIAL ACT 15-2. AN ACT CONCERNING A STUDY OF THE SEXUAL OFFENDER REGISTRATION SYSTEM.
Effective October 1, 2015

This Act requires the Connecticut Sentencing Commission to study (1) the sentencing of sexual offenders; (2) the risk assessment and management of sexual offenders; (3) the registration requirements of sexual offenders; (4) the information available to the public and law enforcement regarding sexual offenders; (5) the effectiveness of a tiered classification system based on the risk of re-offense; (6) methods to reduce recidivism; (7) housing opportunities for sexual offenders; (8) post-sentencing appeals of sexual offender status; (9) sexual offender management; and (10) victim needs and services and community education. A preliminary report must be submitted to the General Assembly's Judiciary Committee by February 1, 2016 and final report is due by December 15, 2017.

VIII. MISCELLANEOUS ACTS OF INTEREST

40. PUBLIC ACT 15-1. AN ACT PERMITTING THE WAIVER OF STATE AGENCY ELECTRONIC FILING REQUIREMENTS AND CONCERNING SPECIAL ELECTIONS FOR MAYORAL CANDIDATES.
Effective October 1, 2015, except as otherwise noted

§§ 1–2—Waiver of Electronic Filing

This Act permits agencies to waive the requirement that client notifications, applications, forms, and communications be done electronically if the client so requests, and demonstrates good cause.

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41. PUBLIC ACT 15-4. AN ACT CONCERNING REPORTING OF PAYMENTS BY MANUFACTURERS TO INDEPENDENTLY-PRACTICING ADVANCED PRACTICE REGISTERED NURSES.
Effective May 11, 2015

This Act modifies the state "sunshine" requirements governing relationships between APRNs and pharmaceutical and medical device manufacturers.

§ 1(a)—Definition of "Payment or Other Transfer of Value"

This section modifies the definition of "payment or other transfer of value" by excluding anything that fulfills the exclusion criteria under 42 U.S.C. § 1320a-7h(e)(10), including: (1) items valued less than $10, unless the aggregate amount for the calendar year exceeds $100 (both valued in 2012 dollars); (2) product samples not intended for patient use; (3) educational materials for the benefit of patients; (4) a loan of a covered device that does not exceed 90 days; (5) items provided under contractual warranty whose terms of the warranty are found within the purchase agreement for the device; (6) items transferred to an individual as a patient, and not acting within the capacity of a covered recipient; (7) discounts and rebates; (8) items used for charity care; (9) dividends or other profit distributions resulting from ownership in a publicly traded security or mutual fund; (10) for manufacturers offering a self-insured plan, payments to employees for health care under the plan; (11) if the recipient is a licensed non-medical professional, payment solely for non-medical professional services, and (12) if the recipient is a physician, payment solely for services in connection with a civil or criminal action or an administrative proceeding.

§ 1(b)—Manufacturer Payment Disclosures

This section modifies manufacturers' obligations to disclose to DCP payments made to an APRN to only require that they disclose payments made to an independent APRN (who is not practicing in collaboration with a physician), in accordance with the list of independent APRNs that the state must publish annually. This section also changes the reporting requirement from quarterly to annually and delays the date of first disclosure to July 1, 2017.

§ 2(b)—Published List of Authorized APRNs

DPH must now publish on its website, prior to December 1, annually, a list of all APRNs in the state who are authorized to practice outside of a collaboration with a physician.

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42. PUBLIC ACT 15-11. AN ACT CONCERNING PERSONS WHO DECONTAMINATE REUSABLE MEDICAL INSTRUMENTS OR DEVICES. *Effective January 1, 2016*

This Act requires any hospital personnel, including personnel of chronic disease hospitals, who decontaminates, inspects, assembles, packages, or sterilizes reusable medical instruments or devices within the hospital to be credentialed. The person must meet one of the criteria below:

1. Pass a national central service exam and maintain a credential from the International Association of Healthcare Central Service Materiel Management;
2. Pass a national central service exam and maintain a credential from the Certification Board for Sterile Processing and Distribution;
3. Be employed as a technician in a health care facility prior to January 1, 2016; or
4. Within two years of the person's date of hire or contracting with the health care facility, obtain a credential from the International Association of Healthcare Central Service Materiel Management or the Certification Board for Sterile Processing and Distribution.

Upon request, hospitals must submit to DPH a list and qualifications of the individuals that the hospital employs or contracts with to perform the functions of a central service technician.

Additionally, technicians must complete ten hours of CE per year in areas related to their functions as a technician.

This Act also allows other individuals to perform the functions of a central service technician, including: (1) health care providers, (2) interns—as a part of training or internship—under the direct supervision of a health care provider, and (3) persons who do not necessarily work in the central service department of the hospital but have been specially trained and determined competent to decontaminate or sterilize reusable medical instruments or devices. Hospitals must maintain a list of the individuals (and their official job titles) who are allowed to perform the functions of a central service technician. Each year, these individuals must complete ten hours of CE related to infection control and the decontamination and sterilization of reusable medical equipment, instruments, and devices.

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43. PUBLIC ACT 15-15. AN ACT AMENDING THE CODE OF ETHICS FOR LOBBYISTS TO REDEFINE "EXPENDITURE" AND RAISE THE THRESHOLD FOR LOBBYIST REGISTRATION.
Effective January 1, 2016

This Act modifies the definition of a lobbying "expenditure" by excluding any cost incurred to transport members, shareholders, or employees to or from a specific site if the members, shareholders, or employees did not receive any compensation or reimbursement for their lobbying efforts. This Act also excludes from the definition of a lobbying "expenditure" any expenditure for a publication that is intended primarily for its members, shareholders, or employees, whether given in written or electronic form, or orally.

This Act also modifies the definition of a "lobbyist" by excluding any individual or employee of a quasi-public agency. Finally, under current law, an individual is considered to be a lobbyist if they spent more than $2,000 in a calendar year on lobbying efforts. This Act changes this threshold amount to $3,000.

44. PUBLIC ACT 15-88. AN ACT CONCERNING THE FACILITATION OF TELEHEALTH.
Effective October 1, 2015

§ 1—Requirements for Providing Telehealth Services

This section specifies that a telehealth provider can only provide telehealth services to a patient when the provider (1) is communicating through real-time, two way communication technology; (2) has access to, or knowledge of, the patient's medical history and health records; (3) conforms to the standard of care applicable to the telehealth provider's profession; and (4) provides the patient with the provider's license number and contact information. During the initial interaction with a patient, the telehealth provider must inform the patient about the treatment methods and limitations with telehealth and obtain his or her consent to provide telehealth services. In each telehealth interaction, the telehealth provider must also obtain the patient's consent before relaying information about the session to the patient's primary care provider. Further, this section prohibits telehealth providers from prescribing controlled substances on Schedule I, II, and III to patients. Providers of telehealth services and the health maintained and disclosed in a telehealth interaction must comply with HIPAA. This section does not prohibit health care providers from providing on-call coverage, consulting other providers about hospital patient care, or communicating orders for hospital outpatients or inpatients.

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§§ 2–3—Insurance for Telehealth Services

This section mandates that individual and group health insurance policies providing telehealth coverage provide coverage for medical advice, diagnosis, care or treatment to the same extent it is available through in-person consultation between an insured and health provider. No policy shall exclude coverage for service solely because that service is provided only through telehealth or be required to reimburse a treating or consulting provider for technical fees for telehealth services. However, nothing here prevents a health insurer from conducting utilization reviews for telehealth services in the same manner, and with the same criteria, as its reviews of in-person services.

45. PUBLIC ACT 15-120. AN ACT CONCERNING VARIOUS REVISIONS TO THE MENTAL HEALTH AND ADDICTION STATUTES.
Effective October 1, 2015

§ 1—Reporting Statistical Information to DSS

This section includes within the definition of public and private agencies that must keep certain statistical information agencies that operate institutions that treat psychiatric disabilities or substance abuse. These agencies are now required to report the required statistical information to DSS upon request in the form and manner prescribed. Failure to provide information results in reporting to DPH or other licensing authority.

§ 2—Ability of Commissioner of DSS to Appoint Employees to Sign on Behalf of DMHAS

Now, the Commissioner of DSS may designate any employee of the department to sign any contract, agreement, or settlement on behalf of DMHAS, not just a deputy commissioner.

§ 5—Repeal Conn. Gen. Stat. § 17a-452

This section repeals Conn. Gen. Stat. § 17a-452, which established two deputy commissioner positions (a deputy commissioner of mental health services and a deputy commissioner of addiction services) and a medical director position.

46. PUBLIC ACT 15-140. AN ACT PERMITTING THE COMMERCIAL USE OF *SOUS VIDE*.
Effective October 1, 2015

This Act permits food service providers to cook by using the technique of *sous vide* if at least two controls of time, temperature, water activity or acidity are in place and the

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food will be eaten at the establishment where it is cooked. *Sous vide* is a method of food preparation whereby raw or partially cooked food is vacuum packaged in an impermeable bag, cooked in the bag, rapidly chilled and refrigerated to prevent bacterial growth. DPH must also promulgate regulations to implement this Act.

47. PUBLIC ACT 15-142. AN ACT IMPROVING DATA SECURITY AND AGENCY EFFECTIVENESS.
Effective October 1, 2015, except as otherwise noted

This Act establishes protocols in order to protect confidential information ("CI"). CI is defined broadly to include anything from name and date of birth to social security number and any information a state contracting agency deems confidential, that a contractor obtains from a state contracting agency pursuant to a written agreement.

§ 1—Security Requirements for State Contractors
Effective July 1, 2015

This section stipulates that any agreement that authorizes a state contracting agency to share confidential information with a contractor must require the contractor, at its own expense, to:

1. Implement and maintain a comprehensive data security program to protect CI;
2. Limit CI access to authorized employees and agents for authorized purposed under confidential agreements;
3. Use certain technology, such as firewalls and intrusion detection software, to maintain all data obtained from state contracting agencies;
4. Implement, maintain, and update appropriate security and breach investigation procedures;
5. Report actual or suspected data breaches, along with a plan to mitigate the effects of any such breach and steps taken to ensure that future breaches do not occur, to the AG and state contracting agency; and
6. Cease all use of data provided by or developed under the written agreement if so directed by the state contracting agency.

This section also prohibits a contractor from storing confidential information on a stand-alone computer, notebook hard disks or other portable devices unless the agreement expressly allows it and includes approved alternative security assurances.

These requirements apply to any health care provider that receives CI from a state contracting agency pursuant to an agreement to provide goods or services to the state. The definition is broad enough to arguably include providers that have entered into Medicaid provider agreements.

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§ 5—Security Requirements for Entities Subject to Department of Insurance Oversight

This section imposes new data security obligations on "companies," which include health insurers, health care centers, other entities licensed to do health insurance business in the State, pharmacy benefits managers, third-party administrators, and utilization review companies.

§ 6—Breach Notification

This section amends the state breach notification law to require notification no later than ninety days after discovery of a breach, unless a shorter time is required by federal law. Additionally, businesses must offer identity theft mitigation services, for at least a year, to each individual affected by a breach. This section applies to all individuals and entities that are currently subject to the state breach verification law; it is not limited to state contractors.

48. PUBLIC ACT 15-151. AN ACT CONCERNING THE RETURN OR USE OF UNUSED GRANT AWARDS FROM THE DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT.
Effective October 1, 2015

This Act requires DECD to include in the grant award the date a grant recipient must either (1) return all amounts of the unused grant, or (2) apply to use the unused grant for another purpose.

49. PUBLIC ACT 15-156. AN ACT CONCERNING THE MUNICIPAL TAX COLLECTION STATUTES.
Effective October 1, 2015

§ 1—Delinquent Party Can Choose Which Property to Attribute Taxes

If a party who is liable for back taxes on multiple properties makes a payment to decrease the liability owed, the municipality must adhere to the party's written instructions on how the party wants to attribute the payment between the taxes owed on the multiple properties.

§ 2—Not a Delinquent Tax or Installment

This section clarifies that any tax or installment paid within the appropriate time via a municipality's electronic system is not considered to be delinquent.

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§ 3—Revoke License for Delinquent Water, Sewer, or Sanitation Charges

This section permits a municipality to revoke any license or permit issued by the municipality if the business has water, sewer, or sanitation charges that were levied by a water pollution control authority and have been delinquent for at least one year.

§ 5—Interest in Escrow is Property of the Municipality

Under current law, if the forced sale of a property to pay delinquent taxes nets an amount greater than the taxes owed, the excess amount shall be held in an interest-bearing escrow account. This section clarifies that the interest earned from this escrow account is the property of the municipality.

50. PUBLIC ACT 15-198. AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION.
Effective October 1, 2015, except as otherwise noted

In an ongoing effort to curb the abuse of prescription controlled substance, the following measures have been enacted:

§§ 1–4—Continuing Education Requirements

Under current law, physicians, nurses, and physicians assistants must complete mandatory CE training to be eligible for renewal of their respective licenses. This Act amends these requirements by adding training for prescribing controlled substances and pain management, as follows:

- Physicians—Under current law, physicians must complete at least fifty hours of CE medical training within the previous twenty-four month period, with at least one hour of training in each of the fields of infectious disease, risk management, sexual assault, domestic violence, cultural competency, and behavioral health. This Act states that the risk management training requirement includes, but is not limited to, training on prescribing controlled substances and pain management;

- Nurses—Under current law, nurses must complete at least fifty hours of CE medical training within the previous twenty-four month period, with at least one hour of training in each of the fields of infectious disease, risk management, sexual assault, domestic violence, cultural competency, and substance abuse. This Act states that the substance abuse training requirement include, but is not limited to, prescribing controlled substances and pain management; and

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- PAs—In addition to other training requirements, PAs must now complete at least one contact hour of training in prescribing controlled substances and pain management in the prior two-year period.

§ 5—Prescriber Requirements

Under current law, physicians are encouraged to consult the PMP prior to prescribing or renewing prescriptions for controlled substances. Now, physicians must review the PMP prior to prescribing a greater than a seventy-two hour supply of a controlled substance. For patients for whom a physician prescribes ongoing controlled substances, the physician must review the PMP every ninety days. If the PMP is temporarily inaccessible, physicians are allowed to prescribe a greater than a seventy-two hour supply, but the physician must review the PMP within twenty-four hours after the program is back online.

§§ 6 & 8—Prescribing Opioid Antagonists
Effective June 30, 2015

Pharmacists may now prescribe opioid antagonists (i.e., naloxone hydrochloride ("Narcan") or any FDA-approved drug that acts similarly) provided the pharmacist (1) has been trained by a program approved by DCP and (2) acts in good faith. Whenever a pharmacist prescribes an opioid antagonist, the pharmacist must provide training to the person on how to administer it and keep a record of the dispensing and training. Pharmacists cannot delegate or direct others to prescribe an opioid antagonist or provide the training. Any pharmacist who prescribes opioid antagonists pursuant to and in compliance with this law shall be deemed not to have violated any standard of care for a pharmacist.

The Act further clarifies that if a health care professional licensed to prescribe an opioid antagonist prescribes such a drug to any individual in compliance with this law, he or she shall not be deemed to have violated the standard of care of that professional. In addition, a licensed health care professional who prescribes, dispenses, or administers an opioid antagonist in accordance with these requirements does not violate the standard of care for such licensed professional.

§ 9—Commission on Aging Added to Council

The COA has been added as a member of the Connecticut Alcohol and Drug Policy Council.

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51. PUBLIC ACT 15-229. AN ACT DELAYING A MUNICIPAL TAX REVALUATION DEADLINE AND CONCERNING MUNICIPAL RESERVE FUNDS.
Effective October 1, 2015, unless otherwise noted

§ 1—North Stonington Exemption
Effective July 7, 2015

This section exempts the town of North Stonington from a property tax revaluation prior to October 1, 2016. In addition, this section requires that any subsequent revaluation of properties in North Stonington be implemented by the first of October no later than five years after the property assessment is completed.

§§ 2–3—Reserve Fund for Property Tax Revaluations

This section permits the legislative body of any municipality to create a reserve fund for expenditures and other costs associated with a property tax revaluation.

52. PUBLIC ACT 15-240. AN ACT CONCERNING ADOPTION OF THE CONNECTICUT UNIFORM POWER OF ATTORNEY ACT.
Effective July 1, 2016

This act establishes the Uniform Power of Attorney Act and repeals current laws governing POA.

§§ 3 & 45—Applicability

These sections make clear that the Act applies to POAs regardless of when they were created. Specifically, the Act applies to judicial proceedings concerning POAs starting on or after October 1, 2015, as well as judicial proceedings before that date unless the court finds that applying one of the Act's provisions interferes with the proceeding. The Act does not apply to the following POAs: (1) POA to the extent it is coupled with an interest in the subject of the power; (2) POA to make health care decisions; (3) proxy or other delegation of voting or management rights; or (4) POA created on a government form for government purposes.

§§ 5–6—Validity

A POA executed on or after October 1, 2015 is valid if the principal or someone he directs signs the principal's name and dates the document in front of two witnesses. Signatures by someone other than the principal must take place in the principal's

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conscious presence. A POA executed before October 1, 2015, is valid if its execution complied with existing law at the time of execution.

The Act makes an out-of-state POA valid in Connecticut if it complied with the requirements of (1) the jurisdiction in which it was created, (2) the jurisdiction indicated in the POA, or (3) federal law if it is a military POA.

Finally, these sections stipulate that a photocopy or electronic copy of the original POA has the same effect as the original, unless another statute or the POA itself provides otherwise.

§§ 8, 48–49 & 53—Conservators

In a POA, a principal can nominate a conservator of his or her estate or person. If the principal becomes the subject of a protective proceeding after executing the POA, a court must appoint the person most recently nominated as conservator unless the person is unwilling or unable to serve or there is substantial evidence disqualify such person.

If a court appoints a conservator of the estate or another fiduciary to manage some or all of the principal's property, the court may continue, limit, suspend, or terminate the POA and must enter a specific order on whether the agent's authority is limited, suspended, or terminated. If the POA continues, the agent is accountable to the fiduciary and principal.

§ 9—When a POA Becomes Effective

A POA is effective when executed unless the POA specifies otherwise. If the POA's effect is based on the occurrence of a future event or contingency, the principal can authorize someone to determine in a record that the event or contingency occurred. If the contingency is the principal's incapacity and the POA does not designate anyone to determine the principal's incapacity, the POA will become effective upon a determination by two independent physicians or a judge.

§ 10—Termination of Authority

A POA terminates if: (i) the principal dies; (ii) the principal becomes incapacitated; (iii) the POA is not durable; (iv) the principal revokes it; (v) the principal states that it is terminated; (vi) the purpose of the POA is accomplished; (vii) the agent dies, resigns, or becomes incapacitated; (viii) the agent is the principal's spouse and an action is filed to dissolve or annul the marriage; or (ix) power is terminated by a court. A principal's effecting of a subsequent POA does not revoke a previous one

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unless the new one states that it revokes all previous POAs. Unless the POA provides otherwise, an agent may exercise his or her authority until the authority terminates, regardless of the amount of time since execution of the POA.

The principal and his or her successors are bound by an agent's actions after an agent's authority or the POA terminates when the agent does not know of the termination and acts in good faith. This also applies when a POA terminates due to the principal's incapacity.

§§ 6, 11–15, & 17– 18—Agents

A POA may designate two or more co-agents who can exercise their authority independently, unless the POA provides otherwise. The POA can also designate successor agents, who have the same authority as the original agent, to replace an agent who resigns, dies, or declines to serve. The POA can grant authority to designate successor agents to an agent or a person designated by name, office, or function.

An agent is entitled to reasonable compensation and reimbursement for expenses reasonably incurred on the principal's behalf. A person accepts an agent appointment if he uses the agent's authority, performs the agent's duties, or takes other actions indicating acceptance.

Regardless of the POA's provisions, an agent who accepts an appointment must act according to the principal's reasonable expectations, in good faith, within the POA's granted authority. Unless the POA provides a different method, an agent may resign by notifying the principal. If the principal is incapacitated, the agent must notify either (1) any appointed guardian, conservator of the estate or person, and any co-agent or successor agent or (2) the principal's spouse and children, someone reasonably believed to have sufficient interest in the principal's welfare, or a representative of DSS' Division of Protective Services for the Elderly.

The agent is not liable:

1. to beneficiaries of an estate plan for failing to preserve it if he or she acts in good faith;
2. solely because he or she also benefits from an act or has an interest or conflict about the principal's property or affairs if the agent acts with care, competence, and diligence for the principal's best interest;
3. if the principal's property declines in value unless the agent breached a duty;

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4. for the acts, errors, or defaults of someone to whom the agent delegates his or her authority or engages on the principal's behalf, if the agent selected and monitored the person using care, competence, and diligence; or
5. for the actions of another agent if he did not participate in or conceal the other agent's breach of fiduciary duty.

An agent with knowledge of a breach or an imminent breach must notify the principal and take reasonable steps to safeguard an incapacitated principal's interests. An agent who fails to take these actions is liable for damages that could have been avoided by taking the required action.

§§ 16 & 47—Probate Court

These sections detail the people that may petition the probate court to construe a POA, review an agent's conduct, or get relief. The person must apply to the probate court in the district (1) where the agent has a place of business; (2) where the agent or principal resides; or (3) if the principal is deceased, the location with jurisdiction over the estate or where the principal resided immediately before death.

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