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

2016 REGULAR AND SPECIAL SESSIONS OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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TABLE OF CONTENTS

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TABLE OF ACRONYMS

AG	Attorney General
AIDS	Acquired Immunodeficiency Syndrome
APRN	Advanced Practiced Registered Nurse
CHRO	Commission on Human Rights and Opportunities
CMEB	Connecticut Medical Examining Board
CMS	Centers for Medicare & Medicaid Services
CON	Certificate of Need
DAS	Department of Administrative Services
DCP	Department of Consumer Protection
DDS	Department of Developmental Services
DESPP	Department of Emergency Services and Public Protection
DMHAS	Department of Mental Health and Addiction Services
DOA	Department on Aging
DOH	Department of Housing
DOL	Department of Labor
DPH	Department of Health
DRG	Diagnosis Related Group
DSS	Department of Social Services
DVA	Department of Veterans' Affairs
EMS	Emergency Medical Services
FDA	Food and Drug Administration

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FDIC	Federal Deposit Insurance Corporation
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
IPA	Independent Practice Association
IRA	Individual Retirement Account
LLC	Limited Liability Company
NCUA	National Credit Union Administration
OCME	Office of the Chief Medical Examiner
OFA	Office of Fiscal Analysis
OHCA	Office of Healthcare Access
OPA	Office of Protection and Advocacy for Persons with Disabilities
OPM	Office of Policy and Management
PA	Physician Assistant
PAPD	Protection and Advocacy for Persons Disabilities
PHI	Protected Health Information
RCH	Residential Care Home
UAPA	Uniform Administrative Procedure Act

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I. SPENDING BILLS AND IMPLEMENTERS

1. PUBLIC ACT 16-2 (MAY SPECIAL SESSION). AN ACT ADJUSTING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017.
Effective July 1, 2016

§§ 1 & 16

This year's Budget amends certain amounts appropriated for the general fund and for other identified funds for the fiscal year ending June 30, 2017. It also enacts new directives to certain state agencies. Of relevance:

- Consistent with provisions under Public Act No. 16-3 (May Special Session) (see page 3, below), which creates a new Commission on Women, Children and Seniors to succeed the existing commissions on aging, women, and children, the Budget reallocates funds from these three commissions and significantly reduces the overall budget dedicated to the new commission, from $1,841,830 aggregated over the three commissions, to $700,000.

- OPM
  - Tax Relief for Elderly Renters is reduced by $1,600,000, from $28,900,000 to $27,300,000.
  - Disability Exemption for Reimbursement Property tax is reduced by $25,935, from $400,000 to $374,065.
  - Property Tax Relief for Veterans is reduced by $192,552, from $2,970,098 to $2,777,546.

- DVA
  - Budget of $180,500 for Support Services for Veterans is eliminated.
  - Burial Expenses is reduced by $534, from $7,200 to $6,666.
  - Headstones is reduced by $24,666, from $332,500 to $307,834.

- PAPD – total budget is reduced by $322,144, from $2,548,785 to $2,226,641.

- DOH
  - Elderly Rental Registry and Counselors is reduced by $150,255, from $1,196,144 to $1,045,889.
  - Subsidized Assisted Living Demonstration is reduced by $151,199, from $2,332,250 to $2,181,051.
  - Elderly Congregate Rent Subsidy is reduced by $160,419, from $2,162,504 to $2,002,085.

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- DPH
  - AIDS Services budget of $85,000 is eliminated.
  - Genetic Disease Programs budget of $237,895 is eliminated.
  - Local and District Departments of Health is reduced by $608,732, from $4,692,648 to $4,083,916.
  - DPH must reduce on a pro rata basis payments to full-time municipal health departments and to health districts, in an aggregate amount equal to $517,114.

- OCME – Medicolegal Investigations is reduced by $3,212, from $26,047 to $22,835.

- DDS
  - Clinical Services is reduced by $863,436, from $3,493,844 to $2,630,408.
  - Autism Services budget of $3,098,961 is eliminated.
  - Rent Subsidy Program is reduced by $100,000, from $5,130,212 to $5,030,212.
  - Supplemental Payments for Medical Services is reduced by $645,503, from $4,908,116 to $4,262,613.
  - Community Residential Services budget of $502,596,014 is eliminated.

- DMHAS
  - Housing Supports and Services is reduced by $232,215, from $24,221,576 to $23,989,361.
  - Connecticut Mental Health Center is reduced by $368,959, from $8,509,163 to $8,140,204.
  - Nursing Home Screening is reduced by $43,888, from $591,645 to $547,757.
  - Medicaid Adult Rehabilitation Option is reduced by $401,471, from $4,803,175 to $4,401,704.
  - Nursing Home Contract is reduced by $54,121, from $485,000 to $430,879.

- DSS
  - Medicaid is reduced by $95,546,739, from $2,541,788,000 to $2,447,241,261.
  - Old Age Assistance is increased by $485,736, from $38,347,320 to $38,833,056.
  - Aid to the Blind is reduced by $128,013, from $755,289 to $627,276.
  - Aid to the Disabled is increased by $466,528, from $61,475,440 to $61,941,968.
  - Services for Persons with Disabilities is reduced by $64,682, from $541,812 to $477,130.

- DOA
  - Programs for Senior Citizens is reduced by $255,531, from $6,150,914 to $5,895,383.

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- Total budget is reduced by $523,651, from $8,823,625 to $8,299,974.
- Fall Prevention budget is reduced by $98,977, from $475,000 to $376,023.

§ 9

This Act provides that $2,000,000 of unobligated funds remaining in the Biomedical Research Trust fund on June 30, 2016 will be transferred to the General Fund for the fiscal year ending June 30, 2017. Any remaining unobligated funds after the transfer must be apportioned to certain institutions, agencies and programs identified by this Act.

§§ 18 & 19

- $550,000 will be transferred from the Tobacco and Health Trust Fund to DPH
  - $150,000 of these funds must be used for the adult asthma program within the Easy Breathing Program
- $750,000 will be transferred from the Tobacco and Health Trust Fund to DDS and $750,000 to DSS; both transfers will be used for autism services and supports

2. PUBLIC ACT 16-3 (MAY SPECIAL SESSION). AN ACT CONCERNING REVENUE AND OTHER ITEMS TO IMPLEMENT THE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017.

Effective as noted

§ 43
Effective October 1, 2016

This Act limits the obligation of full benefit dually eligible Medicare Part D beneficiaries for Part D prescription copayments by capping the monthly amounts they must pay. Under this Act, the dually eligible beneficiaries need only pay up to $17.00 per month in the aggregate for Medicare Part D copayments. DSS must pay any copayment amounts that exceed $17.00 in the aggregate in any month.

§§ 44 & 45
Effective July 1, 2016

The maximum allowable contribution by DSS for funeral services for any beneficiary under the state supplement or temporary family assistance program, or for an indigent person or beneficiary under the state-administered general assistance program, is decreased from $1,400 to $1,200. The formula to calculate DSS's contribution now takes into account two additional factors: the net value of liquid assets in the decedent's estate and contributions in excess of $3,400 from all other sources.

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§ 46
Effective July 1, 2016

All RCHs, community living arrangements, and community companion homes that received a flat rate during the 2016 fiscal year for residential services will receive the same state rates of payment until June 30, 2017.

§§ 47 through 59 & 63
Effective July 1, 2016

This Act makes DSS rather than DDS the lead agency responsible for the federal Combating Autism Act and for coordinating state agencies that are responsible for providing autism spectrum disorder services. This Act also establishes a Division of Autism Spectrum Disorder within DSS.

DSS may now adopt regulations and establish the criteria for administering services to persons qualifying for autism support services. Additionally, DSS is now tasked with making recommendations to the Governor and the General Assembly regarding the legislation and funding necessary to provide services to persons diagnosed with autism spectrum disorder.

DDS is responsible for investigating reports of abuse or neglect of individuals who receive services from DSS's Division of Autism Spectrum Disorder Services. DDS must prepare written findings that include determinations of whether abuse has occurred.

The Division of Autism Spectrum Disorder Services is charged with taking the necessary actions to secure Medicaid reimbursement for home and community-based support services for individuals with autism spectrum disorder. DSS must seek an amendment to the state Medicaid plan or a waiver from federal law to establish a Medicaid-financed home and community-based program that provides services and housing assistance to adults with autism spectrum disorder.

§ 65
Effective July 1, 2016

This Act limits the DMHAS grant program for community-based behavioral health services (which includes (i) care coordination services, and (ii) access to information on, and referrals to, health care and social service programs) by stating that it shall be established "within available appropriations." In addition, DMHAS may, but is no longer required to, issue the grants to organizations that provide acute care and emergency behavioral health services.

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§ 82
Effective July 1, 2016

The Renters' Rebate Program provides grants to qualified low-income renters who are elderly or completely disabled. If needed, OPM must make reductions to grants under the program to stay within available appropriations. OPM must forward a notice of any necessary reduction in claim amounts to the Comptroller not more than 120 days after grant applications are received.

§ 87
Effective June 2, 2016

This Act eliminates the requirement that DSS establish rates based upon reasonable cost to the hospital, or the charge to the public for ward services, or the lowest cost for semiprivate services, whichever is lowest, for hospitals receiving appropriations granted by the General Assembly and for freestanding chronic disease hospitals providing services to persons aided or cared for by the state for routine services. For inpatient hospital services that DSS determines are not appropriate for reimbursement based on DRGs, DSS must reimburse for these services using any other methodology that complies with federal law governing state plans for medical services. Such law generally requires that payments be consistent with efficiency, economy and quality of care, be sufficient to enlist enough providers so that care and services are available under the state's Medicaid plan to the same extent they are available to the general population, and that the payments safeguard against the unnecessary utilization of such care and services.

This Act amends language enacted in 2015 providing that DSS may not increase or adjust upward any rates or method of payment to hospitals based on inflation or based on any inflationary factor unless the approved state budget includes appropriations for such increases or upward adjustments.

This Act does not change current law providing that DSS establish rates to be paid to freestanding chronic disease hospitals within available appropriations.

§§ 95 through 108

These sections make a number of changes to Public Act No. 16-29, which created the Connecticut Retirement Security Authority. Please see the summary of Public Act 16-29 at page 38, below.

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§§ 129 through 175
Effective July 1, 2016

This Act establishes a Commission on Women, Children and Seniors within the state's Legislative Department, which replaces the Permanent Commission on the Status of Women, the Commission on Children, and the Commission on Aging. The commission will be organized into three policy divisions and may adopt regulations to carry out its functions.

The commission will address issues that affect women, children and the family, and elderly persons as underrepresented and underserved populations. Its specific efforts will focus on achieving quality of life results for these constituencies that are healthy, safe, advance educational success, and are free from poverty and discrimination. The commission's responsibilities will include making recommendations to the General Assembly and the Governor for new or enhanced policies, programs, and services; gathering information about its constituencies; reviewing and commenting on proposed legislation as needed; conducting educational and outreach activities; advising the General Assembly regarding the coordination and administration of state programs that affect its constituencies; and serving as a liaison between women, children and the family and the elderly and the state's government agencies. The commission will also submit a status report annually that is organized by policy division and identifies the efforts and progress that has been made in achieving its desired results.

The commission will consist of sixty-three (63) members. Members appointed to one of the three prior commissions before July 1, 2016 will be deemed appointed to serve on the new commission. For members appointed after the effective date, the six (6) legislative leaders will appoint nine (9) members each and the House speaker and president pro tempore of the Senate will also appoint nine (9) members jointly to be allocated evenly among the commission's three constituencies. Certain appointees must also be from one (1) of five (5) identified geographical regions in the state. An executive director and any staff will be employed by the joint committee on legislative management.

These sections implement a number of conforming changes in order to transfer certain reporting and training requirements that applied to the three prior commissions to the new commission. It also grants the new commission representation on various state boards and committees that the prior commissions enjoyed under existing law.

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§ 176
Effective July 1, 2016

This section provides that the Commission on Women, Children and Seniors will conduct a study of the need for emergency power generators at public housing for the elderly in the state. "Public housing for the elderly" is defined as any building where fifty percent (50%) or more of the units are rented to individuals aged sixty-two (62) and older under any program created or financed by DOH municipal housing projects.

The study must include an inventory of public housing for the elderly in each municipality that includes the total number of housing units, the location and a description of each type of housing unit, an indication of whether emergency power generators are provided, and recommendations for the provision of emergency power generators, including an estimation of costs and available grant funds. The commission's executive director must report the results of the study to the joint committees on aging, housing, and public safety no later than January 1, 2017.

§ 179
Effective July 1, 2016

This section increases the filing fee an employer and its employees are each required to pay DOL's Board of Mediation and Arbitration upon filing notice of a grievance or dispute, from $25 to $200. The law requires that the parties be refunded the filing fee whenever a single public member of the board is chosen to arbitrate a grievance or dispute.

§§ 193 & 194
Effective June 2, 2016

Under current law, estates valued at $2 million and over are assessed a base estate fee of $5,615 plus .05% of value in excess of $2 million. This Act does not change this method of calculation for estates valued at between $2 million and $8.877 million. However it creates a new category by imposing a $40,000 cap on probate fees for individuals who die after July 1, 2016 whose estates are valued at $8.877 million or greater. This Act also makes conforming changes to existing law regarding estate fees.

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3. PUBLIC ACT 16-4 (MAY 2016 SPECIAL SESSION). AN ACT AUTHORIZING AND ADJUSTING BONDS OF THE STATE FOR CAPITAL IMPROVEMENTS, TRANSPORTATION AND OTHER PURPOSES AND AUTHORIZING STATE GRANT COMMITMENTS FOR SCHOOL BUILDING PROJECTS.
Effective July 1, 2016

§§ 1 through 17 (New Bond Authorizations)

This Act authorizes up to $302 million in new general obligation bonds for certain state projects and grant programs, which are subject to standard issuance procedures and have a maximum term of twenty (20) years. Included among the authorizations are:

- Grants-in-aid to private non-profit organizations for supportive housing for persons with an intellectual disability, autism, or both, not to exceed $20 million to be issued by DOH; and
- $5 million in proceeds to be issued by DPH for the Biomedical Research Trust Fund.

The authorization to DOH replaces an identical bond authorization to DDS, pursuant to Section 227 of this Act.

§§ 18 through 259, 324 & 325 (Changes to Existing Bond Authorizations)

Bond Increases

This Act increases general obligation and special tax obligation bond authorizations enacted in 2015. One notable change is the $15 million increase from the current authorization of $10 million, totaling $25,000,000, to OPM for grants to private, non-profit, tax-exempt health and human services organizations, to be used for alterations, renovations, improvements, additions, and new construction, including improvements to health, safety, ADA compliance, energy conservation, and information technology systems.

Bond Cancellations

This Act cancels or decreases bond authorizations for a number of projects. Notable changes include:

- Revocation of $500,000 and $750,000 to DSS for facility expansion and the construction of efficiency apartments, respectively, for Martin House, an affordable housing organization in Norwich that helps adults develop self-care and manage their physical and mental health issues;
- $525,000 reduction to DSS, from $1 million to $475,000, for the purchase of buildings for the Greater Danbury AIDS Project;

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- Revocation of $5,878,050 in grants to DPH for hospital-based EMS facilities;
- Revocation of $225,000 to DSS for a replacement roof for the Saugatuck Senior Cooperative in Westport;
- Revocation of $219,510 to DSS for senior center renovations in Easton;
- Revocation of $600,000 to DSS for a new building in Norwich for Hospice Southeastern Connecticut;
- $200,835 reduction to DMHAS, from $6 million to $5,799,165, for fire, safety and environmental improvements to regional facilities for client and staff needs;
- $411,500 reduction to DDS, from $5,000,000 to $4,588,500, for fire, safety, and environmental improvements for client and staff needs, including handicapped access improvements and compliance with codes for intermediate care facilities;
- Revocation of $4,000,000 under two separate provisions allocating proceeds not to exceed $2,000,000 each to DDS for grants to private, non-profit organizations for alterations and improvements to non-residential facilities;
- $4,526,254 reduction to DSS, from $10,000,000 to $5,473,746, for grants-in-aid for neighborhood facilities, elderly centers, multipurpose human resource centers and related facilities;
- Revocation of $10,000,000 to DOH for grants to nursing homes for alterations, renovations, and improvements to convert to other uses in support of right-sizing;
- Reduction of $4,000,000, from $10,000,000 to $6,000,000 to DPH for the Stem Cell Research Fund;
- Revocation of $10,000,000 to Connecticut Innovations, Inc. for the Regenerative Medicine Research Fund;
- Revocation of $7,500,000 and $5,000,000 to DDS and DMHAS, respectively, for (1) fire, safety, and environmental improvements to regional facilities and intermediate care facilities for client and staff needs, including for compliance with current codes; and (2) site improvements, including handicapped access improvements; and
- $15,000,000 reduction to DOH, from $135,000,000 to $120,000,000, for housing development and rehabilitation, including congregate and elderly housing, emergency repair assistance for senior citizens, and loan guarantees for private developers of rental housing for the elderly.

§ 250

In addition to current law authorizing the Biomedical Research Trust Fund to accept transfers from the Tobacco Settlement Fund and apply for and accept gifts, grants, or donations from public or private sources, this Act allows the Fund to contain any moneys required or permitted by law to be deposited in the fund. This Act does not alter any other provisions regarding the trust fund, from which DPH may make grants-in-aid to eligible institutions for the purpose of funding biomedical research in the fields of heart disease, cancer and other tobacco-related illnesses, Alzheimer's, stroke, and diabetes.

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II. ACTS CONCERNING HEALTH PROVIDER SERVICES

4. PUBLIC ACT 16-6. AN ACT CONCERNING NOTIFICATION OF PENALTIES FOR ABUSE AND NEGLECT OF NURSING HOME RESIDENTS.
   Effective October 1, 2016

   This Act requires that DPH amend the licensure application for the acquisition of a nursing home to include a notice to prospective nursing home licensees or owners about liability for resident abuse and neglect. It contains a specific notice that DPH must include on the first page of the licensure application. This notice warns prospective nursing home licensees or owners that they may be subject to civil or criminal liability, or subject to federal and state administrative sanctions for abuse or neglect of a resident perpetrated by any employee. This Act explicitly provides that inclusion of this notice on the licensure application does not expand or affect the existing liability of any person or entity; it merely puts an applicant on notice of such potential liability.

5. PUBLIC ACT 16-8. AN ACT CONCERNING THE LONG-TERM CARE OMBUDSMAN'S NOTICE TO NURSING HOME RESIDENTS.
   Effective July 1, 2016

   Under current law governing nursing home CONs, a nursing home facility that plans to close or substantially reduce its total bed capacity must submit a letter of intent to DSS, provide written notice to all patients, guardians, and conservators, and post a notice in a conspicuous location at the facility. This Act requires that this written notice be accompanied by an informational letter issued jointly from the Office of the Long-Term Care Ombudsman and DOA on patients' rights and services available as they relate to the letter of intent. A copy of this required written notice from the Office of the Long-Term Care Ombudsman and DOA is included with the text of the Act at Tab 5.

6. PUBLIC ACT 16-25. AN ACT CONCERNING TELEHEALTH PROVIDERS.
   Effective October 1, 2016

   By law, "telehealth" means "delivering healthcare services through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's physical and mental health." This Act adds licensed speech and language pathologists, respiratory care practitioners and audiologists to the list of health care providers authorized to provide health care services using telehealth. As with all practitioners, these providers may only provide telehealth services within their professions' scope of practice and standard of care.

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7. PUBLIC ACT 16-39. AN ACT CONCERNING THE AUTHORITY AND RESPONSIBILITIES OF ADVANCED PRACTICE REGISTERED NURSES.
Effective October 1, 2016 unless otherwise noted

Physicians are authorized by statute to perform a number of tasks. This Act updates these various statutes to authorize APRNs, in addition to physicians, to perform certain tasks. Despite these changes, nursing home providers should consult CMS guidance regarding the services APRNs may provide as that guidance may be more restrictive than state law.

- Under the Uniform Power of Attorney Act, the court can terminate an agent's authority when that agent becomes incapacitated. This Act establishes that in addition to two physicians, two independent APRNs or one independent physician and one independent APRN can determine whether an agent is incapacitated. (§ 1)
- The Achieving a Better Life Experience (ABLE) program helps pay the qualified disability expenses related to the blindness or disability of a designated beneficiary. This Act now permits APRNs to sign disability certificates which prove that those wishing to join ABLE are disabled and eligible to participate in the program. (§ 2)
- The Connecticut Homecare Option Program for the elderly allows individuals to plan for the cost of services that will allow them to remain in their homes or in a noninstitutional setting as they age. The Connecticut Home Care Trust Fund contains individual savings accounts for those qualified home care expenses not covered by a long-term care insurance policy, and for those qualified home care expenses that supplement the coverage provided by a long-term care policy or Medicare. This Act now allows APRNs to sign certifications that are required for individuals to withdraw funds from these savings account. (§ 3)
- Permanent employees who request a medical leave of absence due to their serious illness or a family leave of absence, or in order to serve as an organ or bone marrow donor, can now be provided with sufficient written certifications signed by APRNs. (§ 4)
- This Act now permits APRNs to sign written statements that will allow those who have physical disabilities or impairments to be free from wearing seatbelts. (§11)
- Under current law, on behalf of a Medicaid applicant, a nursing home may request an extension of time to claim undue hardship if: (A) the applicant is receiving long-term care services in such nursing home; (B) the applicant has no legal representative; and (C) the nursing home provides certification from a physician. This Act now permits the certification needed to file this extension to be signed by an APRN. (§ 14)
- Any health care professional or hospital must file a petition when such health care professional or hospital has any information that appears to show that a health care professional is, or may be, unable to practice his or her profession with reasonable skill or safety for various reasons. This Act now permits APRNs to conduct a physical or mental examination of that health care professional who is allegedly

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unable to practice his or her profession, and to make written statements about their findings. (§ 16)

- This Act now permits APRNs to document the basis for the transfer or discharge of a nursing home resident in the medical record. It also amends the requirement that a resident's physician document the basis for transfer or discharge where the welfare, health or safety of the resident is concerned to permit the resident's APRN to provide such documentation. With respect to discharge plans, this Act permits the resident's personal APRN to develop the discharge plan and also requires that a copy of the discharge plan be provided to the resident's personal APRN. (§ 18)
- Various provisions in the Patients' Bill of Rights for nursing home, RCH and CDH residents allow physicians to perform certain tasks. This Act now permits APRNs to perform the same tasks, such as:
    - Documentation of whether a potential room transfer is "medically contraindicated."
    - Documenting in the medical record when honoring certain rights is medically contraindicated for that resident, including the rights to be fully informed of his or her medical condition, communicate with persons of the resident's choice, participate in social and similar activities, use his or her own clothing and possessions, and share a room with his or her spouse;
    - Maintaining the authority to order the administration of psychopharmacologic drugs or the use of restraints under certain circumstances; and
    - Inclusion in the consultative process for certain room to room transfers in nursing homes or rest homes with nursing supervision.

  This Act also specifies that a patient in these facilities has the right to choose his or her own physician or APRN, not just physician, as part of the patients' bill of rights. (§ 19)
- This Act now permits APRNs to enjoy the same immunities from civil and criminal liability that physicians maintain for withholding or causing the removal of a life support system under specified conditions, including that the APRN:
    - based the decision on his/her best medical judgment according to medical standards;
    - deemed the patient to be in a terminal condition or, in consultation with a neurologist or other qualified physician, deemed the patient to be permanently unconscious; and
    - considered the patient's wishes, including in a living will or similar document. (§ 20)
- This Act references the authority of APRNs to issue a do not resuscitate order by providing that DPH regulations governing the system for recognition of do not resuscitate orders when patients are transferred must require an APRN or physician who issued a do not resuscitate order to assist a patient or the patient's authorized representative in utilizing the system. (§ 21)

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- By law, general consent is required for HIV-related testing; however, there are several exceptions to this rule. Under current law, general consent is not required if health care providers or other individuals have had significant exposure to HIV from a patient. This Act now permits APRNs, in additions to physicians, to provide certification demonstrating that factors are met for court-ordered HIV testing if a health care provider or other individual had significant exposure to HIV from a patient. (§22)
- This Act allows APRNs to diagnose and treat Lyme disease and requires APRNs to document in a medical record if prescribing, administering, or dispensing long-term antibiotic therapy for Lyme disease. (§ 26)
- This Act permits APRNs to order paramedics to administer controlled substances, other drugs and IV solution. (§ 29)
- By law, in individual cases involving medical disabilities or illnesses, waivers of the continuing education requirements or an extension of time in which to fulfill the requirements can be granted as long as (1) the licensee submits an application for waiver or extension of time on a form prescribed by DPH; and (2) a certification from a physician. This Act allows the certification required to request a waiver of the continuing education to also be issued by an APRN. This Act permits APRNs to issue certifications of a disability or illness for a continuing education waiver or extension for various professions. (§§ 31-42)
- This Act permits APRNs to receive licenses to possess and supply marijuana for the treatment of the side effects of chemotherapy and authorizes APRNs to certify a patient's use of medical marijuana. This includes:
    - diagnosing a patient's qualifying debilitating condition;
    - issuing a written certification for medical marijuana use after (1) making this diagnosis, (2) explaining the potential risks and benefits to the patient and parent or guardian of a patient lacking legal capacity, and (3) meeting other criteria; and
    - extending to APRNs the same protections from civil, criminal, and disciplinary liability that currently apply to physicians under the medical marijuana law.

  An APRN may not issue a certification when the patient's debilitating medical condition is glaucoma. (§§ 45-51; effective January 1, 2017)
- By law, health insurance policies that provide coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when: (1) the renewal is requested by the insured less than thirty (30) days from the later of (A) the date the original prescription was distributed to the insured, or (B) the date the last renewal of such prescription was distributed to the insured and (2): the prescribing physician indicates that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed. This Act authorizes APRNs and optometrists to prescribe prescriptions for eye drops that cannot be denied by health insurance providers. (§ 58)

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- This Act redefines certain terminology for purposes of individual health insurance policies providing basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, accident only coverage, limited benefit health coverage, hospital or medical service plan contracts, and hospital and medical coverage provided to subscribers of a health care center, as well as for purposes of state law on home health care by recognized nonmedical systems:
    - For the purposes of health insurance policies only, this Act redefines "home health care" to mean "the continued care and treatment of a covered person who is under the care of a physician or an APRN." Previously, only physicians were mentioned as individuals who could care for covered patients under the definition of "home health care." (§ 59)
    - For the purposes of health insurance policies only, this Act also includes APRNs in the definition of "home health agency" for the purpose of defining the agency or organization that provides home health care. "Home health agency" is now defined as an agency or organization that meets certain requirements, including that its policies are established by a professional group associated with such agency or organization, including at least one physician or APRN, and that it provides for full-time supervision of such services by a physician, APRN, or registered nurse. (§ 59)
    - This Act allows APRNs, in addition to physicians, to approve plans of care provided by a licensed occupational therapist, consistent with the definition of "occupational therapy" for these same insurance-related purposes. (§ 61)
    - Under current law, "comprehensive rehabilitation services" consist of services provided in a comprehensive rehabilitation facility, and include a plan of care approved by a physician, that will be reviewed by that physician every thirty (30) days to determine that the continuation of such services are medically necessary for the rehabilitation of the patient. This Act establishes that under the definition of "comprehensive rehabilitation services," APRNs can now approve plans of care, and review their plans every thirty (30) days to ensure that those services are medically necessary for the rehabilitation of the patient. (§ 66)
- By law, each Medicare supplement policy must provide coverage for home health aide services for each individual covered under the policy when such services are not paid for by Medicare if; (1) such services are provided by a certified home health aide employed by a home health care agency that is licensed; and (2) the individual's physician has certified, in writing, that such services are medically necessary. This Act now permits APRNs to certify in writing that services are medically necessary for home health aide services to be provided under Medicare supplement policies. (§ 60)

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- Under current law, certain individuals are prohibited from being evicted except for good cause. This prohibition on eviction is applicable to: (A) those who are sixty-two (62) years old or older, or whose spouse, sibling, parent or grandparent is sixty-two (62) years of age or older and permanently resides with that resident; or (B) has a physical or mental disability, or whose spouse, sibling, child, parent or grandparent is a person with a physical or mental disability who permanently resides with that tenant, but only if such disability can be expected to result in death or to last for a continuous period of at least twelve (12) months. This Act authorizes APRNs to issue statements confirming a tenant's alleged blindness or other physical disability if a landlord wants to determine if their tenant is a protected tenant. (§ 70)

This Act also creates certain requirements of APRNs:

- APRNs must to report in writing to DRS within thirty (30) days of each blind person coming under his or her private or institutional care in Connecticut. These reports are not allowed to be open to public inspection. (§ 8)
- If a patient is removed from life support, this Act requires APRNs to notify next of kin, if available, about having to remove his or her family member from life support within a reasonable amount of time. (§ 25)
- By law, physicians must act in accordance with written protocols when treating patients with respiratory issues. This Act now requires APRNs to act in accordance with those same written protocols. (§ 27)
- This Act requires APRNs, at the request of a veteran whom they are treating, to submit a report to DVA documenting their belief that the veteran has been exposed to Vietnam herbicides. This report should include: (1) any symptoms of exposure to a Vietnam herbicide; (2) diagnosis of the veteran; and (3) methods of treatment prescribed. (§ 55)

8. PUBLIC ACT 16-43. AN ACT CONCERNING OPIOIDS AND ACCESS TO OVERDOSE REVERSAL DRUGS.
Effective as noted

§ 1
Effective May 27, 2016

This Act requires municipalities to make changes to their local emergency services plans no later than October 1, 2016 to ensure that emergency responders receive appropriate training for administering opioid antagonists and that they are equipped with these drugs when arriving at the scene of a medical emergency.

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§§ 2 & 3
Effective January 1, 2017

This Act prohibits certain individual and group health insurance policies from requiring prior authorization for opioid antagonists.

§ 5
Effective October 1, 2016

This section makes changes to protocols involving the use of auricular acupuncture for substance abuse treatment. Practicing individuals must now maintain certification with the National Acupuncture Detoxification Association. There is no change to the requirement that these providers offer their services under a physician's supervision. This Act also expands the facilities where this modality may be provided to include any setting where auricular acupuncture is an appropriate adjunct therapy for substance abuse treatment.

§ 7
Effective July 1, 2016

This section defines a number of terms related to the prescribing of opioid medications. Authorized practitioners may not issue more than a seven (7) day supply of an opioid drug to an adult patient for first-time outpatient use or to a minor at any time. When issuing the a seven (7) day or less supply to a minor, the practitioner must discuss the risks associated with taking opioid drugs with the minor and his or her guardian or parent if present. Section 7 makes an exception to the seven (7) day limit when, in the professional judgment of the prescribing practitioner, more than a seven (7) day supply is needed to treat an adult's or a minor's acute medical condition, chronic pain or pain associated with cancer diagnosis, or for palliative care; "palliative care" is defined as "specialized medical care to improve the quality of life of patients and families facing the problems associated with a life-threatening illness." The prescribing practitioner must document the condition triggering the need for more than a seven (7) day supply and also indicate that an alternative to the opioid drug was not appropriate to address the medical condition. Finally, this section provides that its restrictions (seven (7)-day limit and documentation for exceptions) do not apply to medications designed for treating opioid abuse or dependence.

§§ 8 & 9
Effective as noted below

DCP maintains an electronic prescription drug monitoring program to prevent improper or illegal drug use and prescribing. All practitioners authorized to prescribe controlled substances must consult the electronic program prior to prescribing a controlled

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substance to a patient. Section 9 of this Act creates a mechanism for practitioners to delegate these functions to staff who are not licensed healthcare providers. Effective October 1, 2016, Section 8 expands the definition of "agent" for purpose of Connecticut law on dependency-producing drugs to include an authorized person who acts at the direction of a prescribing practitioner. Effective July 1, 2016, Section 9 eliminates the requirement that a prescribing practitioner's authorized agent be a licensed healthcare professional for purposes of obtaining access to information reported to DCP's electronic prescription drug monitoring program. This Act requires DCP to release controlled substance prescription information to agents on behalf of the prescribing practitioner.

The rules are slightly different for a prescribing practitioner who provides services to a hospital. Such practitioners must receive approval from DCP before designating an agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information. The practitioner must submit a written request and a written protocol for oversight of the authorized agent(s), which must designate either the hospital's medical director, a hospital department head who is a prescribing practitioner, or another prescribing practitioner as the person responsible for ensuring that the agents' access is limited to authorized purposes and that the confidentiality of patient information remains protected.

On July 1, 2016, other changes go into effect regarding DCP's electronic prescription drug monitoring program. These include extending the reporting deadline for pharmacists and other controlled substance dispensers from no more than twenty-four (24) hours after dispensing a prescription to no later than the end of the following business day. If the electronic prescription drug monitoring program is not operational, the pharmacy or dispenser must report the information not later than the following business day after regaining access to the program.

This Act also creates an exception for review of records for continuous or prolonged treatment using schedule V nonnarcotic controlled substances, requiring the prescribing practitioner or his or her agent to review the patient's records not less than once a year instead of once every ninety days. Finally, this Act specifies that prescribing practitioners and their agents are subject to HIPAA regulations for protecting electronic PHI, and a prescribing practitioner may receive disciplinary sanctions for the acts of his or her authorized agent.

§ 10
Effective October 1, 2016

This Act enables DCP to take disciplinary action against a controlled substance registrant for failing to establish or implement administrative safeguards to ensure HIPAA compliance protecting PHI, as well as for breach of these safeguards by the practitioner's authorized agent.

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§ 11
Effective May 27, 2016

This Act requires the chairpersons of the joint standing committee on public health to convene a working group to study whether limiting opioid drug prescriptions to a maximum three (3) day supply for treating a minor's acute medical condition constitutes best practices.

9. PUBLIC ACT 16-47. AN ACT CONCERNING NURSING HOME BEDS FOR AIDS PATIENTS.
Effective July 1, 2016

Under existing law, DSS cannot accept or approve any requests for additional nursing home beds. This Act reinstates nursing home beds for AIDS patients as an exception to the nursing home bed moratorium. It also leaves unchanged the current exceptions for: (1) beds used for patients requiring neurological rehabilitation; (2) beds associated with a continuing care facility that guarantees life care for its residents; (3) Medicaid certified beds to be relocated from one licensed nursing facility to another consistent with a priority need as identified and authorized pursuant to a DSS strategic plan to rebalance Medicaid long-term care supports; and (4) Medicaid beds to be relocated from a licensed facility or facilities to a new licensed facility, provided at least one licensed facility is closed in the process and the new facility bed total is not less than ten percent lower than the total number of relocated beds.

10. PUBLIC ACT 16-59. AN ACT EXPANDING UTILIZATION OF PATIENT-DESIGNATED CAREGIVERS.
Effective October 1, 2016

This Act extends to nursing home facilities certain requirements governing designation of patient caregivers that are similar to current requirements in the hospital setting. Under the Act, DPH may adopt regulations to set minimum standards for a nursing home facility discharge planning. These standards must include, but are not limited to, (1) a written discharge plan prepared in consultation with either the resident or resident's family, representative and physician and (2) a procedure for advance written notice of the resident's discharge and provision of a copy of the discharge plan to the resident or the resident's representative before discharge.

Whenever a resident is discharged from a nursing home facility to the resident's home, the resident must be allowed, but is not required, to designate a caregiver at, or prior to, the time when the written discharge plan is provided.

If a resident designates a caregiver, the nursing home must record the designation, as well as the designated caregiver's name, relationship to the resident, and contact information

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in the discharge plan. The caregiver is not required to provide any assistance or agree to receive instructions. Although not required, facilities may wish to record in the discharge plan or the medical record (1) a decision by the resident not to designate a caregiver or (2) any refusal by a designated caregiver to perform post-discharge assistance or receive instructions.

If a resident designates a caregiver, then prior to any discharge to the resident's home, the nursing home must make more than one reasonable attempt to notify the caregiver of the discharge as soon as practicable. This Act makes it clear that if the nursing home cannot contact the caregiver, the lack of contact shall not interfere with, or delay, or otherwise affect medical care provided to the resident or an appropriate discharge.

Prior to discharge, the facility must provide the designated caregiver with instructions in all post-discharge assistance tasks described in the discharge plan. Training and instructions may be provided in writing or conducted in person or through video technology, as determined by the facility, and must be provided in nontechnical language to the extent possible. At a minimum, instructions shall include (1) a written, live or recorded demonstration of the tasks performed by an individual designated by the facility who is able to perform the tasks in a culturally competent matter, with language access services if required under state and federal law; (2) the opportunity for the designated caregiver to ask questions about the post-discharge assistance tasks and (3) answers to the questions provided in a culturally competent manner and in accordance with state and federal requirements to provide language access services. Any instruction provided should be documented in the resident's medical record, including at minimum, the date, time and subject of the instruction.

This Act also makes clear that it does not create a private right of action against the nursing home, or its employees, agents, consultants or contractors, and that a nursing home, its employees, agents, consultants and contractors shall not be liable for services rendered or not rendered by a designated caregiver to the resident at the resident's home. Additionally, this Act does not affect any health insurer's obligations to provide coverage and provides that a designated caregiver shall not be reimbursed by any government or commercial payor for post-discharge assistance. Finally, this Act provides that it shall not affect, or take precedence over, a resident's advance directive, conservatorship or other proxy health care rights.

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11. PUBLIC ACT 16-66. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Effective October 1, 2016 unless otherwise noted

§ 3

This Act expands the requirement enacted in 2015 that certain health care professionals must notify DPH if they are aware that a health care professional is unable to practice with skill and safety because he or she is impaired. Specifically, the section adds additional categories of licensed professionals, including nursing home administrators, to the definition of "health care professional" under the law.

§ 4

Substance abuse treatment facilities that are licensed as institutions and offer medication assisted treatments for opioid addiction are now permitted to provide methadone delivery and related substance abuse treatment services to persons in nursing homes. These deliveries can occur as long as DPH determines that such delivery would not endanger the health, safety or welfare of any patient. Substance abuse treatment facilities must get approval from DPH to make such deliveries. If DPH approves a request, it can impose conditions to ensure patients' health, safety or welfare. DPH also has the discretion to revoke requests made by substance abuse treatment facilities at any time upon a finding that the health, safety or welfare of any patient will not be jeopardized.

§ 5

This Act amends certain definitions of terms pertaining to the licensing of health care institutions. "Mental health facilities" will now be renamed "behavioral health facilities." "Behavioral health facilities" are currently defined as "any facility that provides mental health services to persons eighteen years of age or older, or substance use disorder services to persons of any age in an outpatient treatment, or residential setting to ameliorate mental, emotional, behavioral or substance use disorder issues."

Section 5 removes the term "rest home" from the list of DPH-licensed institutions. It also contains a revised definition of "residential care homes" and "rest homes." They are defined as "a community residence that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry and may qualify as a setting that allows residents to receive home and community-based services funded by state and federal programs."

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The terms "nursing home" and "nursing home facility" have also been defined as: (1) any chronic and convalescent nursing home or rest home with nursing supervision that provides 24-hour nursing supervision under a medical director; or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic or acute diseases, convalescent stages, or injuries. Conforming references to this revised definition are also set forth in Sections 6 and 7 of this Act.

§ 8—MOLST Pilot Program
Effective May 27, 2016

This Act changes the end date for the Medical Orders for Life-Sustaining Treatment (MOLST) pilot program from October 1, 2016 to October 2, 2017.

§ 23—Chronic Disease Hospital Record Storage

Under current law, chronic disease hospitals must keep their medical records on-site and in an accessible manner. This Act allows chronic disease hospitals to keep their medical records at an off-site location so long as they can retrieve them not later than the end of the next business day after receiving a request for such records.

§ 33—Home Health Aide Recertification for Medication Administration

Under current law, nurses are permitted to delegate the administration of medications that are not administered by injection to home health aides who have obtained certification for medication administration. This Act now requires that those home health aides who wish to administer medications to patients be recertified every three years after their initial certification.

§ 34—RCH Medication Administration

This Act amends the statute governing DPH regulations concerning the administration of medications in RCHs by requiring that unlicensed personnel who are certified to administer medications in the RCH setting be recertified every three years.

§§ 35 & 36—Music Therapists and Art Therapists

This Act establishes standards for the practice of music and art therapy and certification requirements for those who practice in these areas.

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§ 37—Zoning for Small Hospice Residences

This Act amends statutes prohibiting zoning regulations from treating certain community settings differently from single family residences. Specifically, it amends the description of the hospice community setting to cover any residence that provides licensed hospice care and services to six or fewer persons. Such a residence still must be managed by a federally tax exempt organization, located in a city with a population of more than 100,000 and served by public water and sewer, and adds the requirement that the residence be constructed in accordance with applicable building codes for occupancy "by six or fewer persons who are not capable of self-preservation."

§ 46
Effective May 27, 2016

This Act establishes a task force to study the appropriate time frame for health care providers or institutions to respond to medical records requests, the cost of responding to such requests, and the HIPAA regulations concerning individuals' access to their own PHI. The task force must submit its findings to the Public Health Committee by January 1, 2017.

§§ 47-50
Effective May 27, 2016

This Act eliminates OPA as of July 1, 2017 and establishes the Connecticut protection and advocacy system. This system must provide protection and advocacy services as well as a client assistance program for people will disabilities as defined by federal law. OPA's investigation responsibilities are now transferred to the Department of Rehabilitation Services.

§51

This Act established a Diabetes Advisory Council within DPH.

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12. PUBLIC ACT 16-77. AN ACT CONCERNING PATIENT NOTICES, DESIGNATION OF A HEALTH INFORMATION TECHNOLOGY OFFICER, ASSETS PURCHASED FOR THE STATE-WIDE HEALTH INFORMATION EXCHANGE AND MEMBERSHIP OF THE STATE HEALTH INFORMATION TECHNOLOGY ADVISORY COUNCIL.
Effective June 2, 2016

§ 1

This Act revises the 2015 law governing hospital notices to patients about the right to request quality and cost information. In addition to steps that hospitals must take under current law, they must also, within three (3) business days of scheduling any diagnosis or procedure for nonemergency care, notify patients of the corresponding Medicare reimbursement amount for the procedure or diagnosis. If there is not a corresponding reimbursement amount then the hospital must notify the patient of either the amount that Medicare would have paid the hospital for the services or the percentage of the hospital's charges that Medicare would have paid.

§ 2

This Act also amends the requirements for billing statements that include a facility fee. Such bills must now include the approximate amount that Medicare would have paid the hospital for the facility fee on the billing statement or the percentage of the hospital's charges that Medicare would have paid the hospital for the facility fee.

§§ 4 through 7

This Act requires the designation of a Health Information Technology Officer. This officer, rather than DSS, is delegated responsibilities relevant to implementing and overseeing the development of a State-wide Health Information Exchange.

The purpose of the Health Information Exchange is to help consumers make effective health care decisions, allow real-time and secure access to patient health information secure, and make progress toward the state's public health goals. Any health information exchange technology asset purchased must be capable of interoperability with a State-wide Health Information Exchange. Interoperability means the ability of two or more systems to exchange and use information.

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13. PUBLIC ACT 16-68. AN ACT CONCERNING THE LABOR DEPARTMENT AND CERTAIN PROFESSIONAL OPPORTUNITIES FOR VETERANS, IMPROVING CUSTOMER SERVICE TO VETERANS BY THE ADVOCACY AND ASSISTANCE UNIT OF THE DEPARTMENT OF VETERANS' AFFAIRS AND STRENGTHENING COORDINATION BETWEEN THE DEPARTMENT OF VETERANS' AFFAIRS AND MUNICIPALITIES.
Effective October 1, 2016

§ 1

This Act requires DOL to establish a Special Operations Resource Network to serve as a clearinghouse for veterans and members of the armed forces and National Guard who have acquired knowledge, experience or a set of skills most compatible with certain professional opportunities. Any veteran or member of the armed forces or National Guard may apply for inclusion in such database by submitting: (1) evidence of the military training received by the veteran or member describing the particular knowledge, experience or set of skills acquired; and (2) if applicable, a veteran's military discharge document or a certified copy thereof.

§ 2

The veterans' advocacy and assistance unit at DOL must develop a written outreach plan that identifies: (1) strategies for conducting outreach to veterans and their spouses, eligible dependents and family members for purposes of providing assistance in claims for veterans' services or benefits; and (2) to the extent possible, specific events and other opportunities to provide such assistance that are sponsored by the unit or in which the unit is participating.

DOL must require administrators of nursing homes and assisted living facilities in the state to notify the unit no later than April 1, 2017 and annually thereafter of any new resident who is a veteran or veteran's spouse, eligible dependent or family member. However, this information may only be provided with the resident's consent. A "new resident" is a resident about whom the facility has not previously notified the unit.

This Act also requires DOL to create an annual schedule for each service officer to visit nursing homes and assisted living facilities. The unit must compile any information collected from those visits and provide quarterly reports consisting of that information to the Board of Trustees for the DVA. The quarterly reports will include: (1) concerns raised by veterans or their spouses, eligible dependents, or their relatives; (2) petitions filed by such individuals; and (3) copies of any filed petitions.

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14. PUBLIC ACT 16-90. AN ACT CONCERNING THE REPORTING OF INJURIES RESULTING FROM THE DISCHARGE OF A FIREARM AND STAB WOUNDS.
Effective October 1, 2016

Under current law, hospitals, outpatient surgical facilities, and outpatient clinics must report to the police any injuries caused by firearm discharge as soon as possible after treatment. This Act extends that reporting obligation to include any injuries caused by a knife or sharp object. This Act also expands the information these health care facilities are required to report to now include the patient's age and sex, the type of wound, and the name of the health care provider treating the wound.

Employees of these health care facilities now must ensure that any bullet, foreign object, or clothing showing damage related to a gunshot or stab wound is removed and identified as having come from the patient. Employees must ensure that any items that are removed are stored so that their integrity is preserved until the earlier of surrender to police or period for retention under facility's policy expires.

Hospital outpatient centers, surgical outpatient clinics and their employees are immune from civil or criminal liability or action against their licenses so long as they, in good faith and without gross negligence or wanton misconduct, make a report pursuant to this Act, cooperate during the course of the investigation, and surrender any items they preserved from the patient to the police.

15. PUBLIC ACT 16-95. AN ACT CONCERNING MATTERS AFFECTING PHYSICIANS, HEALTH CARE FACILITIES AND MEDICAL FOUNDATIONS.
Effective as noted

§ 1
Effective July 1, 2016

The enforceability of covenants not to compete in agreements with physicians is now significantly limited. Codifying well-known guidance from case law, this Act affirms that such covenants are valid and enforceable only if they are necessary to protect a legitimate business interest; reasonably limited in time, geographic scope and practice restrictions to protect such business interest; and otherwise consistent with the law and public policy.

This Act, however, goes on to provide that covenants not to compete entered into, amended, extended or renewed on or after July 1, 2016 may not restrict a physician's competitive activities: for a period of more than one (1) year; and in a geographic region of more than fifteen (15) miles from the "primary site" where the physician practices. "Primary site" means either the location from which the majority of the physician's revenue is generated or any other location where the physician practices that is mutually agreed upon and specifically identified in the covenant not to compete.

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This Act also limits the circumstances under which valid covenants not to compete will be enforceable. No covenant not to compete entered into, amended, extended or renewed on or after July 1, 2016, will be enforceable against the physician if: (i) the agreement was not made in anticipation of, or as a part of, a partnership or ownership agreement and such agreement expires and is not renewed, unless, prior to expiration, the employer makes a bona fide offer to renew on the same or similar terms; (ii) the agreement is terminated by the employer for any reason other than "cause;" (iii) and the covenant is not separately and individually signed by the physician.

§ 3
Effective July 1, 2016

Health care providers are currently required to provide written notice to patients when making a referral to an affiliated provider. The notice no longer must provide the website and toll-free number of the patient's health insurance carrier, but rather, must advise the patient to contact his or her health insurance carrier to obtain information about in-network providers and estimated out-of-pocket costs for the referred service.

Hospitals are required to provide certain information on all bills to patients and to third-party payors, including an explanation of any items identified by code or by initials. Hospitals must now also include the hospital's cost-to-charge ratio.

§§ 6 through 8
Effective October 1, 2016

Effective October 1, 2016, certain groups of independent physicians will also be permitted to form medical foundations, which can be operated on a nonprofit or for-profit basis. Physicians may "own" a medical foundation through (i) an IPA that is owned by independent providers or by a tax-exempt state-wide professional medical membership association controlled by independent providers or (ii) any business entity that is registered to do business in the State, has a principal place of business in the State, and has 60% of its ownership or control held by providers.

The prohibition against serving on the board of directors of a medical foundation is expanded to forbid any director from serving on the board of more than one medical foundation and anyone who is employed by, represents, owns or controls a hospital, health system or medical school, whether for-profit or not-for-profit, from serving on the board of a medical foundation organized by an IPA or the other entities newly permitted to form medical foundations as discussed above.

This Act also expands the amount of information that medical foundations must file with OHCA each year to include: (i) the name and address of the medical foundation's organizing members; (ii) the name and specialty of each physician employed by or acting

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as an agent of the medical foundation; (iii) the location(s) where each such physician practices and a description of services provided at each location; (iv) a copy of the medical foundation's governing documents and bylaws; and (v) the name and employer of each member of the medical foundation's board of directors.

16. PUBLIC ACT 16-109. AN ACT CONCERNING VETERANS' HEALTH RECORDS.
Effective June 3, 2016

This Act prohibits licensed health care institutions, including hospitals, nursing homes, RCHs, assisted living services agencies, hospice facilities and home health care agencies, from charging a patient, his attorney or conservator for furnishing a health record or part of a health record for the purpose of supporting a claim or appeal for veterans' benefits under any provision of federal law pertaining to veterans' benefits or Connecticut law pertaining to veterans. It does not change the requirement under current law that these institutions furnish the record within 30 days of the request.

17. PUBLIC ACT 16-149. AN ACT CONCERNING PROTECTIVE SERVICES FOR VULNERABLE PERSONS.
Effective July 1, 2016

§§ 1 & 2

This Act requires DSS to develop a strategic plan to: (1) incorporate the Administration for Community Living's Voluntary Consensus Guidelines for State Adult Protective Services into the state's elderly protective services program; and (2) align the state's data collection with the National Adult Maltreatment Reporting System. DSS must submit a plan recommending legislative changes to the General Assembly's joint standing committees on aging and human services no later than July 1, 2017.

DSS must also develop an educational training program to facilitate the accurate and prompt identification and reporting of elder abuse, neglect, exploitation and abandonment. This training program will be made available on the DSS website to mandated reporters and interested parties, and will also be delivered in person at certain times and locations throughout the state. Mandated reporters include, among others, physicians, registered nurses, dentists, patient advocates, EMS providers, police officers, and pharmacists, as well as nursing home administrators, nurse's aides, orderlies, paid care providers and staff in nursing home facilities or RCHs.

§§ 3 & 4

Section 3 of this Act expands the conditions under which DSS must disclose the results of an investigation into reported elder abuse, neglect, exploitation or abandonment. No later than forty-five (45) days after completion of the investigation, DSS must disclose its

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general results to the person(s) who reported the suspected abuse, neglect, exploitation or abandonment or to the person(s) who filed a complaint or report pursuant to Connecticut law mandating such reporting, provided: (1) such person(s) are legally mandated reporters; (2) the information is not privileged or confidential under state or federal law; (3) the names of witnesses and those interviewed are kept confidential; and (4) the names of the individuals suspected to be responsible for the abuse, neglect, exploitation or abandonment are not disclosed unless such persons have been arrested pursuant to the investigation.

These changes are significant because under current law, DSS must only comply with these disclosure requirements if the elderly person is a resident of a long-term care facility, but under the new provisions, DSS must adhere to the disclosure requirements regardless of where the alleged victim resides. Section 4 of this Act amends the statute requiring notification of the reporter when the elderly person is a long-term care facility resident to be consistent with the requirements summarized above for Section 3, including the forty-five (45) day limit for notice and the four conditions required for providing such notice.

§ 5

This Act directs the Commission on Aging to conduct a comprehensive evaluation of the state's protective services system for elderly persons and to recommend whether the state should adopt a protective services program that serves individuals aged eighteen (18) and older. The evaluation must include: (1) an overview of the state's current protective services structure; (2) identification of any gaps in the current system; (3) if recommended, an explanation of the need for a protective services system for individuals aged eighteen (18) and older; (4) a description of the models employed by other states; and (5) an assessment of the capacity of the current system to fulfill present and future needs. These reports must be submitted to the joint standing committees on aging and human services no later than October 1, 2017.

18. PUBLIC ACT 16-198. AN ACT CONCERNING TELEHEALTH SERVICES FOR MEDICAID RECIPIENTS.
Effective July 1, 2016

This Act provides that DSS shall now provide coverage under Medicaid, within its resource limits, for categories of health care services that the Commissioner determines are: (1) clinically appropriate to be provided by means of telehealth; (2) cost effective for the state; and (3) likely to expand access to medically necessary services. DSS is tasked with finding any available federal reimbursement under the Medicaid plan.

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Telehealth services are defined as services provided via communication technologies for the purpose of diagnosis, consultation, treatment, education or management of a patient's health.

19. PUBLIC ACT 16-209. AN ACT CONCERNING NURSING HOME RESIDENT ADMISSION AGREEMENTS.
Effective July 1, 2016

    Nursing home facilities must provide clear and conspicuous notice of the duties, responsibilities and liability of any person who signs a resident admission agreement as a responsible party. The notice must be in fourteen (14)-point bold type, initialed by the party, and include the circumstances under which the responsible party will be legally liable. If this notice is not included and signed, the agreement will be unenforceable against the responsible party.

20. SPECIAL ACT 16-3. AN ACT CONCERNING A COMMITTEE ON THE PRACTICE OF NATUROPATHY.
Effective May 26, 2016

    This Act allows DPH to establish a committee to consider the education and examination requirements and other qualifications necessary to allow licensed naturopaths to prescribe, dispense and administer prescription drugs and develop a naturopathic formulary of prescription drugs. Any health care professional or person representing a group of health care professionals who may be affected by a change to allow naturopaths to prescribe, dispense or administer prescription drugs may submit a written statement to DPH no later than June 1, 2016 for consideration by DPH and any committee that it may establish.

21. SPECIAL ACT 16-17. AN ACT CONCERNING RADIOLOGICAL AND IMAGING SERVICES.
Effective June 9, 2016

    This Act requires DSS to provide data quarterly on utilization trends in radiological imaging services paid for by Medicaid to DSS's Council on Medical Assistance Program Oversight, which must review the data to determine the effect, if any, on patient access to these services due to reduced reimbursement for the services.

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III. ACTS CONCERNING HOUSING AND REAL PROPERTY

22. PUBLIC ACT 16-16. AN ACT CONCERNING THE DISCLOSURE OF HOUSING DISCRIMINATION AND FAIR HOUSING LAWS.
Effective May 6, 2016

This Act requires the CHRO to create and make accessible on its website on or before July 1, 2016 a one (1)-page disclosure form in an easy-to-read and easy-to-understand format containing information on housing discrimination and federal and state fair housing laws. Beginning sixty (60) days after the disclosure is posted, every person who offers a residential property containing two (2) or more units for sale, exchange, or lease with an option to buy shall attach a copy of the disclosure form, signed by the purchaser, to any purchase agreement, option or lease containing a purchase option at the time of closing. Failure to do so, however, does not result in any penalties and will not void an otherwise valid sale.

23. PUBLIC ACT 16-45. AN ACT CONCERNING CONCRETE FOUNDATIONS.
Effective as noted

This Act establishes certain requirements for concrete foundations in residential and commercial buildings.

§ 1
Effective October 1, 2016

An applicant for a certificate of occupancy for a new residential or commercial building for which a concrete foundation was installed must provide the building official with written documentation of the individuals or entities that supplied and installed the concrete before the certificate of occupancy is issued. The building official must maintain these records for not less than fifty (50) years.

§ 2
Effective May 25, 2016 and applicable to assessment years commencing on or after October 1, 2016

This Act provides measures for property owners who seek to obtain inspections and reassessments of a residential property with a foundation that has been evaluated to have been constructed with defective concrete by a professional engineer. The new assessment must reflect the property's current value, is valid for five (5) assessment years, and is appealable under the same procedures available for standard assessment appeals. The property owner must notify the assessor within thirty (30) days if he or she repairs or replaces the foundation within the five (5)-year period.

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§ 3
Effective July 1, 2016

This section requires DCP, in consultation with the AG, to submit a report to the joint standing committees on planning and zoning on the potential cause(s) of failing concrete foundations. This report shall be made available on DCP's website no later than January 1, 2017.

§§ 4 & 5
Effective May 25, 2016

This Act requires executive branch agencies to maintain as confidential any documentation provided or obtained regarding owners' claims of faulty or failing concrete foundations in residential buildings for at least seven (7) years.

24. PUBLIC ACT 16-51. AN ACT CONCERNING THE RIGHTS AND RESPONSIBILITIES OF LANDLORDS AND TENANTS REGARDING THE TREATMENT OF BED BUG INFESTATIONS.
Effective October 1, 2016

This Act creates a system for identifying and treating bed bug infestations in residential rental properties, including public housing but excluding detached single-family homes.

§ 1

This Act requires that a tenant promptly notify a landlord orally or in writing when the tenant knows or reasonably suspects that the tenant's dwelling unit is infested with bed bugs. Landlords are required to inspect or obtain an inspection by a qualified inspector of the dwelling unit and any contiguous unit that the landlord owns, leases, or subleases no later than five (5) business days after a tenant's prompt notice of a suspected bed bug infestation. The landlord must then provide written notice to the tenant within two (2) days of the inspection indicating whether or not the unit is infested and notifying the tenant that he or she may contact the local health department if the tenant remains concerned about a possible infestation. If the inspection determines that the unit or a contiguous unit is infested with bed bugs, the landlord is obligated to take reasonable measures to treat the infestation not later than five (5) days after the inspection and this Act identifies specific procedures that the landlord must follow in undertaking treatment and inspection.

The landlord maintains responsibility for all costs associated with the inspection and treatment of bed bug infestations, with exceptions for tenants who fail to comply with their own obligations under the law. This Act also imposes certain obligations on the tenant, who is responsible for costs associated with preparing a dwelling unit for

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inspection and treatment and who may be held liable for bed bug treatments if the tenant knowingly and unreasonably fails to comply with appropriate treatment and inspection measures. This Act also identifies procedures to be undertaken by the landlord and tenant in the event that the tenant is physically unable to comply with preparation or treatment measures that he or she is responsible for under this Act.

The law also specifies that nothing in this Act shall be construed to require the landlord to provide alternative lodging or to pay to replace the tenant's personal property; nor shall this Act be construed to preempt the provisions of Connecticut's law on human rights and opportunities or any other state or federal law concerning reasonable accommodations for persons with disabilities.

Additionally, this Act prohibits a landlord from renting a dwelling unit that the landlord knows or reasonably suspects is infested with bed bugs, and requires the landlord to disclose to a tenant whether the unit being offered for rent or any contiguous unit that the landlord owns, leases, or subleases is currently infested. Upon the tenant's or prospective tenant's request, the landlord is required to disclose the last date on which the dwelling being rented or offered for rent was inspected and found to be free of a bed bug infestation. Landlords who fail to comply with these provisions may be liable to the tenant for damages and reasonable attorneys' fees. This Act also provides that landlords may apply to the Superior Court for injunctive relief and obtain such relief as may be appropriate against a tenant who fails to comply with his or her obligations under the law. This Act does not limit or restrict the authority of any state or local housing or health code enforcement agency.

§ 2

This Act modifies the existing chapter on the rights and responsibilities of landlord and tenant in the general statutes to provide a cause of action for a tenant seeking relief against a landlord who has failed to comply with his or her legal duties regarding bed bug inspections, treatments and disclosures.

§ 3

This Act instructs the Connecticut Agricultural Experiment Station, in consultation with DPH and the Department of Energy and Environmental Protection, and within available appropriations, to develop and publish best practices and guidelines that identify the most effective and least burdensome methods of investigating and treating bed bug infestations.

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25. PUBLIC ACT 16-74. AN ACT CONCERNING SECURITY DEPOSITS FOR AGE-RESTRICTED PUBLIC HOUSING.
Effective October 1, 2016

This Act amends current law requiring that any housing authority or community housing development corporation approved to provide state-assisted public housing for senior citizens and disabled persons return a tenant's security deposit with interest at rates specified under the statute to any tenant who has resided in the housing for at least one (1) year. This Act deletes the statutory interest rate provisions and the requirement that the security deposit be returned after one (1) year. Now a landlord must return any security deposit with interest at the time the tenancy is terminated; the landlord is no longer required to return the security deposit after the tenant has resided in the housing for one (1) year.

Any housing authority or community housing development corporation providing state-assisted public housing for senior citizens and disabled persons must now permit tenants, pursuant to a written agreement, to pay security deposits in installments over a period of at least twelve (12) months in amounts that are reasonable in light of each tenant's income. These entities may waive or agree to extend the time period for paying the security deposit to more than twelve (12) months.

The payments must be due in regular intervals not exceeding one (1) month and any interest payable shall not begin to accrue or come due until the entire security deposit, including all installments, has been paid.

26. PUBLIC ACT 16-108. AN ACT CONCERNING THE REPLACEMENT OF HOUSING PROJECTS BY HOUSING AUTHORITIES.
Effective October 1, 2016

Existing law generally prohibits housing authorities that receive or have received state aid from selling, leasing, transferring, or destroying a housing project if the housing project would no longer be available for low- or moderate-income rental housing. However, an exception allows DOH to approve such an action after a public hearing if certain conditions are met. One of these conditions is that an adequate supply of low- or moderate-income rental housing must exist in the municipality where the project is located.

In deciding whether to grant such an exception, this Act requires DOH to consider the extent to which the project's housing units will be replaced with housing that is affordable to households with incomes that are below 25% and below 50% of the area median income.

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27. PUBLIC ACT 16-143. AN ACT CONCERNING THE REAPPLICATION PROCEDURE FOR ELDERLY PROPERTY TAX RELIEF.
Effective October 1, 2016

By law, the elderly in Connecticut must reapply for property tax relief every two (2) years. This Act pushes back the deadline by which the elderly are required to reapply for tax relief from March 15th to April 15th. This new deadline now aligns with the deadline for filing federal tax returns, which will give taxpayers additional time to complete their tax forms and submit them to the municipality. The new deadline will affect the following programs:

- the state funded Tax Relief Program for Elderly and Totally Disabled Homeowners;
- the local option Elderly Property Tax Freeze Program; and
- the state funded Elderly Property Tax Freeze Program.

This Act also pushes back the deadline, from April 1 to April 30, by which assessors must notify taxpayers for whom they did not receive an application by the filing deadline. Finally, this Act requires assessors to notify these taxpayers by regular mail that is evidenced by a certificate of mailing instead of by certified mail.

28. SPECIAL ACT 16-5. AN ACT ESTABLISHING A TASK FORCE TO STUDY THE ZONING OF TEMPORARY HEALTH CARE STRUCTURES.
Effective June 3, 2016

This Act establishes a task force to study the zoning of temporary health care structures and develop a model zoning ordinance for temporary health care structures. A "temporary health care structure" is defined as "a transportable residential structure that provides an environment in which a caregiver may provide care for a mentally or physically impaired person, is primarily assembled at a location other than its site of installation, is limited to one occupant who is the mentally or physically impaired person, is larger than 300 gross square feet, and complies with the applicable provisions of the State Building Code and Fire Safety Code." A "mentally or physically impaired person" is defined as a person who requires assistance with two or more activities of daily living, including, but not limited to, bathing, dressing, grooming, eating, meal preparation, shopping, housekeeping, transfer, bowel and bladder care, laundry, communication, and self-administration of medication and ambulation, as certified in writing by a Connecticut licensed physician. A "caregiver" is the person who is responsible for the care of the mentally or physically impaired person.

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This task force study must include an examination of regulations, ordinances and legislation pertaining to temporary health care structures in other states. The task force must submit a report on its findings by January 1, 2017 to the General Assembly's joint committees having cognizance of matters relating to local governments and aging, the Department on Aging and the Connecticut Chapter of the American Planning Association.

29. SPECIAL ACT 16-7. AN ACT CONCERNING SENIOR CENTERS.
Effective July 1, 2016

This Act establishes a task force to study best practices regarding the delivery of health and human services and related information to individuals aged sixty (60) and older by senior centers, appointed municipal agents for elderly persons, and other municipal employees. The task force will examine: (1) the resources and training needs of senior center personnel and municipal agents and employees in facilitating the delivery of health and human services and related information; (2) the most effective means for providing these resources and training; (3) existing delivery practices; (4) best practices in Connecticut and in other states; (5) access barriers to information; and (6) data provided by EMS, municipal police departments and other entities on the costs and staff provided in the delivery of health and human services and information during the calendar year 2015.

This Act also delineates the composition of the task force. The task force must submit a report on its findings and recommendations to the joint standing committee having cognizance of matters relating to aging no later than July 1, 2017, upon which date the task force will terminate.

30. PUBLIC ACT 16-1 (MAY 2016 SPECIAL SESSION). AN ACT CONVEYING CERTAIN PARCELS OF STATE LAND.
Effective June 2, 2016

This Act authorizes new conveyances and amends prior conveyances of state property, including the relevant transactions noted below.

§ 2

This Act amends certain conditions regarding the previous conveyance of a forty-five (45)-acre parcel of land to the town of Southbury. Under current law, the land must be used for housing purposes or else it will revert to the state. Current law maintains an exception permitting lease of the land to a non-profit organization for senior housing. This Act creates a further exception that allows a nonprofit lessee to sublease to another entity for the purpose of the development, construction, or management of low-income

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senior housing, if the sublease is entered into for the purposes of enabling state financing or the allocation of federal tax credits and subsequent investment.

§ 4

This Act authorizes DMHAS to convey the Shepherd Home and the parcel of land containing the Shepherd home located in Middletown to the city of Middletown, for a cost equal to the administrative expenses incurred via the conveyance. The transaction is contingent upon the Shepherd Home and its land being used as permanent supportive housing with a focus on veterans. This Act also authorizes the city of Middletown to convey the land to an organization to be used for this same purpose, provided that the organization assumes the costs and liabilities incurred from separating the parcel and buildings from any connected mechanical systems.

IV. ACTS CONCERNING MEDICAID ELIGIBILITY AND INSURANCE

31. PUBLIC ACT 16-12. AN ACT CONCERNING THE TREATMENT OF THE CASH VALUE OF LIFE INSURANCE POLICIES WHEN EVALUATING MEDICAID ELIGIBILITY.
Effective May 6, 2016

Under current law, DSS is prohibited from determining that an individual is ineligible for Medicaid solely based on having a life insurance policy with a cash value less than $10,000, provided the: (1) individual is pursuing the policy's surrender; and (2) proceeds are used to pay for the individual's long-term care once the policy is surrendered. This Act eliminates the requirement that proceeds be used to pay for the individual's long term care.

32. PUBLIC ACT 16-19. AN ACT CONCERNING REVISIONS TO HUSKY PLUS.
Effective May 6, 2016

This Act amends the statute governing the HUSKY PLUS program, a supplemental program for HUSKY B members whose medical needs are not met by the basic benefits plan, to accept the HUSKY PLUS payment rates as payment in full. HUSKY Plus supplements coverage for these medically eligible members with intensive physical health needs.

This Act requires that DSS contract with one or more entities, within available appropriations, to administer the HUSKY Plus program and to conduct an external quality review of the program by July 1, 2017.

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This Act also contains more general language about the medical assistance program, requiring that providers not enrolled in the medical assistance program accept the medical assistance program rates as payment in full and such other conditions as DSS may specify.

By July 1, 2017, DSS must enact regulations to establish criteria and specify services for the HUSKY PLUS program. These criteria must give priority to members with household income levels at or below 249% of the federal poverty level.

33. PUBLIC ACT 16-21. AN ACT CONCERNING REMOVAL OF OBSOLETE PROVISIONS FROM THE CHOICES HEALTH INSURANCE ASSISTANCE PROGRAM STATUTE.
Effective October 1, 2016

    In connection with the CHOICES program (Connecticut's program for health insurance assistance, outreach, information and referral, counseling and eligibility screening), this Act removes as a definition the term "Medicare organization" (defined essentially as an insurer operating a Medicare Advantage Plan) as well as a provision that authorizes the Insurance Commissioner to require Medicare organizations to submit information that would be relevant to plan beneficiaries.

34. PUBLIC ACT 16-82. AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR TOMOSYNTHESIS FOR BREAST CANCER SCREENINGS.
Effective January 1, 2017

    Under current law, certain types of individual and group health insurance policies must cover baseline mammograms for women aged 35-39 years and a mammogram every year for women aged 40 years and over. This Act requires that these insurance policies permit, at the woman's option, the use of breast tomosynthesis for these mammograms. Breast tomosynthesis is a three-dimensional mammographic technique.

35. PUBLIC ACT 16-175. AN ACT CONCERNING CLINICAL REVIEW CRITERIA FOR UTILIZATION REVIEW AND ADVERSE DETERMINATION NOTICES.
Effective January 1, 2017

    This Act makes certain revisions to the clinical review criteria that health carriers (e.g., insurance companies and HMOs) may use for utilization reviews.

    The health carrier must post on its website: (1) the clinical review criteria it uses; and (2) links to any rule, guideline, protocol, or other criterion it relied upon to render an adverse determination consistent with its obligations under existing law on utilization review and

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benefit determinations. This Act sets forth additional utilization review requirements for certain clinical conditions, including adult mental disorder and substance use disorder.

36. PUBLIC ACT 16-205. AN ACT CONCERNING STANDARDS AND REQUIREMENTS FOR HEALTH CARRIERS' PROVIDER NETWORKS AND CONTRACTS BETWEEN HEALTH CARRIERS AND PARTICIPATING PROVIDERS.
Effective January 1, 2017

This Act contains extensive revisions to statutes governing health carrier provider networks. It requires that each health carrier establish and maintain a network with a sufficient number and appropriate types of participating providers to assure access and develop standards for selecting and tiering participating providers. This Act also requires that the Insurance Commissioner determine the sufficiency of a health carrier's network pursuant to criteria set forth in the Act.

Under this Act, each health care carrier must establish a process to ensure that a covered person receives a covered benefit at an in-network level from a non-participating provider under circumstances specified in the Act and each carrier must also disclose to a covered person the process to request a covered benefit from a nonparticipating provider.

A health carrier must give a participating provider at least sixty (60) days written notice before removing the provider from the network. After receipt of such notice, the provider must give the carrier a list of the provider's patients who are covered under the health carrier's network. A participating provider must also give a carrier sixty (60) days written notice in the event that the provider chooses to leave the carrier's network.

In order for a health carrier to grant a continuity of care period in the event of a termination, the treating provider must agree in writing to accept the same payment from the health carrier and abide by the same terms and conditions as provided in the contract that existed when the treating provider was a participating provider. The provider may not seek payment from the covered person if that person would not have been responsible for such payment while the provider was still a participating provider.

This Act prohibits a health carrier from engaging in certain activities affecting providers participating in the health carrier's network. A health care carrier may not offer or provide inducements to a participating provider to encourage or incentivize the provider to provide less than medically necessary services. In addition, a health care carrier may not prohibit a provider from discussing treatment options with covered persons, regardless of the health carrier's position on such options, and may not prohibit a health care provider from advocating on behalf of covered persons within the utilization review process. Finally, the health carrier may not penalize a participating provider for reporting

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in good faith to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

In addition to addressing provider networks and nonparticipating providers, this Act also contains new provisions governing the content of contracts between a health care carrier and a participating provider. It also requires each health care carrier to post on its internet web site a current and accurate participating provider directory.

37. SPECIAL ACT 16-8. AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID RECIPIENTS.
Effective July 1, 2016 (vetoed by the Governor but veto overridden on June 20, 2016)

Under federal law, state Medicaid programs must provide an assurance that non-emergency medical transportation services will be available to convey Medicaid recipients to and from medically necessary appointments. DSS's current non-emergency medical transportation contract expires on December 31, 2016. This Act requires that no later than September 1, 2016, DSS initiate a plan to implement a new service delivery model for the coordination and administration of non-emergency medical transportation services for medical assistance recipients.

No later than November 1, 2016, DSS must also issue a request for proposals for transportation broker services for the coordination and administration of non-emergency medical transportation services for medical assistance recipients. When considering forms of services, DSS must consider eight factors provided in this Act.

V. ACTS CONCERNING EMPLOYMENT

38. PUBLIC ACT 16-29, AS AMENDED BY PUBLIC ACT 16-3 SECTIONS 95 THROUGH 108. AN ACT CREATING THE CONNECTICUT RETIREMENT SECURITY PROGRAM.
Effective May 27, 2016

This Act creates the Connecticut Retirement Security Exchange, which establishes a program for individual retirement accounts for eligible private-sector employees, who are automatically enrolled unless they choose to opt out.

§ 1—Definitions

The state-run retirement program applies to all "qualified employers" who do not offer retirement savings plans. A "qualified" employer is any for-profit or non-profit employer in the private sector with at least five (5) employees who have earned a minimum of $5,000 in wages in the previous calendar year. "Covered employees" are those employed

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by a qualified employer for a minimum of one hundred and twenty (120) days who are at least nineteen (19) years of age.

§ 2—The Connecticut Retirement Security Authority

This Act establishes a Connecticut Retirement Security Authority (the "Authority") as a public instrumentality and political subdivision of the state. Its powers are vested in a Board of Directors, whose composition is defined by this Act.

§ 4—Informational Materials

This Act requires that the Authority prepare informational materials regarding the Program. Qualified employers must distribute the informational materials to plan participants and prospective plan participants. This section contains specific requirements for the content of the informational materials.

§ 5—IRA Program

IRAs must be established and maintained through the Authority instead of third-party entities. The Authority must minimize the Exchange's total annual fees, defined to include investment management charges, administrative charges, broker and trading fees, and other costs necessary to administer the program. On or after the completion of the fourth calendar year following the first date on which the exchange becomes effective, the total annual fees must not exceed three-quarters of one percent of the total value of program assets.

Interest, investment earnings, and investment losses must be allocated to each participant's IRA. A participant's benefit under the program must be equal to the balance in his or her IRA as of any applicable measurement date.

The Authority must establish processes to prevent a participant's contributions to the IRA program from exceeding the annual maximum deduction amount set in federal tax law (26 U.S.C. § 219(b)(1)).

Finally, this Act provides that the states shall not be held liable for the payment of any benefits to any participant or beneficiary of any participant or for any liability or obligation of the Authority.

§ 7—Employer Responsibilities and Automatic Enrollment

Not later than January 1, 2018, and annually after that date, each qualified employer must provide its covered employees with the informational materials prepared by the

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Authority, as described in section 4 of this Act. For any employee hired on or after January 1, 2018, or who does not meet the definition of covered employee under this Act, the qualified employer must provide the employee with the informational materials no later than thirty (30) days, or another time period the Authority prescribes, after, (A) the date of such employee's hiring or (B) the date the employee meets the definition of a covered employee.

Qualified employers that maintain a retirement plan recognized under the federal tax code or approved by the Authority are exempt from this Act's requirements to provide the informational material and automatically enroll qualified employees.

Employees can affirmatively opt out of the automatic contribution plan. Covered employees may opt out of the program by electing a contribution level of zero.

This Act permits the Authority to delay the effective date of the program, in whole or in part, and for particular categories of employers, as it deems necessary to implement this Act's provisions and minimize the disruption and burdens that may exist for any qualified employer.

An employer that is not otherwise required to participate under this Act may make the program available to its employees subject to rules and procedures the Authority establishes. However, an employer may not require an employee to enroll. Individuals may also participate in the program according to procedures the Authority establishes and may roll over funds from other retirement accounts to the extent legally permitted.

This Act requires qualified employers to transmit withheld employee contributions on the earliest day that the amount held can be segregated from the employer's assets but no later than ten (10) business days following the date that the contribution was withheld.

§ 10—Employer Penalties

This Act provides that if a qualified employer fails to remit contributions to the program in the time period specified in this Act, then such failure will constitute a violation of existing state law prohibiting employer withdrawals from employee wages.

If a qualified employer fails to enroll a covered employee as required by this Act, the covered employee or the Labor Commissioner may bring a civil action to require the employer to enroll the employee and may recover the costs and reasonable attorney's fees as allowed by the court.

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39. PUBLIC ACT 16-83. AN ACT CONCERNING FAIR CHANCE EMPLOYMENT. *Effective January 1, 2017*

This Act prohibits employers from inquiring about a prospective employee's prior arrests, criminal charges or convictions on a preliminary employment application unless: (1) the employer is required to do so as a matter of state or federal law; or (2) a security, fidelity or equivalent bond is required for the position that the employer is seeking to fill. This Act also provides that employees or prospective employees may file a complaint with DOL alleging an employer's violation of any restrictions on background checks and employee disclosures of prior arrests, criminal charges or convictions.

Because Connecticut law requires nursing homes, RCHs, home health agencies, assisted living, chronic disease hospitals, intermediate care facilities for individuals with intellectual disabilities and hospice providers to perform national background checks on potential direct care employees and volunteers, these providers may continue to ask about prior criminal records on employment applications for positions involving direct patient care.

40. PUBLIC ACT 16-125. AN ACT ALLOWING EMPLOYERS TO PAY WAGES USING PAYROLL CARDS.
Effective October 1, 2016

§ 1

This Act provides that employers may use payroll cards (stored value cards) to deliver wages to their employees as long as each employee has the option of being paid through direct deposit or negotiable check and the employee has voluntarily authorized compensation by a payroll card.

If an employer uses payroll cards, the employee must "voluntarily and expressly" authorize this method of payment, either in writing or electronically. Before employees can consent to receiving wages through a payroll card, employers must give employees clear and conspicuous notice of the following: (i) other means of compensation available; (ii) the terms, conditions, and fees relating to the use of the payroll card; (iii) the methods available for accessing their full wages and checking their balances; and (iv) a statement of any additional fees third parties may assess.

Employers must provide employees with a means of checking their payroll card balance through an automated telephone system twenty-four (24) hours a day, seven (7) days a week and provide employees with a pay stub for every pay period. Additionally, payroll cards must be associated with an ATM network that ensures a substantial number of in-network automated teller machines and the compensation paid through the payroll cards

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must be deposited in an account insured by the FDIC or the NCUA. These accounts are exempt from execution or attachment by creditors of the employers.

Employees must be able to make three (3) withdrawals per pay period from the payroll card without incurring a fee. Employers cannot pass any of the costs associated with paying wages through a payroll card onto the employees. Neither employers nor payroll card issuers may assess fees for any of the following: issuing the initial payroll card or one (1) replacement card per year, transferring wages from the employer to the payroll card account, closing a payroll account, maintaining a low balance, inactivity or dormancy for up to twelve (12) months, point of sale transactions, or overdrafts. This Act does not limit the fees a payroll card issuer may charge an employer.

§ 3

This Act amends the language of the statute governing the records an employer must provide to any employee with regard to hours worked and deductions, to make it permissible to now furnish employees with their pay stubs electronically so long as the employee consents. If an employer does furnish the records electronically, then the employer must provide the employee with a means to securely, privately, and conveniently access and print the records. The employer must incorporate reasonable safeguards regarding any information furnished electronically to protect the confidentiality of an employee's personal information.

41. PUBLIC ACT 16-169. AN ACT CONCERNING UNEMPLOYMENT COMPENSATION APPEALS AND HEARINGS, EMPLOYEE PAY PERIODS AND MINOR AND TECHNICAL REVISIONS TO THE GENERAL STATUTES RELATING TO THE LABOR DEPARTMENT.
Effective October 1, 2016 unless otherwise noted

§ 1

This Act allows both notices of determination of a claimant's benefit entitlement and statements of charges to employers to be provided to an employer by means other than U.S. mail. Additionally, the start of the timeline for employers to appeal the benefits charged to them has been changed from the time the statement was mailed to the time it was provided.

§ 6

Hearings regarding determination of eligibility for unemployment benefits may now be conducted over the phone rather than strictly in person. Additionally, electronic appeals of benefits decisions are now acceptable and considered timely filed so long as they are received within twenty-one (21) days of receiving the decision.

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§ 16

Currently, a person who has received an excess sum of benefits is entitled to a hearing to determine whether and how the benefits should be repaid. This Act still provides a beneficiary with a right to such determination; however the determination may be made using evidence presented by writing, telephone, or other electronic means. The examiner may, in his or her discretion, conduct a hearing either by phone or in person. If there is a hearing, notice of the time and place must be provided to the beneficiary no less than five (5) days before the hearing is to take place.

§ 33
Effective June 6, 2016

Employers are now permitted to compensate their employees once every two (2) weeks without first seeking prior approval from DOL. For unionized employees, employers may need to collectively bargain to make any changes to the timing of payroll.

VI. ACTS CONCERNING PROBATE

42. PUBLIC ACT 16-7. AN ACT CONCERNING PROBATE COURT OPERATIONS.
Effective October 1, 2016

§ 1

If a Connecticut Probate Court finds it does not have jurisdiction to hear a petition, application or motion, it may: transfer the action to the court it determines has jurisdiction or dismiss the petition, application or motion for lack of jurisdiction. If more than one court has jurisdiction over the matter, the transferring court may choose the jurisdiction that is most convenient for the parties.

§3

If a person under voluntary representation in a conservatorship who is not represented by an attorney waives the right to a hearing, the court must hold a hearing to determine that the waiver represents the person's wishes. This applies to hearings that are required before a conservator may change a person's residency, including placement into a long term care facility.

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§4

Applications that authorize DSS to enter the premises of an "elderly person," meaning any resident of Connecticut who is sixty (60) years of age or older, to determine whether protective services are necessary now require a $225 filing fee.

§ 8

This Act expands the definitions of "conservator of the estate" and "conservator of the person" to now include LLCs, partnerships, and other entities recognized under Connecticut law regardless of whether they are operated for profit.

43. PUBLIC ACT 16-40. AN ACT CONCERNING REVISIONS TO THE CONNECTICUT UNIFORM POWER OF ATTORNEY ACT.
Effective October 1, 2016

§ 1

This Act states that a power of attorney executed in Connecticut after October 1, 2016 is only valid if it complies with the signature and witnessing requirements for a power of attorney under state law. A power of attorney executed before October 1, 2016, however, is valid so long as it complied with the law as it existed at the time of execution.

§ 2

This Act amends some of the previous language and also sets forth an additional power to those granted to an agent by a power of attorney. It authorizes the agent to execute a written document in advance of the principal's death directing the disposition of a deceased person's body or designating an individual to have custody and control of the disposition of a deceased person's body. The written document must designate an alternate.

§ 3

Although other forms of power of attorney are still permissible, this Act adopts a new statutory short form. The short form is similar to the long form except that it does not include the "Optional Estate Planning Powers" found in the long form. Both forms require the principal to cross out and initial in the box next to any powers that he or she does not wish to grant. Contrastingly, the principal must initial next to any of the "Optional Estate Planning Powers" he or she wishes to grant.

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§ 8

This Act limits a court's authority to reinstate the authority of an agent when a conservatorship terminates. Now courts can only reinstate an agent whose power of attorney was previously limited or suspended by the court due to a conservatorship, but the court can no longer reinstate an agent whose power of attorney was terminated.

44. PUBLIC ACT 16-49. AN ACT CONCERNING GUARDIANSHIP OF PERSONS WITH AN INTELLECTUAL DISABILITY.
Effective October 1, 2016

This Act expands the types of entities that a probate court may appoint as a guardian of a person with an intellectual disability. In addition to legally authorized state officials, this Act enables corporations, LLCs, partnerships, or other entities recognized under Connecticut law, whether or not operated for profit, to serve as plenary or limited guardians. This Act does not change existing law that provides that hospitals, nursing home facilities or residential care facilities cannot serve as plenary guardians and that hospitals and nursing homes cannot serve as limited guardians. The standard definitions of "nursing home facility" and "residential care home" under Connecticut law are operative for these purposes. Plenary guardians supervise all aspects of a protected person's care, while limited guardians supervise only certain aspects of care enumerated under Connecticut probate law.

This Act updates certain terminology, including replacing "ward" with "protected person" to refer to the individual for whom a probate court grants guardianship. It also modifies the requirements involving the confidentiality of documents in guardianship cases. It requires that all records related to guardianship of a protected person be kept confidential and not open to public inspection or disclosure, except that the records must be available to the parties to a case and their counsel, DSS and the office of the Probate Court Administrator. If the court appoints a guardian, the names of the guardian and the protected person will be made public. Additionally, the court may, after hearing with notice to the respondent, respondent's counsel, the guardian and DSS, permit records to be disclosed for cause shown.

45. PUBLIC ACT 16-168. AN ACT CONCERNING THE INHERITANCE RIGHTS OF A BENEFICIARY OR SURVIVOR WHO IS FOUND NOT GUILTY OF MURDER OR MANSLAUGHTER BY REASON OF MENTAL DISEASE OR DEFECT.
Effective October 1, 2016

Under current law, persons found guilty of certain crimes are prohibited from inheriting from their victim's estate, life insurance, or annuity benefits. This Act expands the list of

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prohibited crimes to include persons found not guilty by reason of mental disease or defect and second degree manslaughter and second degree manslaughter with a firearm.

VII. MISCELLANEOUS ACTS OF INTEREST

46. PUBLIC ACT 16-3. AN ACT CONCERNING INSTALLERS OF RESIDENTIAL STAIR LIFTS.
Effective May 2, 2016

DCP must consult with the Elevator Installation, Repair and Maintenance Board and adopt regulations to establish a residential stair lift technician's license. The regulations will govern the experience, training, and education necessary to obtain such license. Tradesmen whose licenses already permit them to install and repair residential chairlifts do not need to obtain this license as well.

47. PUBLIC ACT 16-20. AN ACT CONCERNING IRREVOCABLE FUNERAL SERVICE CONTRACTS.
Effective July 1, 2016

This Act increases the maximum amount that an irrevocable funeral service contract may be entered into for from $5,400 to $8,000.

48. PUBLIC ACT 16-23. AN ACT CONCERNING THE PALLIATIVE USE OF MARIJUANA.
Effective October 1, 2016

§ 1

This Act adds to the list of conditions for which Medical marijuana may now be prescribed: uncontrollable intractable seizure disorder; irreversible spinal cord injury with objective neurological indication of intractable spasticity; cerebral palsy; cystic fibrosis; and terminal illness requiring end-of-life care.

§ 3

Currently, when medical marijuana patients register with DCP, they must select a licensed, in-state dispensary from which to obtain their medical marijuana. Anyone holding a valid registration certificate from DCP for medical marijuana (including a primary caregiver holding the certificate) who is found to be in possession of medical marijuana that is not from the patient's selected dispensary may be brought before DCP for a possible enforcement action.

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§ 4

This Act now extends the legal protections that physicians receive for administering medical marijuana to qualifying patients to nurses. Nurses shall not be arrested, prosecuted, or penalized in any manner for administering medical marijuana to qualifying patients or research programs in hospitals or health care facilities that are licensed by DPH.

§ 7

Dispensaries may now distribute medical marijuana to hospices or other inpatient care facilities licensed by DPH. The receiving hospice or other inpatient care facility must have in place a DCP approved protocol for the handling and distribution of medical marijuana. Dispensaries may also distribute medical marijuana to laboratories and organizations engaged in research programs.

§ 9

DCP's Board of Physicians may now review the list containing debilitating medical conditions that qualify patients to receive medical marijuana and may make recommendations to the General Assembly regarding the removal of a debilitating medical condition or treatment from such list.

§§ 12 & 13—Research Programs and Research Program Employees

Sections 12 and 13 of this Act address DCP approval of medical marijuana research programs administered or overseen by a hospital or health care facility licensed by DPH, an institution of higher education, a licensed producer or a licensed dispensary.

49. PUBLIC ACT 16-32. AN ACT CONCERNING THE IMPACT OF PROPOSED REGULATIONS ON SMALL BUSINESSES.
Effective October 1, 2016 (vetoed by the Governor but veto overridden on June 20, 2016)

This Act changes the definition of "small business" from a business that employs fewer than seventy-five (75) employees to one that employs fewer than 250 full-time employees. Regardless of the number of employees, a company with gross sales of less than $5,000,000 is considered a small business.

Now, any agency, meaning any state board, commission, department or officer authorized to create regulations, must prepare a "regulatory flexibility analysis" for any regulation it intends to implement. This analysis must include the type of businesses potentially affected by the proposed regulation and whether small businesses will have to

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create and file any additional reports, implement any recordkeeping or administrative procedures, or make additional expenditures in the form of employees or resources to comply with the proposed regulation.

50. PUBLIC ACT 16-58. AN ACT REVISING THE REGULATION REVIEW PROCESS.
Effective as noted

§§ 1 & 2
Effective October 1, 2016

The UAPA currently states that agencies can make technical amendments to or repeal existing regulations without prior notice under certain circumstances. This Act now allows agencies to make technical amendments without a public comment period. This Act also expands the circumstances under which it would be permissible to make technical amendments without notice, public comment or hearing to include:

- transferring or renumbering sections of regulations to correspond with the transferring or renumbering of the section of the general statutes containing the statutory authority for the regulation;

- amending an existing regulation solely to conform the regulation to amendments to the general statutes (provided the amendments to the regulation do not entail any discretion by the agency);

- updating or correcting contact information contained in the regulation; or

- correcting spelling, grammar, punctuation, formatting or typographical errors, with no substantive changes made.

The UAPA governs the regulation-adoption process for state agencies, and allows agencies to adopt emergency regulations without prior notice or hearing. This Act establishes that agencies may also adopt emergency regulations without a public comment period. This Act also changes the amount of time the Legislative Regulation Review Committee has to approve or disapprove proposed emergency regulations after its submissions from ten (10) to fifteen (15) calendar days. Emergency regulations have previously been effective after their approval for up to 120 days, but this Act allows emergency regulations to be effective for up to 180 days. Each emergency regulation will now be effective when posted on the eRegulations System by the Secretary of the State.

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§ 4
Effective May 31, 2016

Under current law, every five (5) years, the Legislative Regulation Review Committee must establish a date when each state agency will submit a review of its existing regulations. This Act now establishes that each state agency must submit a review of its existing regulations every seven (7) years. Further, each agency's legislative committee of cognizance must establish the dates by which such review must occur by July 1, 2017.

§ 9
Effective May 31, 2016

Under current law, the eRegulations system must be easily accessible and searchable to the public. This section now also requires members of the public to have the ability to request and receive an electronic notification when an agency posts a notice of intent to adopt regulations.

51. PUBLIC ACT 16-78. AN ACT MODERNIZING THE SYMBOL OF ACCESS FOR PERSONS WITH DISABILITIES.
Effective June 1, 2016

This Act requires DAS, no later than January 1, 2017 to adopt policies and regulations for designating a new access symbol to be used on signs that identify access for persons with disabilities. The symbol will convey the same meaning as the previously used international symbol of access, but the new symbol must consist of a "dynamic character leaning forward with a sense of movement" and be easily identifiable.

The new symbol will replace all references to the international symbol of accessibility in the State Building Code and be used in all buildings or structures that are built, substantially renovated, or expanded after January 1, 2017. The new symbol will also replace the international access symbol on special license plates, removable windshield placards and their accompanying number plates, and temporary removable windshield placards.

This Act also makes changes to the signage required to designate parking spaces for persons who are blind and persons with disabilities. Beginning January 1, 2017, whenever an existing sign is replaced, repaired, or erected, it is required to say, "reserved parking, permit required" instead of "handicapped parking, permit required". Additionally, it must bear the new access symbol and, consistent with current law, state that "violators will be fined" and provide an indication of the minimum applicable fine, which is generally $150 for an initial violation and $250 for subsequent violations.

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52. PUBLIC ACT 16-97. AN ACT CONCERNING ADOPTION OF THE CONNECTICUT UNIFORM LIMITED LIABILITY COMPANY ACT.
Effective July 1, 2017

This Act makes numerous changes to the laws governing LLCs in the state and is modeled after the Revised Uniform Limited Liability Company Act promulgated by the Uniform Law Commission. Generally, the law supplies default provisions that apply when an LLC's operating agreement is silent on certain matters pertaining to the relations among members and between members and the LLC, the rights and duties of a manager, the activities and affairs of the company and its related conduct, and the means and conditions for amending an operating agreement. Given the extent of these revisions, this Act should be consulted when an LLC is formed, or when any questions arise about structure, governance, liability and state filings.

Of note, this Act makes changes to certain requirements for LLCs that are established to provide professional services, such as LLCs for physicians or nurses. It adds PAs to the enumerated occupations that may constitute a professional service. It also requires that LLCs formed after the effective date include "professional limited liability company", "P.L.L.C." or "PLLC" in its name. "Limited" may be abbreviated as "Ltd." and "company" may be abbreviated as "Co." This Act does not change provisions under current law that allow members of two or more of the following professions to form a PLLC: (1) psychology, marital and family therapy, social work, nursing, and psychiatry; (2) medicine and surgery, occupational therapy, social work, and alcohol and drug counseling; and (3) medicine and surgery, and chiropractic.

This Act clarifies that none of its provisions should be interpreted to abolish, repeal, modify, or restrict any existing laws that are applicable to the liabilities between the persons furnishing and receiving professional services. Any member, manager, agent or employee of an LLC rendering professional services will be personally liable only for negligent or wrongful acts or misconduct committed by that person or by a person under his or her direct supervision and control, and an LLC rendering professional services will be liable up to the full value of its property for any negligent or wrongful acts or misconduct committed by any of its member, managers, agents or employees while they are engaged in rendering professional services on behalf of the LLC. The personal liability of members of a PLLC in their capacity as members shall not be greater in any respect than that of a shareholder who is an employee of a corporation.

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53. PUBLIC ACT 16-185. AN ACT ADOPTING THE REQUIREMENTS OF NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS V. FEDERAL TRADE COMMISSION AND REVISING CERTAIN BOARDS AND COMMISSIONS STATUTES.
Effective July 1, 2016

§ 2

To conform to the holding in the recent Supreme Court decision, *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, this Act requires that any exercise of statutory functions by boards or commissions within DCP be considered proposed decisions subject to approval, rejection or modification by the Commissioner of DCP. Boards or commissions are now required to submit any proposed decisions to DCP, which may render a final decision about its status within thirty (30) days after receiving it. DCP must notify the board or commission in writing of the Commissioner's decision and include in such notification the rationale of such decision.

§ 3

DCP is required to receive complaints concerning the work practices of persons licensed, registered or certified by boards or commissions and is required to receive complaints concerning unauthorized work and practice by persons not licensed, registered or certified by boards or commissions. This Act requires that DCP distribute a quarterly, rather than monthly, list of all complaints received within the previous quarter to the chairperson of the appropriate board or commission.

54. PUBLIC ACT 16-214. AN ACT CONCERNING THE USE OF EXPERIMENTAL DRUGS.
Effective October 1, 2016

This Act allows a terminally ill patient, subject to a number of restrictions, to receive treatment in the form of an "investigational drug, biological product or device." An "investigational drug, biological product or device" is one that has not been approved for general use and remains under investigation by the FDA but has completed a Phase I clinical trial.

Patients are only eligible to receive this form of treatment if they have considered all available approved options, been unable to participate in a clinical trial for the illness, given informed written consent, and received a recommendation for this course of treatment from their treating physician who provides written documentation that the patient meets the requirements for treatment.

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For the purposes of this Act, informed written consent occurs when the patient signs, verified by a witness and the treating physician, a document that: (1) provides that the physician explained the approved treatments for the patient's terminal illness; (2) the patient agrees with the treating physician that all other available treatments are unlikely to prolong life; (3) identifies the proposed "investigational drug, biological product or device;" (4) describes both the worst and the most likely outcome of using the proposed treatment; (5) states the patient's health carrier; (6) states that the patient's eligibility for hospice care could be withdrawn; (7) states that in-home health care may be denied; and (8) states that the patient understands that he or she is liable for the costs associated with the treatment.

This Act provides that neither DPH nor CMEB will take disciplinary action against a physician for recommending treatment by means of "investigational drug, biological product or device" so long as the recommendation is consistent with the medical standard of care. It also addresses insurance coverage for investigational drugs, products and devices.

55. SPECIAL ACT 16-2. AN ACT ESTABLISHING A TASK FORCE TO STUDY HOARDING.
Effective May 23, 2016

This Act establishes a task force to study issues concerning hoarding. The task force shall:

- review current methods used by various public agencies to address hoarding;
- identify barriers faced by public agencies to intervene and assist persons who compulsively hoard;
- create a framework to coordinate the efforts among state and local public agencies to address the public safety and health issues associated with hoarding; and
- study whether it is permissible to waive a period of Medicaid ineligibility with regard to an individual who compulsively hoards and whose assets have been discovered after such individual applies for Medicaid.

Not later than January 1, 2017, the task force shall submit a report on its findings and recommendations to the General Assembly's joint standing committees on public safety and security.

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56. SPECIAL ACT 16-18. AN ACT ESTABLISHING A TASK FORCE TO STUDY VALUE-BASED PRICING OF PRESCRIPTION DRUGS.
Effective June 10, 2016

This Act establishes a task force that is responsible for studying value-based pricing of prescription drugs. The task force must be appointed by July 10, 2016. On or before January 1, 2017, the task force must submit a report on its findings to the joint committees on consumer protection, insurance and public health.

57. SPECIAL ACT 16-20. AN ACT ESTABLISHING A HEALTH DATA COLLABORATIVE WORKING GROUP.
Effective June 7, 2016

The Commission on Economic Competiveness shall appoint a health data working group to examine and make recommendations regarding the digital infrastructure needs of the health care, insurance, public and private universities and research industries and the potential economic and employment benefits of such digital infrastructure. The working group shall submit a report on its findings to the joint committees of the General Assembly by January 15, 2017.

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