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Introduction:

This Legislative Update provides readers with a summary of Connecticut legislation affecting healthcare providers and other healthcare related entities or agencies. Please note that this Legislative Update only summarizes what we believe to be the legislative highlights or the most significant new laws from the General Assembly's latest session and, thus, should only be used as a starting or reference point when determining what steps to take, if any, for complying with new laws that apply to you.

The specific Public Acts are summarized herein for your reference and convenience along with the link to the specific Public Act. Pages 1-2 list the specific Public Acts that are covered along with a reference to the page in this Alert where its corresponding summary is located. Tax legislation relevant to healthcare entities is addressed in the Tax Law legislative update published by Shipman & Goodwin's State and Local Tax Practice Group, available at: <http://www.shipmangoodwin.com/files/upload/CTTaxAlertBudget071511.pdf>.

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Summaries:

1. AN ACT CONCERNING THE PROVISION OF PROPHYLACTIC AND EMERGENCY CARE TO HOSPITAL PATIENTS. **See Public Act No. 11-2.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00002-R00HB-06545-PA.htm>
 - a. **Section 1: Administration of Care (effective 10/1/2011).** Public Act 11-2 (the “Act”) permits a hospital to administer care to patients, without a physician’s order, after an assessment of contraindications if such care is “emergent, timely and necessary” or is for the purpose of “advancing patient care.” The care must be provided in accordance with a physician-approved hospital policy and applicable federal law. Though not specifically required by the Act, hospitals should develop protocols to guide clinicians. We presume that once a patient is stabilized, physician orders would be required.
 - b. **Section 1: Administration of Prophylactic Care or Treatment (effective 10/1/2011).** The Act also permits a hospital to administer, without a physician’s order, prophylactic care or treatment to healthy newborns who are born at the hospital, or who are admitted to the hospital nursery. The care must be provided in accordance with a physician-approved hospital policy and applicable federal law. The Act does not indicate whether parental consent would be required in these situations.
2. AN ACT CONCERNING EXEMPTIONS FROM THE CERTIFICATE OF NEED PROCESS FOR RESEARCHERS UTILIZING CERTAIN TECHNOLOGIES THAT HAVE NO IMPACT ON HUMAN HEALTH. **See Public Act No. 11-10.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00010-R00HB-06371-PA.htm>
 - a. **Section 1: Certificate of Need (“CON”) Not Required (effective 5/24/2011).** Public Act 11-10 provides that a CON is not required for the acquisition of any equipment that is to be used exclusively for scientific research that is not conducted on humans.
3. AN ACT CONCERNING REVISIONS TO STATUTES RELATING TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES INCLUDING THE UTILIZATION OF RESPECTFUL LANGUAGE WHEN REFERRING TO PERSONS WITH INTELLECTUAL DISABILITY. **See Public Act No. 11-16.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00016-R00HB-06279-PA.htm>
 - a. **Section 1: Respectful and Updated Language (effective 5/24/2011).** Public Act 11-16 (the “Act”) updates certain statutes with more “respectful” language including replacing “mental retardation” with “intellectual disability” and “autism” with “autism spectrum disorder.” The Act also substitutes “community training homes” with “community companion homes and community living arrangements” to reflect more modern terminology.
 - b. **Section 8: Contracting Process (effective 5/24/2011).** The Act eliminates the requirement that each Department of Developmental Services (“DDS”) contract to construct, renovate, or rehabilitate a community-based residential facility be awarded to the lowest responsible and qualified bidder through DDS’s competitive bid process.
 - c. **Section 13: Quality Service Reviews (effective 5/24/2011).** The Act specifies that DDS regulations include requirements regarding quality service reviews in addition to licensing inspections and that at least half of all quality service reviews, licensing inspections, or facility visits conducted by DDS after initial licensure must be unannounced.

- d. **Section 13: DDS Licensure Requirements for Community Living Arrangements and Community Companion Homes (effective 5/24/2011).** The Act provides that community living arrangements and community companion homes which provide lodging, care or treatment to persons with intellectual disability, Prader-Willi Syndrome or autism spectrum disorder must be licensed by DDS. Previously, any “residential facility” providing such services was required to be licensed by DDS.
 - e. **Section 13: Right to an Administrative Hearing (effective 5/24/2011).** The Act specifies that anyone aggrieved by a DDS regulatory requirement or licensure denial or revocation may request an administrative hearing.
4. AN ACT PERMITTING INQUIRY ACCESS TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES’ ABUSE AND NEGLECT REGISTRY FOR CHARITABLE ORGANIZATIONS WHICH RECRUIT VOLUNTEERS TO WORK WITH PERSONS WITH INTELLECTUAL DISABILITIES. **See Public Act No. 11-26.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00026-R00SB-00885-PA.htm>
- a. **Section 1: Charitable Organization’s Access to the DDS Abuse and Neglect Registry (effective 6/3/2011).** Public Act 11-26 provides that charitable organizations which recruit volunteers to support programs for persons with intellectual disability may now access DDS’s Abuse and Neglect Registry for conducting background checks on such volunteers, upon application to and approval by DDS.
5. AN ACT REQUIRING HEALTH CARE PROVIDERS TO DISPLAY PHOTOGRAPHIC IDENTIFICATION BADGES DURING WORK HOURS. **See Public Act No. 11-32.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00032-R00HB-05045-PA.htm>
- a. **Section 1: Photo Identification (“ID”) Badges Required for Health Care Providers (effective 10/1/2011).** Public Act 11-32 (the “Act”) requires health care providers who provide direct patient care to wear a photo ID badge issued by the health care facility in which he or she is providing services. The photo ID badge must be worn in plain view during the provider’s working hours and must contain: (i) the provider’s name; (ii) the name of the health care facility; and (iii) the provider’s license, certificate, or employment title. Health care facilities, in consultation with the Department of Public Health (“DPH”), must develop policies and procedures concerning: (a) the size, content, and format of the photo ID badge; and (b) any exemptions to the requirement to wear a photo ID badge necessary to ensure the safety of patients and providers. The Act applies to hospitals, nursing homes, rest homes, home health care agencies, homemaker-home health aide agencies, EMS organizations, assisted living agencies, outpatient surgical facilities (aka “ambulatory surgery centers”), and educational infirmaries.
6. AN ACT CONCERNING THE ADMINISTRATION OF PERIPHERALLY-INSERTED CENTRAL CATHETERS IN LONG-TERM CARE SETTINGS. **See Public Act No. 11-40.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00040-R00HB-06373-PA.htm>
- a. **Section 1: Administration of Peripherally-Inserted Central Catheters (effective 10/1/2011).** Public Act 11-40 (the “Act”) permits an intravenous (“IV”) therapy nurse employed or contracted by a nursing home or rest home with nursing supervision that operates an IV therapy program¹ to administer a peripherally-inserted central catheter (“PICC”) as part of the facility’s IV therapy program.

¹ The Act defines an “IV therapy program” as the overall plan by which a nursing home or rest home with nursing supervision implements, monitors and safeguards the administration of IV therapy to patients.

7. AN ACT CONCERNING THE BUREAU OF REHABILITATIVE SERVICES AND IMPLEMENTATION OF PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH. See Public Act No. 11-44. <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00044-R00SB-01240-PA.htm>

a. **Sections 1 - 4: Bureau of Rehabilitative Services (effective 7/1/2011).**

Public Act 11-44 (the "Act") creates a Bureau of Rehabilitative Services within the Department of Social Services ("DSS") to provide: (i) services to the deaf and hearing impaired; (ii) services to the blind and visually impaired; and (iii) rehabilitation services. All functions, powers and duties of the Commission of the Deaf and Hearing Impaired, the Board of Education and Services for the Blind and the Bureau of Rehabilitation Services of DSS are transferred to the Bureau of Rehabilitative Services.

b. **Section 85: Podiatry and Medicaid (effective 7/1/2011).** By October 1, 2011, the Act requires DSS to amend the Medicaid state plan to include podiatry as an optional service under the Medicaid program.

c. **Section 92: Fee Schedule (effective 7/1/2011).** The Act provides that DSS may establish a uniform fee schedule for the payment of outpatient hospital services under the Medicaid program. Currently, DSS's payment formula may result in different hospitals being paid at different rates for the same service.

d. **Section 95: Small House Nursing Homes (effective 7/1/2011).** DSS is now authorized, but is not required, to establish one small house nursing home with up to 280 small house nursing home beds. For purposes of the Act, a small house nursing home is an alternative nursing home facility that: (i) consists of one or more units that are designed and modeled as a private home; (ii) houses no more than 14 individuals in each unit; (iii) includes private rooms and bathrooms; (iv) provides for an increased role for support staff in the care of residents; (v) incorporates a philosophy of individualized care; and (vi) is licensed as a nursing home.

e. **Section 104: Transfers of Assets and the Medicaid Program (effective 6/13/2011).** An "institutionalized individual"² can be penalized for an asset transfer, even if the entire amount is returned, if DSS determines that the Medicaid recipient (or his or her spouse or authorized representative) intended to change the start date of the penalty period for improper transfers or shift nursing facility costs to the Medicaid program.

f. **Section 110: Medical Homes (effective 6/13/2011).** The Act permits DSS to implement policies and procedures to establish medical homes as a model for delivering care to medical assistance program beneficiaries.

g. **Section 110: Health Care Reform (effective 6/13/2011).** The Act allows DSS to implement policies and procedures to carry out optional provisions relating to the federal Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (collectively, the "Affordable Care Act") relating to:

- family planning services;
- establishing a temporary high risk pool for individuals with preexisting conditions;

² For purposes of the Act, an "institutionalized individual" means an individual who is receiving (i) services from a long term care facility or similar facility, or (ii) home and community-based services under a Medicaid waiver.

- establishing an incentive program to prevent chronic diseases;
- providing health homes to medical assistance beneficiaries with chronic conditions;
- establishing Medicaid payments to institutions for a mental disease demonstration program;
- establishing a dual eligible demonstration program;
- establishing a balancing incentive payment program for home and community-based services³;
- establishing a “Community First” option⁴;
- establishing a demonstration project to make bundled payments to hospitals; and
- establishing a demonstration project to allow pediatric medical providers to organize as accountable care organizations.

h. Sections 111 & 174 - 177: Disproportionate Share (“DSH”) Payments (effective 7/1/2011). Beginning July 1, 2011, the Act permits DSS to make interim monthly Medicaid DSH payments to short-term general hospitals other than children’s hospitals or state operated hospitals (i.e. Connecticut Children’s Medical Center and John Dempsey Hospital). The total amount of these payments must maximize federal Medicaid matching payments, as DSS determines in consultation with the Office of Policy and Management. Effective July 1, 2011, interim payments for the succeeding 15 months shall be based on 2009 federal fiscal year data. Effective October 1, 2012, interim payments will be based on the most recent federal fiscal year data available.

The Act eliminates a requirement that each hospital obtain an independent audit of its level of charges, payments, and discharges to government and nongovernment payors and the amount of uncompensated care. However, hospitals must continue to file audited financial statements by February 28 annually and such filings must include a verification of the hospital’s “net revenue” for the most recently completed fiscal year in an Office of Health Care Access (“OHCA”)-prescribed format. The Act eliminates DSH payments from the current definition of “net revenue.”

i. Section 112: Blended Payments (effective 7/1/2011). The Act permits DSS to establish a blended inpatient hospital case rate⁵, which includes services provided to all Medicaid recipients and may exclude certain diagnoses if DSS determines the rates are necessary to ensure that the planned conversion to an administration services organization is, in the aggregate, cost neutral to hospitals and ensures patient access.

j. Section 117: Establishment of a State Chronic or Convalescent Nursing Home (effective 7/1/2011). The Act permits the Departments of Correction and Mental Health and Addiction Services (“DMHAS”) and DSS to establish or contract to establish a chronic or convalescent home on state-owned or private property for people who require nursing home-level services and are transitioning from prison into the community or are DMHAS clients. The facility’s development is exempt from state CON requirements.

3 The balancing incentive payment program will award participating states additional federal financial assistance if the states commit to shifting more of their Medicaid long-term services and supports spending toward noninstitutional care.

4 The Community First option will allow states to receive an increase in federal matching funds for providing community-based attendant services and supports to Medicaid beneficiaries.

5 The Act does not set forth a definition for this term. We assume DSS will define this term and provide details of how such a rate is calculated if and when DSS decides to establish and implement a “blended inpatient hospital case rate.”

k. Section 150: Prescriptions for Epilepsy and Seizure Drugs (effective 10/1/2011).

The Act provides that a pharmacist must not fill a prescription for drugs to treat epilepsy or seizures by using a different drug manufacturer or distributor of the prescribed drug unless the pharmacist provides prior notice to the patient and prescribing practitioner and obtains the written consent of the prescribing practitioner. This provision does not apply to pharmacies: (i) in long-term care facilities; (ii) serving hospital in-patients; or (iii) in other institutional facilities.

l. Sections 153 - 159: False Claims (effective 6/13/2011). The Act makes numerous changes to Connecticut's False Claims Act (the "CFCA") based upon similar recent changes in federal law.

Definitions. The Act broadens the definition of a "claim" to include demands for money or property, regardless of whether it belongs to the state, so long as the demand is submitted to: (i) a state officer, employee, or agent; or (ii) a contractor, grantee, or other recipient, if the money or property is to be spent or used on the state's behalf or to "advance a state program or interest." The Act also establishes new definitions of "material" and "obligation." Under the Act, something is "material" if it may influence, or be capable of influencing, the payment or receipt of money or property. An "obligation" is a duty arising from: (a) an express or implied contractual, grantor-grantee, or licensor-licensee relationship; (b) a fee-based or similar relationship; (c) statute or regulation; or (d) the retention of an overpayment.

Violations. The Act makes it a violation of the CFCA to: (i) "knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the state" under a DSS medical assistance program⁶; or (ii) knowingly make, use or cause to be made or used, a false record or statement "material to" a false or fraudulent claim under a DSS medical assistance program.

Public Disclosure Bar. The Act provides that, unless opposed by the state or brought by an "original source", a court must dismiss a claim brought under the CFCA if the information upon which it is based has been publicly disclosed. Under the Act, an "original source" must have: (i) informed the state before the information was publicly disclosed; or (ii) knowledge that is independent of and materially adds to the disclosed allegations and has provided the information to the state before filing suit.

Relate Back. The Act authorizes the attorney general to intervene in a CFCA action brought by a private party. When this occurs, the Act permits the state to: (i) file its own complaint; (ii) amend the plaintiff's complaint to clarify or add detail to claims; or (iii) add additional claims. If the additional pleadings are based on the same conduct, transactions, or occurrences as in the original complaint, the state's claims "relate back" to the date the original complaint was filed. As a practical matter, the "relate back" provision may operate to extend the statute of limitations in CFCA suits.

Retaliation. The Act applies the CFCA's current retaliation provisions to contractors and agents. The Act also provides that actions taken by employees, contractors, or agents to stop a violation of the CFCA may trigger the CFCA's retaliation provisions.

⁶ For example, retaining overpayments would now be considered a violation of the CFCA.

8. AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET CONCERNING GENERAL GOVERNMENT. **See Public Act No. 11-48.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00048-R00HB-06651-PA.htm>

a. **Section 38: Newborn Screening (effective 10/1/2011).** Public Act 11-48 requires all health care institutions caring for newborn infants to test such newborns for severe combined immunodeficiency disease (“SCID”)⁷, unless, as allowed by law, their parents object on religious grounds. The testing must be done as soon as is medically appropriate.

9. AN ACT ESTABLISHING A STATE HEALTH INSURANCE EXCHANGE. **See Public Act No. 11-53.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00053-R00SB-00921-PA.htm>

a. **Sections 1-18: Health Insurance Exchange (effective 7/1/2011).** Public Act 11-53 (the “Act”) provides that the Connecticut Health Insurance Exchange, a State of Connecticut “quasi-public agency” (the “Exchange”) be created as a market for insurers to offer “qualified health plans.” The Exchange will operate through an 11 member board of directors, consisting primarily of governmental and legislative representatives with no ties to either the health care or insurance industries. The Exchange will also have a chief executive officer responsible for administering its programs. The purpose of the Exchange is to reduce the number of individuals without health insurance in the state by facilitating the enrollment of individuals in qualified health benefit plans. The Exchange is authorized to accomplish this goal through its enumerated powers, which include: (i) determining which plans to offer; (ii) certifying health plans as qualified health plans; (iii) assigning a rating to each qualified plan and determining each plan’s level of coverage and health benefit options; (iv) maintaining an internet web site through which enrollees and prospective enrollees can obtain information about qualified plans; (v) informing individuals regarding eligibility requirements for the Medicaid program or any other governmental health insurance programs; and (vi) screening applications for such program eligibility, all in accordance with the Affordable Care Act. The Exchange will also (a) offer a program for the collection and administration of premiums, (b) grant certifications to individuals for the purpose of notifying the Internal Revenue Service of individuals exempt from the individual responsibility penalty under the Affordable Care Act, and (c) conduct public education and enrollment through firms referred to as “Navigators.” As of January 1, 2014, the Exchange is to offer different qualified health plans to qualified individuals and employers. Qualified health plans will be offered at different levels and must comply with minimum standards with respect to premium increases, claims payment policies and practices, financial disclosures, data reporting, out-of-network coverage and other data reporting requirements.

10. AN ACT CONCERNING HEALTHCARE REFORM. **See Public Act No. 11-58.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00058-R00HB-06308-PA.htm>

a. **Section 11: State-Wide Multipayer Data Initiative (effective 7/1/2011).** Public Act 11-58 (the “Act”) provides that the Office of Health Reform and Innovation (as discussed in subsection (c)) must convene a working group to develop a plan to implement a state-wide multipayer data initiative to enhance the state’s use of health care data to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors. The working group is charged with submitting a report to the legislature.

⁷ SCID (aka “bubble boy disease”) is a primary immune deficiency disease. The defining characteristic is usually a severe defect in both the T- & B-lymphocyte systems. This usually results in the onset of one or more serious infections within the first few months of life including, but not limited to, pneumonia, meningitis or bloodstream infections.

- b. **Section 12: Reporting of Inpatient Discharge Data (effective 7/1/2011).** The Act requires that each hospital submit to the Office of Health Reform and Innovation patient-identifiable inpatient discharge data and ambulatory surgery center and emergency department data. A committee of industry representatives shall be convened to review and make specific recommendations with respect to obstacles and new reporting requirements in the outpatient setting. All reported data shall be considered confidential and not subject to Freedom of Information Act requests; provided, however, de-identified information may be released to the public. In addition, OHCA will permit the State Comptroller access to the data, provided the Comptroller agrees to maintain the confidentiality of such information.
- c. **Section 13: Establishment of the Office of Health Reform and Innovation (effective 7/1/2011).** The Act requires the establishment of the Office of Health Reform and Innovation to serve as the Special Advisor to the Governor on Healthcare Reform. The Office of Health Reform and Innovation shall be responsible for: (i) coordinating state and federal health care reform efforts; (ii) identifying grants and other funding sources to enhance access to health care, reduce costs and increase the quality of health care in the state; (iii) recommending legislation to implement the Affordable Care Act; (iv) promoting public input and transparency in implementing health care reform; and (v) ensuring coordination in efforts among the relevant state agencies implementing health care reform, including coordination with Medicaid enrollment planning. The Office of Healthcare Reform and Innovation shall also convene a consumer advisory board that consists of not less than 7 members in consultation with the Sustinet Health Care Cabinet.
- d. **Section 14: Establishment of the Sustinet Health Care Cabinet (effective 7/1/2011).** The Act establishes the Sustinet Health Care Cabinet to advise the Governor and the Office of Health Reform and Innovation with respect to: (i) ensuring an adequate healthcare force in the state; (ii) implementing a basic health program option under the Affordable Care Act; (iii) submitting a business plan along with risk analysis and recommendations to the Governor and the Office of Health Reform and Innovation regarding providing adequate health insurance products commencing July 1, 2014; and (iv) advising the Governor regarding state and federal health care policies, priorities and objectives for improving health care access and the quality, affordability and sustainability of the state's healthcare system.

11. AN ACT CONCERNING THE UNIVERSITY OF CONNECTICUT HEALTH CENTER. **See Public Act No. 11-75.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00075-R00SB-01152-PA.htm>

- a. **Section 1: New UCONN Health Center Projects and Funding (effective 7/8/2011).** The University of Connecticut ("UCONN") Health Center and John Dempsey Hospital are to advance health care, education and economic development in Connecticut by encouraging collaboration, innovation, job creation and new investment by UCONN, various hospitals and other institutions involved in the health and bioscience industries of UCONN. Public Act 11-75 (the "Act") now calls for the construction of a new ambulatory care center at the UCONN Health Center. The Act, however, deletes UCONN's directive to have: (i) an institute for clinical and translational science on the campus of UCONN's Health Center; and (ii) a Connecticut Institute for Nursing Excellence on the campus of the UCONN School of Nursing.
- b. **Section 3: Funding of UCONN Health Center Projects (effective 7/8/2011).** In order to finance the acquisition, construction, reconstruction, improvement or equipping of any project, UCONN may borrow money and issue securities. The

Act provides that UCONN cannot borrow money or issue securities that exceed the aggregate principal amount of \$1,719,900,000 for the fiscal years ending June 30, 2006, to June 30, 2018 (inclusive), which is an increase from the previous amount of \$1,457,000,000.

- c. **Section 4: Allocation of Funds for UCONN Health Center Projects (effective 7/8/2011).** The Act increases the amount of funds to be allocated to the renovation of UCONN Health Center's Main Building from \$50,000,000 to \$125,000,000 and increases the amount of funds to be allocated to the new construction and renovation of UCONN's Health Center from \$207,000,000 to \$394,900,000.
- d. **Section 4: UCONN Health Center's Contribution Obligations (effective 7/8/2011).** The Act provides that the UCONN Health Center shall: (i) contribute not less than \$69,000,000 of funds from operations, special eligible gifts or other sources toward the UCONN Health Center's new construction and renovation; and (ii) provide for construction of a new ambulatory care center through debt or equity financing obtained from one or more private developers who contract with UCONN to construct such new ambulatory care center.
- e. **Section 7: Extension of NICU Transfer and Increase in Bed Capacity of John Dempsey Hospital Deadline (effective 7/8/2011).** Not later than June 30, 2011, Connecticut Children's Medical Center ("CCMC") and John Dempsey Hospital shall: (i) jointly notify the Office of Policy and Management ("OPM") regarding their agreement to proceed with the NICU transfer and increase in bed capacity of John Dempsey Hospital; or (ii) notify OPM, either jointly or individually, that CCMC, John Dempsey Hospital, or both, have abandoned their plans to proceed with the NICU transfer and increase in bed capacity.

12. AN ACT CONCERNING THE PHARMACY PRACTICE ACT AND PRACTITIONER CONTROLLED SUBSTANCE REGISTRATION. **See Public Act No. 11-121.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00121-R00HB-06354-PA.htm>

- a. **Section 6: Denial of Controlled Substance Registration (effective 1/1/2012).** Public Act 11-121 (the "Act") provides that in determining whether to deny a health care provider's registration to distribute, prescribe, administer or dispense any controlled substance, the Department of Consumer Protection ("DCP") shall now also consider whether there has been a suspension, revocation, expiration or surrender of, or other disciplinary action taken against, any other professional license or registration held by the health care provider.
- b. **Section 7: Sufficient Cause for Disciplinary Action Against Controlled Substance Registration (effective 1/1/2012).** DCP must have "sufficient cause" to suspend, revoke or refuse to renew a health care provider's controlled substance registration. The Act expands the definition of "sufficient cause" to now include the "suspension, revocation, expiration, surrender or other disciplinary action taken against any professional license or registration held by the practitioner."

13. AN ACT CONCERNING MOST FAVORED NATION CLAUSES IN HEALTH CARE PROVIDER CONTRACTS. **See Public Act No. 11-132.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00132-R00HB-06471-PA.htm>

- a. **Section 2: Managed Care Organization Contract Restrictions (effective 10/1/2011).** Public Act 11-132 provides that a "contracting health organization"

(aka a managed care organization or “MCO”) cannot include in any participating provider contract, contract with a dentist or contract with a hospital, that is entered into, renewed or amended on or after October 1, 2011 any clause, covenant or agreement that: (i) requires the provider, dentist or hospital to (a) disclose to the MCO the provider’s, dentist’s or hospital’s payment or reimbursement rates from any other MCO the provider, dentist or hospital has contracted, or may contract with, (b) provide services or procedures to the MCO at a payment or reimbursement rate equal to or lower than the lowest of such rates the provider, dentist or hospital has contracted, or may contract, with any other MCO or (c) certify to the MCO that the provider, dentist or hospital has not contracted with any other MCO to provide services or procedures at a payment or reimbursement rate lower than the rates contracted for with the MCO; (ii) prohibits or limits the provider, dentist or hospital from contracting with any other MCO to provide services or procedures at a payment or reimbursement rate lower than the rates contracted for with the MCO; or (iii) allows the MCO to terminate or renegotiate a contract with the provider, dentist or hospital prior to renewal if the provider, dentist or hospital contracts with any other MCO to provide services or procedures at a lower payment or reimbursement rate than the rates contracted for with the MCO. In addition, please note that if a contract is already in effect prior to October 1, 2011, and includes a prohibited clause, covenant or agreement as described above, such clause, covenant or agreement shall be void and unenforceable on the date such contract is next renewed or on January 1, 2014, whichever is earlier. Such invalidity shall not affect other provisions of such contract. It would seem that “Most Favored Nation” clauses will now be a thing of the past in Connecticut.

14. AN ACT CONCERNING ADMINISTRATIVE HEARINGS UNDER THE MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM AND RETURN RECEIPTS FOR AGENCY NOTICES. **See Public Act No. 11-137.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00137-R00HB-06357-PA.htm>
- a. **Section 1: Electronic Health Record (“EHR”) Incentive Program (effective 7/8/2011).** Public Act 11-137 (the “Act”) provides that, pursuant to Section 4201 of the American Recovery and Reinvestment Act of 2009, DSS shall establish a Medicaid EHR incentive program to provide incentives for hospitals and other health care providers⁸ which adopt and meaningfully use EHR. For your reference, please click on the following link for our previous Client Alert regarding EHR Incentive programs. [<http://www.shipmangoodwin.com/files/upload/HealthLawAlertEHR092010.pdf>]
- b. **Section 1: Adverse Decision Regarding EHR Incentives (effective date 7/8/2011).** The Act provides that a hospital or other health care provider that receives an adverse decision by DSS under the Medicaid EHR incentive program concerning the hospital’s or provider’s: (i) eligibility for incentive payments; (ii) incentive payment amounts; (iii) demonstration of adopting, implementing or upgrading an EHR; or (iv) fulfillment of meaningful use criteria may request DSS to review its decision or pursue an administrative hearing to contest DSS’s determination.

⁸ For purposes of the EHR Incentive Program, “hospital” shall have the same meaning as provided in section 19a-490 and “other health care provider” means any person, corporation, limited liability company, organization, partnership, firm, association, facility or institution that is licensed or certified by the state to provide health care services and contracts with DSS to provide such services to recipients of benefits under the Medicaid program.

15. AN ACT CONCERNING MEDICAL FOUNDATIONS. **See Public Act No. 11-151.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00151-R00HB-06614-PA.htm>
- a. **Section 2: Medical Schools (effective 10/1/2011).** Public Act 11-151 permits medical schools to organize and become a member of a medical foundation. Previously, only hospitals and health systems were permitted to do so.
16. AN ACT CONCERNING ACCESS TO RECORDS OF THE DEPARTMENT OF CHILDREN AND FAMILIES. **See Public Act No. 11-167.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00167-R00SB-01043-PA.htm>
- a. **Section 1: Who May View Records or Give Consent (effective 10/1/2011).** Public Act 11-167 (the “Act”) permits a *guardian ad litem* and an attorney to act as an “authorized representative”. This means that these individuals now have the ability to request and receive Department of Children and Families (“DCF”) records on behalf of the individual they are representing. The Act also eliminates the ability of a parent whose parental rights have been terminated to consent to the disclosure of a minor’s records or to access such records.
- b. **Section 1: Revisions to Existing Mandatory Disclosures (effective 10/1/2011).** The Act makes revisions to various existing mandatory disclosures, as follows: (i) broadens required disclosure to DCF employees by requiring disclosure for any reason reasonably related to DCF’s purposes; (ii) broadens information that must be given to physicians and others authorized to take children and youth into protective custody; (iii) restricts prosecutors’ access to delinquency records; (iv) removes current restrictions on the chief child protection attorney’s use of DCF records; (v) adds that the State Legislature’s Human Services Committee may receive records in the course of their official functions; (vi) requires disclosure to the Department of Motor Vehicles (“DMV”) of information obtained in child abuse investigations; and (vii) requires disclosure to law enforcement only for purposes of investigating child abuse cases.
- c. **Section 1: New Mandatory Disclosures (effective 10/1/2011).** The Act now requires DCF to disclose records without consent to the following parties now: (i) the child advocate or designee; (ii) foster or prospective adoptive parents, but only records relating to social, medical, psychological, or educational needs of children currently placed with them or being considered for placement, and so long as no information that identifies biological parents is disclosed without the biological parents’ consent; (iii) DMHAS, for the purpose of treatment planning for young adults who have transitioned from DCF care; (iv) Superior Court judges in criminal prosecutions, for purposes of an in camera review if the court has ordered that it be given the record or a party to the proceeding has subpoenaed the record; (v) probate court judges as required to perform their official duties; and (vi) DDS for determining eligibility, facilitating enrollment, and planning services for a DDS client who is not participating in its voluntary services program.
- d. **Section 1: Certain Permissive Disclosures Now Mandatory (effective 10/1/2011).** The Act requires DCF to disclose records to: (i) the attorney general’s office for the purpose of representing DCF; (ii) the Auditors of Public Accounts; and (iii) Superior Court judges to assist the judge in deciding how to dispose of a delinquency or family with a service needs matter.

- e. **Section 1: New Permissive Disclosures (effective 10/1/2011).** The Act now permits DCF to disclose records without consent to the following parties: (i) DCF employees or former employees, or their authorized representatives, for purposes of participating in any court, administrative, or disciplinary hearing, as long as DCF discloses only records it determines are relevant to the proceeding; (ii) providers of professional services for children, youth, and parents, provided disclosure is limited to information they need to provide services; (iii) DCF contractors, to identify and assess potential foster and adoptive parents, as long as no information identifying a child's or youth's biological parent is disclosed without that parent's consent; (iv) law enforcement officers and prosecutors if there is reasonable cause to believe a child or youth is being, or is at risk of being, abused or neglected as a result of criminal activity; (v) anyone interviewed in a child abuse or neglect investigation who is not otherwise entitled to disclosure, as long as the information disclosed is limited to (a) the general nature of the allegations, (b) the identity of the alleged victim, and (c) information needed to effectively conduct the investigation; (vi) individuals who are looking for a missing parent, child, or youth, provided the disclosure is limited to information that helps in the search; (vii) a court, when a DCF employee is subpoenaed and ordered to testify about the records; and (viii) non-DCF employees who arrange, perform, or help perform functions on DCF's behalf. The Act eliminates the requirement that DCF find the disclosure to be in the subject's best interest prior to making the disclosure.
- f. **Section 1: Public Information (effective 10/1/2011).** The Act permits DCF to disclose records without consent to any individual when information concerning an incident of abuse or neglect has been made public or DCF reasonably believes publication of such information is likely. The disclosure is limited to: (i) reporting information; (ii) in general terms, any action taken by DCF; (iii) confirmation or denial of the accuracy of information that has been made public; and (iv) in general terms, the legal status of a case.
- g. **Section 1: Confidentiality of Abuse or Neglect Reporter (effective 10/1/2011).** The Act amends current law to provide that the name of an abuse reporter shall be kept confidential upon: (i) request; or (ii) DCF determining that disclosing the reporter's name might be detrimental to the reporter's safety or interests. However, DCF is required to disclose the reporter's name (and the name of people who cooperate with an investigation) to: (a) a DCF employee for reasons reasonably related to DCF business; (b) state's attorney for purposes of investigating or prosecuting abuse or neglect; (c) an assistant attorney general or other legal counsel representing DCF; (d) a Superior Court judge and all necessary parties in abuse and neglect proceedings or a criminal prosecution involving abuse or neglect; (e) a state child care licensing agency; or (vi) the executive director of any institution, school, or facility, or superintendent of schools.
- h. **Section 1: Disclosure Procedure (effective 10/1/2011).** The Act permits DCF to refuse to disclose records to an individual if DCF: (i) notifies the requestor that the records are being withheld; (ii) informs the requestor of the record's general contents; (iii) provides its reasons for the withholding; and (iv) gives notice of judicial relief options. The Act also expands the reasons a court may uphold DCF's non-disclosure decisions. Currently, a court may uphold DCF's refusal to disclose if it finds that disclosure would be contrary to the individual's interests. Under the Act, the court may also uphold DCF's decision when it determines that disclosure: (i) would be contrary to the best interests of the person who is the subject of the record; (ii) could reasonably result in harm to any person; or (iii) would contravene the state's public policy.

17. AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS. **See Public Act No. 11-175.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00175-R00SB-00970-PA.htm>

- a. **Section 1: Workplace Safety Committee (effective 7/1/2011).** On or before October 1, 2011, Public Act 11-175 (the “Act”) requires “health care employers”⁹ to convene a workplace safety committee to address health and safety issues pertaining to “health care employees.”¹⁰ The workplace safety committee must include representatives from the administration; physician, nursing and other direct patient care staff; security personnel; and any other staff determined appropriate by the employer. The committee must select a chairperson from its membership. It must meet at least quarterly and make meeting minutes and other records of proceedings available to all employees. For your convenience, please click on the following link for a sample Workplace Violence Prevention Policy. [<http://www.shipmangoodwin.com/files/upload/ModelWorkplaceViolencePreventionPolicy.pdf>]
- b. **Section 1: Workplace Violence Prevention and Response Plan (effective 7/1/2011).** By October 1, 2011 and annually afterwards, each health care employer must prepare an assessment of the factors that put any health care employee at risk for workplace violence. Based on these findings, the employer, by January 1, 2012 and annually afterwards, must develop and implement a written workplace violence prevention and response plan in collaboration with the workplace safety committee. We presume that this means a facility must update its plan annually based upon its annual risk assessment. A hospital may use an existing committee to assist with the plan if at least 50% of the committee’s membership are nonmanagement employees. A health care employer can meet the Act’s requirements for a workplace violence prevention and response plan by using existing policies, plans, or procedures if, after performing the risk assessment, the employer, in consultation with the workplace safety committee, determines that they are sufficient.
- c. **Section 1: Adjusting Patient Assignments (effective 7/1/2011).** To the extent practicable, a health care employer must adjust patient care assignments so that an employee requesting an adjustment does not have to treat a patient who the employer knows has intentionally physically abused or threatened the employee. When adjusting patient care assignments, the employer must consider its obligation to meet the needs of all patients. Where adjusting the patient assignment is not practicable, an employee who has been physically abused or threatened by a patient may request that a second employee be present when treating the patient.
- d. **Section 2: Records and Reporting (effective 10/1/2011).** Health care employers must maintain records of workplace violence and the records must include the specific area or department of the employer’s premises where the incident occurred. Upon DPH’s request, health care employers must report to DPH the number of workplace violence incidents occurring on the employer’s premises and the specific area or department where such incidents occurred.

⁹ “Health care employer includes hospitals; residential care homes; health care facilities for the handicapped; nursing homes; rest homes; home health care agencies; homemaker-home health aide agencies; assisted living services agencies; outpatient surgical facilities; infirmaries operated by educational institutions; facilities caring for or treating mentally ill persons or substance abusers; licensed residential care facilities for persons with intellectual disability; and community health centers.”

¹⁰ “Health care employee means any individual directly or indirectly employed by, or serving as a volunteer for, a health care employer, who (i) is involved in direct patient care, or (ii) has direct contact with the patient or the patient’s family when (i) collecting or processing information needed for patient forms and record documentation, or (ii) escorting or directing the patient or the patient’s family on the premises of the health care employer.”

- e. **Section 3: Reporting to Local Law Enforcement (effective 10/1/2011).** The Act requires health care employers to report to local law enforcement “any act which may constitute an assault or related offense” against a health care employee, unless the act was committed by a person with a mental or physical disability or mental retardation. The notice must be provided within 24 hours of the occurrence of the act.
 - f. **Section 4: Assault of Health Care Personnel (effective 10/1/2011).** The Act makes assault of a health care employee a Class C felony. The Act also specifies that a mental or physical disability or mental retardation may be a defense to the assault of a health care employee.
18. AN ACT REQUIRING CERTIFICATE OF NEED APPROVAL FOR THE TERMINATION OF INPATIENT AND OUTPATIENT SERVICES BY A HOSPITAL. **See Public Act 11-183.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00183-R00HB-05048-PA.htm>
- a. **Section 1: CON Required (effective 7/13/2011).** Public Act 11-183 (the “Act”) requires a hospital to obtain a CON for the termination of inpatient or outpatient services offered by the hospital. The Act also requires an outpatient surgical facility (aka an “ambulatory surgery center”), or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, to obtain a CON for the termination of surgical services, unless the termination is due to either insufficient patient volume or the termination of any subspecialty service.
19. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH’S OVERSIGHT RESPONSIBILITIES RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS. **See Public Act No. 11-209.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00209-R00HB-06549-PA.htm>
- a. **Section 1: Scope of Practice Requests (effective 7/1/2011).** Public Act 11-209 (the “Act”) sets forth the framework and related policies and procedures for persons or entities to establish a new scope of practice or change a profession’s scope of practice. One must submit a written scope of practice request to DPH not later than August 15th of the year preceding the commencement of the next regular session of the General Assembly.
 - b. **Section 1: Contents of Written Scope of Practice Requests (effective 7/1/2011).** The Act lists the information that the written scope of practice request must contain including, but not limited to: (i) the impact that the request will have on public access to health care; and (ii) a brief summary of state or federal laws that govern the health care profession making the request.
 - c. **Section 1: Exemptions from Standard Scope of Practice Request Processes (effective 7/1/2011).** The Act provides that any person or entity may submit a request for an exemption from the standard scope of practice request process. Such request must include the reasons for the exemption, including, but not limited to: (i) exigent circumstances which necessitate an immediate response to the scope of practice request; (ii) the lack of any dispute concerning the scope of practice request; or (iii) any outstanding issues among health care professions concerning the scope of practice request that can easily be resolved. Such request for exemption shall be submitted to DPH no later than August 15th of the year preceding the commencement of the next regular session of the General Assembly.

- d. **Section 1: DPH's Decision Concerning the Scope of Practice Request (effective 7/1/2011).** The Act provides that not later than September 15th of the year preceding the commencement of the next regular session of the General Assembly, DPH shall: (i) provide written notification of the request to the General Assembly's Public Health Committee; and (ii) post any such request, including any request for exemption, and the name and address of the requestor on DPH's web site.
- e. **Section 1: Parties Impacted by Scope of Practice Request (effective 7/1/2011).** The Act provides that any person or entity that may be directly impacted by a scope of practice request may submit to DPH a written statement identifying the nature of the impact not later than October 1st of the year preceding the next regular session of the General Assembly. Not later than October 15th of such year, the requestor shall submit a written response to DPH and any person or entity that has provided a written impact statement.
- f. **Section 2: Scope of Practice Review Committee (effective 7/1/2011).** The Act provides that on or before November 1st of the year preceding the commencement of the next regular session of the General Assembly, DPH shall establish a scope of practice review committee (the "Review Committee"), to review and evaluate the scope of practice request. The Review Committee shall provide its findings to the General Assembly's Public Health Committee by February 1st following the date of the Review Committee's establishment.

20. AN ACT CONCERNING EMERGENCY MEDICAL ASSISTANCE FOR PERSONS EXPERIENCING AN OVERDOSE AND THE DESIGNATION OF CERTAIN SYNTHETIC STIMULANTS AS CONTROLLED SUBSTANCES. **See Public Act No. 11-210.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00210-R00HB-06554-PA.htm>

- a. **Sections 1 & 2: Not Guilty of Drug Possession When Done So While Providing Emergency Medical Assistance (effective 10/1/2011).** Public Act 11-210 (the "Act") provides that a person will not be guilty of illegally possessing a controlled, narcotic or hallucinogenic substance or drug paraphernalia if the person: (i) in good faith, seeks medical assistance for another person who such person reasonably believes is experiencing an overdose from the ingestion, inhalation or injection of intoxicating liquor or any drug or substance; (ii) for whom another person, in good faith, seeks medical assistance, reasonably believing such person is experiencing an overdose from the ingestion, inhalation or injection of intoxicating liquor or any drug or substance; or (iii) who reasonably believes he or she is experiencing an overdose from the ingestion, inhalation or injection of intoxicating liquor or any drug or substance and, in good faith, seeks medical assistance for himself or herself. This exception applies only when evidence of the illegal possession of the controlled, narcotic or hallucinogenic substance or use or possession of the drug paraphernalia was obtained as a result of the seeking of such medical assistance. "Good faith" does not include seeking medical assistance during the course of the execution of an arrest warrant or search warrant or a lawful search.
- b. **Section 3: Designation as a Schedule I Controlled Substance (effective 7/1/2011).** The Act provides that (i) Mephedrone (4-methylmethcathinone) and (ii) MDPV (3,4-methylenedioxypropylvalerone) shall be designated by DCP as Schedule I Controlled Substances.

21. AN ACT CONCERNING INVESTIGATIONS BY PROTECTIVE SERVICES FOR THE ELDERLY. **See Public Act No. 11-224.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00224-R00SB-00365-PA.htm>

- a. **Section 1: Penalty for False Report of Elder Abuse (effective 10/1/2011).** Public Act 11-224 (the “Act”) provides that a person who makes a report of suspected abuse, neglect, exploitation, or abandonment or need for protective services for an elderly person (an “Abuse Report”) is guilty of a Class A Misdemeanor when he/ she: (i) willfully makes a fraudulent or malicious Abuse Report to DSS; (ii) conspires with another person to make or cause to be made such Abuse Report; or (iii) willfully testifies falsely in any administrative or judicial proceeding arising from such Abuse Report.
- b. **Section 2: DSS Investigator to Interview Abused Elderly Person Alone Unless Medically Contraindicated (effective 10/1/2011).** DSS shall conduct an investigation upon receiving an Abuse Report. The investigation shall include an interview with the elderly person alone unless the elderly person refuses to consent to such interview or DSS determines that such interview is not in the best interests of the elderly person. The Act provides that this investigative interview will not be conducted alone if a physician, having examined the elderly person not more than 30 days prior to or after the date on which DSS receives such Abuse Report, provides a written letter stating that in his/her opinion an interview with the elderly person alone is medically contraindicated.

22. AN ACT CONCERNING THE TRANSFER AND DISCHARGE OF NURSING FACILITY RESIDENTS AND AUDITS OF CERTAIN LONG-TERM CARE FACILITIES. **See Public Act 11-236.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00236-R00HB-06552-PA.htm>

- a. **Section 1: Definition of Transfer (effective 7/13/2011).** Public Act No. 11-236 (the “Act”) defines “transfer” as the moving of a resident from one facility to another facility or institution (including a hospital emergency department) if that resident is admitted to the receiving facility or institution or is under the care of the receiving facility or institution for more than 24 hours.
- b. **Section 1: Notice Upon Discharge or Transfer (effective 7/13/2011).** The Act provides that notice of discharge or transfer must include, in addition to the requirements under current law, the: (i) date by which an appeal must be initiated in order to preserve the resident’s right to a hearing; (ii) date by which an appeal must be initiated in order to stay the proposed transfer or discharge; and (iii) the possibility of extending the date by which an appeal must be initiated in order to stay the proposed transfer or discharge, if the resident can show good cause.
- c. **Section 1: Appeal Rights (effective 7/13/2011).** The Act grants residents the right to appeal a transfer or discharge by submitting a written request to DSS within 60 days after the facility issues the notice of proposed transfer or discharge. In order to stay a proposed transfer or discharge, the resident must initiate an appeal within 20 days of the notice, unless the resident demonstrates good cause for failing to initiate such an appeal.
- d. **Section 1: Hearing Dates (effective 7/13/2011).** When transfers and discharges are appealed, DSS must hold a hearing between 10 and 30 days from the date of the request. Under current law, DSS must issue a decision within 60 days from the end of the hearing or 90 days from the date the hearing is requested, whichever occurs sooner. The Act reduces these time frames to 30 days and 60 days, respectively.

- e. **Section 1: Stays (effective 7/13/2011).** When DSS receives a transfer or discharge hearing request and the facility's notice is not compliant with statutory requirements, the Act requires DSS to order a stay of the transfer or discharge within 10 days "after the date of receipt of the notice" and return the notice to the facility. Once the facility receives the notice, it must issue a revised notice. This requirement does not apply in the case of an emergency or when the resident is not physically present in the facility.
- f. **Section 1: Emergency Transfers and Discharges (effective 7/13/2011).** A resident who is transferred or discharged on an emergency basis may request a hearing upon the later of 20 days after receipt of notice of transfer or discharge (instead of the current 10 days) or 20 days after the date of transfer or discharge (instead of the current 10 days). The 20 day deadline may be extended if the resident can demonstrate good cause for failing to request a hearing within the time frame. The Act also increases from 7 to 15 the number of business days DSS has from the date DSS receives the hearing request to hold the hearing, and it requires DSS to issue a decision within 30 days from the date the hearing is closed.
- g. **Section 1: Improper Transfer or Discharge (effective 7/13/2011).** If DSS determines, after a hearing, that a facility has improperly transferred or discharged a resident, it can require the facility to readmit the resident to a semi-private room or a private room, if medically necessary. DSS may require this remedy regardless of whether the resident: (i) has already accepted placement in another facility pending the hearing decision; or (ii) is awaiting availability of a bed in the facility that transferred or discharged him or her.
- h. **Section 1: Residents No Longer In Need of Care (effective 7/13/2011).** Residents who receive notice from DSS that they no longer need the level of care that the facility provides, and as a result the resident's coverage for facility care will stop, can request a hearing before the date coverage is to end. The resident's coverage must continue pending the hearing's outcome.
- i. **Section 2: Exceeding Bed Hold Period (effective 7/13/2011).** In the event a resident's hospitalization exceeds the period of time that a facility is required to reserve a resident's bed or the facility is not required to reserve a bed, the facility shall, upon receipt of notification from the hospital that a resident is medically ready for discharge, provide the resident the first bed available in a semi-private or private room, if medically necessary.
- j. **Section 2: Nursing Home Concerns With A Resident (effective 7/13/2011).** If a facility is concerned about a readmission based on its ability to meet the resident's needs or the resident presents a danger to him/herself or others, the facility must request a consultation with the hospital and the resident (or the resident's representative) within 24 hours of receiving the hospital's notice that the resident is medically ready to leave. The purpose of the consultation is to develop an appropriate care plan to meet the resident's care needs, including determining a readmission date that best meets these needs. The Act requires the resident's wishes and the hospital's recommendations to be considered as part of the consultation process. The facility must reserve a bed until the consultation process is complete. The consultation must begin as soon as practicable and must be completed within 3 business days after the facility requests it. The hospital must participate in the consultation, grant the facility access to the resident in the hospital, and permit the facility to review the resident's hospital records.

- k. **Section 2: Refusal To Readmit (effective 7/13/2011).** The Act provides that a facility may not refuse to readmit a resident unless: (i) it cannot meet the resident's needs; (ii) the resident no longer needs the facility's services due to improved health; or (iii) other residents' health and safety would be endangered if the facility were to readmit the resident. If a facility decides to refuse to readmit a resident either without requesting a consultation or following a consultation, it must notify, in writing, the hospital, the resident, and the resident's guardian, conservator, legally liable relative, or other responsible party within 24 hours of making the decision. The notice must include the following: (a) the refusal; (b) the reasons for the refusal; (c) the resident's right to appeal and procedures for initiating the appeal; (d) notice that the resident has 20 days from the date he or she receives the notice to initiate an appeal and the possibility to extend this deadline for good cause; (e) contact information for the Long-Term Care Ombudsman; (f) the resident's right to representation; and (g) if the resident is, or the facility alleges a resident is, mentally ill or developmentally disabled, the contact information of the Office of Protection and Advocacy for Persons with Disabilities. The Act provides that a resident may file a complaint with DSS if, following a consultation, the facility does not readmit the resident.

- l. **Section 2: Improper Refusal Of Readmission (effective 7/13/2011).** In the event a resident has been improperly refused readmission to a facility, the resident shall retain the right to be readmitted to the transferring facility regardless of whether the resident has already accepted placement in another facility.

- m. **Section 3: Facilities In Receivership (effective 7/13/2011).** The Act clarifies that when a facility is placed in receivership, it is the duty of the receiver to notify each resident and each resident's guardian or conservator, if any, or legally liable relative or other responsible party, if known.

- n. **Section 4: Hospital Referrals To Nursing Facilities (effective 7/13/2011).** The Act requires a hospital to make copies of a patient's record available to a facility whenever it refers the patient to a nursing facility as part of the discharge planning process or when the patient requests such a referral. The hospital must also allow the facility access to the patient for care planning and consultation.

- o. **Section 6: DSS Audits (effective 7/13/2011).**

Overview. The Act provides that DSS shall conduct audits of licensed chronic and convalescent nursing homes, chronic disease hospitals associated with a chronic and convalescent nursing home, rest homes with nursing supervision, licensed residential care homes, and residential facilities for the mentally retarded that are certified as intermediate care facilities. DSS must provide written notification of an audit to the facility at least 30 days prior, unless DSS determines, that: (i) the health or safety of recipient of services is at risk; or (ii) the facility is engaging in vendor fraud.

Extrapolation. The finding of an overpayment or underpayment by DSS shall not be based on extrapolated projections unless: (i) there is a high or sustained level of payment error involving the facility; (ii) documented educational intervention has failed to correct the level of payment error; or (iii) the value of the claims in aggregate exceeds \$150,000 on an annual basis.

Process. The Act provides that a facility shall have at least 30 days to provide documentation in response to audit findings. DSS must prepare a preliminary report no more than 60 days after the end of the audit and hold an exit conference with the facility to discuss the preliminary report. Within 60 days of the exit conference, DSS

must provide to the facility a final report, unless the facility and DSS agree to a later date or there are other referrals or investigations pending concerning the facility. The facility may request a rehearing within 90 days of the final report.

23. AN ACT CONCERNING VARIOUS REVISIONS TO PUBLIC HEALTH RELATED STATUTES. **See Public Act No. 11-242.** <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00242-R00HB-06618-PA.htm>

- a. **Section 1: DPH Disciplinary Action (effective 7/1/2011).** Public Act 11-242 (the “Act”) provides that DPH, or any board or commission under its jurisdiction, may take disciplinary action against a practitioner’s license or permit as a result of the practitioner having been subject to disciplinary action by a duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction (collectively, a “Foreign Agency”). Such board or commission or DPH may also rely upon the findings and conclusions made by the Foreign Agency.
- b. **Section 3: DPH License Suspension or Restriction During Pendency of Investigation (effective 7/1/2011).** DPH may conduct any necessary investigation in connection with complaints regarding persons subject to regulation or licensing by DPH. The Act now provides that in connection with any such investigation, DPH may restrict, suspend or otherwise limit the license or permit of any person subject to regulation or licensing by DPH pursuant to an interim consent order entered during the pendency of such investigation.
- c. **Section 5: Institution’s¹¹ Responsibilities Regarding Foundlings¹² (effective 10/1/2011).** The Act provides that an agency or institution, upon accepting the temporary custody of any foundling, shall, not later than 10 days after the date of such acceptance, report to the registrar of vital statistics of the town or city where such foundling was found or voluntarily surrendered, in a format prescribed by DPH. Also and except for an infant voluntarily surrendered pursuant to the provisions of Conn. Gen. Stat. § 17a-58 (aka “The Safe Haven Act”), if a child for whom a report of foundling has been registered is later identified and a certificate of birth is found or obtained, the certificate of birth shall be substituted and the report of foundling shall be sealed and filed in a confidential file.
- d. **Section 5: Foundling Report by Hospital (effective 10/1/2011).** The Act provides that for any infant surrendered pursuant to the provisions of Conn. Gen. Stat. § 17a-58, the hospital shall prepare a report of foundling as described above. If a certificate of birth has already been filed in the state birth registry, the report of foundling shall substitute for the original certificate of birth which shall be sealed and filed in a confidential file at DPH. The original certificate of birth shall not be released except upon order of a court of competent jurisdiction.
- e. **Section 8: Conservator of the Person’s Access to Birth and Fetal Death Records and Certificates (effective 10/1/2011).** The Act provides that a conservator of the person may have access to and receive issuance of a certified copy of birth and fetal death records and certificates less than 100 years old.

¹¹ “Institution means any public or private facility that provides inpatient medical, surgical or diagnostic care or treatment, or nursing, custodial or domiciliary care, or to which persons are committed by law.”

¹² Section 4 of Public Act 11-242 provides that “foundling” means (i) a child of unknown parentage, or (ii) an infant voluntarily surrendered to hospital personnel in accordance with the provisions of Conn. Gen. Stat. § 17a-58.

- f. **Section 9: Prescription of Oral Antibiotics Without Physical Examination (effective 10/1/2011).** The Act provides that a prescribing practitioner who diagnoses a chlamydia or gonorrhea infection in a patient may prescribe and dispense oral antibiotic drugs to such patient's partner or partners in order to prevent further infection without a physical examination of such partner or partners.

- g. **Section 21: Disease Reporting Obligations of Clinical Laboratories (effective 10/1/2011).** The Act provides that a "Clinical Laboratory"¹³ shall report each finding of any disease identified on DPH's list of reportable laboratory findings to DPH not later than 48 hours after such finding. A Clinical Laboratory that reports an average of more than 30 findings per month shall make such reports electronically in a format approved by DPH. Any Clinical Laboratory that reports an average of less than 30 findings per month shall submit such reports, in writing, by telephone or in an electronic format approved by DPH. All such reports shall be confidential and not open to public inspection except as provided for in Conn. Gen. Stat. § 19a-25. DPH shall provide a copy of all such reports to the director of health of the town, city or borough in which the affected person resides or, in the absence of such information, the town where the specimen originated.

- h. **Section 25: 90 Days to File CON Application (effective 10/1/2011).** The Act provides that an applicant must file its CON application with OHCA not later than 90 days after publishing notice in the newspaper that a CON application will be submitted.

- i. **Section 33: Licensed Practical Nurses ("LPNs") (effective 7/13/2011).** In addition to licensed physicians and dentists, the Act now provides that LPNs may execute a medical regimen under the direction of physician assistants, podiatrists, and optometrists.

- j. **Sections 37 & 38: Freedom of Information Act Request Limitations (effective 10/1/2011).** The Act provides that nothing in the Freedom of Information Act shall be construed to require disclosure of: (i) communications privileged by the marital relationship, clergy-penitent relationship, doctor-patient relationship, therapist-patient relationship or any other privilege established by the common law or the general statutes, including any such records, tax returns, reports or communications that were created or made prior to the establishment of the applicable privilege under the common law or the general statutes; or (ii) records obtained during the course of inspection, investigation, examination and audit activities of an institution, as defined in Conn. Gen. Stat. § 19a-490¹⁴, that are confidential pursuant to a contract between DPH and the United States Department of Health and Human Services relating to the Medicare and Medicaid programs.

13 Section 21 of Public Act 11-242 provides that a "Clinical Laboratory" means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances.

14 "Institution means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for the mentally retarded licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded."

- k. **Section 43: Drug Screenings (effective 10/1/2011).** The Act provides that DPH, in consultation with DMHAS, must permit the use of saliva-based drug screening or urinalysis when conducting initial and subsequent drug screenings of persons who abuse substances other than alcohol at DPH-licensed facilities.
- l. **Section 45: Fluoroscopy Procedures by Physician Assistants (effective 10/1/2011).** The Act provides that prior to engaging in the use of fluoroscopy for guidance of diagnostic and therapeutic procedures, a physician assistant (“PA”) shall: (i) successfully complete a course that includes 40 hours of didactic instruction relevant to fluoroscopy which includes, but is not limited to, radiation biology and physics, exposure reduction, equipment operation, image evaluation, quality control and patient considerations; (ii) successfully complete a minimum of 40 hours of supervised clinical experience that includes a demonstration of patient dose reduction, occupational dose reduction, image recording and quality control of fluoroscopy equipment; and (iii) pass an examination prescribed by DPH. The Act also provides that a PA who is engaging in the use of fluoroscopy for guidance of diagnostic and therapeutic procedures or positioning and utilizing a mini C-arm in conjunction with fluoroscopic procedures prior to October 1, 2011, may continue to do so, without completing the course or supervised clinical experience requirements described above, provided such PA passes the examination prescribed by DPH on or before July 1, 2012.
- m. **Section 50: Hospital Pilot Program for “Electronic Technology” or “Telepharmacy” (effective 7/13/2011).** The Act provides that DCP, in consultation with DPH, may establish a pilot program to permit a hospital which operates a hospital pharmacy to use “electronic technology or telepharmacy”¹⁵ at the hospital’s satellite or remote locations for purposes of allowing a clinical pharmacist to supervise pharmacy technicians in the preparation of IV admixtures. Under the pilot program, a clinical pharmacist shall be permitted to supervise a pharmacy technician through audio and video communication. The pilot program may commence operation on or after July 1, 2011, and shall terminate not later than December 31, 2012.
- n. **Section 52: Nursing Home Transfers (effective 10/1/2011).** The Act provides that a nursing home may, without regard to the order of its waiting list, admit an applicant who seeks to transfer from a nursing home in which the applicant was placed following the closure of the nursing home where such applicant previously resided or, in the case of a nursing home placed in receivership, the anticipated closure of the nursing home where such applicant previously resided, provided: (i) the transfer occurs not later than 60 days following the date that such applicant was transferred from the nursing home where he or she previously resided; and (ii) the applicant submitted an application to the nursing home to which he or she seeks admission at the time of the applicant’s transfer from the nursing home where he or she previously resided.
- o. **Section 56: Residential Care Homes Co-Located with a Chronic and Convalescent Nursing Home or a Rest Home (effective 7/1/2011).** The Act provides that a residential care home that is co-located with a chronic and convalescent nursing home or a rest home with nursing supervision may request

¹⁵ “Electronic technology or telepharmacy means the process: (A) By which each step involved in the preparation of IV admixtures is verified through use of a bar code tracking system and documented by means of digital photographs which are electronically recorded and preserved; and (B) which is monitored and verified through video and audio communication between a licensed supervising clinical pharmacist and a pharmacy technician.”

permission from DPH to meet the requirements of section 19-13-D6(j)¹⁶ of the Public Health Code concerning attendants in residence from 10:00 p.m. to 7:00 a.m. through the use of shared personnel.

- p. **Section 56: New Residential Care Home Rules (effective 7/1/2011).** The Act provides that a residential care home shall: (i) maintain temperatures in resident rooms and all other areas used by residents at the minimum temperature of 71 degrees Fahrenheit; and (ii) ensure that the maximum time span between a resident's evening meal and breakfast does not exceed 14 hours unless a substantial bedtime nourishment is offered by the residential care home. In addition, and on and after July 1, 2011, DPH shall no longer: (i) require that a person seeking a license to operate a residential care home supply to DPH a certificate of physical and mental health, signed by a physician, at the time of an initial or subsequent application for licensure; and (ii) approve the time scheduling of regular meals and snacks in residential care homes.
- q. **Section 79: Provision of Medical Test Results by Clinical Laboratories (effective 10/1/2011).** The Act provides that upon the request of a patient or a provider who orders medical tests on behalf of a patient, a "Clinical Laboratory"¹⁷ (not including a state laboratory established by DPH) shall provide medical test results relating to the patient to any other provider who is treating the patient for the purposes of diagnosis, treatment or prognosis of such patient. In addition, a provider, who requests that his or her patient submit to repeated medical testing at regular intervals, over a specified period of time, for purposes of ascertaining a diagnosis, prognosis or recommended course of treatment for such patient, may issue a single authorization that allows the Clinical Laboratory to directly communicate the results of such testing to the patient for the period of time that such testing is requested by the provider.
- r. **Section 80: CON Required (effective 7/13/2011).** The Act provides that a CON shall be required for the termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Medicare or Medicaid.
- s. **Section 85: DPH Disciplinary Action for Health Care Institutions¹⁸ (effective 10/1/2011).** The Act provides that DPH, after a hearing, may now impose a directed plan of correction in any case in which DPH finds that there has been a substantial failure to comply with the requirements established under Chapter 368v of the Connecticut General Statutes, the Public Health Code or licensing regulations.
- t. **Sections 86 & 89: Increased Penalties for Late Payment of OHCA Assessments (effective 7/1/2011).** Conn. Gen. Stat. § 19a-632 provides that OHCA, on or before September 1st each year, shall determine: (i) the total net revenue of each hospital

16 Regs., Conn. State Agencies § 19-13-D6 (j) Attendants required. At no time shall there be less than one attendant on duty for each twenty-five residents or fraction thereof from 7 a.m. to 10 p.m. and one attendant in residence for each twenty-five residents from 10 p.m. to 7 a.m."

17 Pursuant to Section 79 of Public Act 11-242, Clinical Laboratory means "any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances."

18 "Institution means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for the mentally retarded licensed pursuant to section 17a-227 and certified to

for the most recently completed hospital fiscal year beginning October 1st; and (ii) the proposed assessment on the hospital for the state fiscal year. In addition and on or before December 31st each year, a hospital shall pay OHCA 25% of the OHCA assessment and then shall pay the remaining 75% of its assessment to OHCA in 3 equal installments on or before the following March 31st, June 30th, and September 30th. The Act provides that DPH shall impose a fee equal to (a) 2% of the assessment if such failure to pay is for not more than 5 days, (b) 5% of the assessment if such failure to pay is for more than 5 days but not more than 15 days, or (c) 10% of the assessment if such failure to pay is for more than 15 days. If a hospital fails to pay any assessment for more than 30 days after the date when due, DPH may, in addition to the aforementioned fees, impose a civil penalty of up to \$1,000 per day for each day past the initial 30 days that the assessment is not paid. In addition, the Act provides that DPH may require a hospital to pay the assessment by way of an approved method of electronic funds transfer.

u. **Section 90: Creation of Criminal History and Patient Abuse Background Search Program for Long-Term Care Facilities¹⁹ (“LTCFs”) (effective 1/1/2012).** The Act provides that DPH, on or before July 1, 2012, shall create and implement a criminal history and patient abuse background search program (the “LTCF Background Search Program”) in order to facilitate the performance, processing and analysis of the “criminal history and patient abuse background search”²⁰ of individuals who have “direct access”²¹ to individuals in LTCFs.

v. **Section 90: LTCF’s Duty to Perform Background Searches (effective 1/1/2012).** The Act provides that each LTCF, prior to extending an offer of employment to or entering into a contract for the provision of long-term care services with any individual who will have direct access, or prior to allowing any individual to have direct access while volunteering at such LTCF, shall require that such individual submit to a background search. DPH will prescribe the manner in which such background searches are performed.

w. **Section 90: Background Search Exception (effective 1/1/2012).** The Act provides that a LTCF shall not be required to perform a background search if the individual provides evidence to the LTCF that he or she submitted to a background search in accordance with the above requirements not more than 3 years immediately preceding the date such individual applies for employment, seeks to enter into a contract or begins volunteering with the LTCF and that the prior background search confirmed that the individual did not have a “disqualifying offense.”²²

19 “Long-term care facility means any facility, agency or provider that is a nursing home, as defined in section 19a-521 of the general statutes, a home health agency, as defined in section 19a-490 of the general statutes, an assisted living services agency, as defined in section 19a-490 of the general statutes, an intermediate care facility for the mentally retarded, as defined in 42 USC 1396d(d), a chronic disease hospital, as defined in section 19a-550 of the general statutes, or an agency providing hospice care which is licensed to provide such care by the DPH or certified to provide such care pursuant to 42 USC 1395x.”

20 “Criminal history and patient abuse background search or background search means (A) a review of the registry of nurse’s aides maintained by the DPH pursuant to section 20-102bb of the general statutes, (B) checks of state and national criminal history records conducted in accordance with section 29-17a of the general statutes, and (C) a review of any other registry specified by the DPH which the department deems necessary for the administration of a background search program.”

21 Section 90 of the Act provides that “direct access” means physical access to a patient or resident of a long-term care facility that affords an individual with the opportunity to commit abuse or neglect against or misappropriate the property of a patient or resident.

22 “Disqualifying offense” means a conviction of any crime described in 42 USC 1320a-7(a)(1), (2), (3) or (4) or a substantiated finding of neglect, abuse or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 USC 1395i-3(g)(1)(C) or 42 USC 1396r(g)(1)(C).

- x. **Section 90: Review of Background Search Report by DPH and Notification to Individual (effective 1/1/2012).** The Act provides that DPH shall review all background searches performed pursuant to the LTCF Background Search Program and that if any such report contains evidence indicating that an individual has a disqualifying offense, DPH shall provide notice to the individual and the LTCF indicating the disqualifying offense and providing the individual with the opportunity to file a request for a waiver.
- y. **Section 90: LTCF Background Search Program Waivers (effective 1/1/2012).** The Act provides that an individual may file a written request for a waiver with DPH not later than 30 days after the date DPH mails notice to the individual regarding a disqualifying offense. DPH shall mail a written determination indicating whether the DPH shall grant a waiver not later than 15 business days after DPH receives the request from the individual, except that the time period shall not apply to any request for a waiver in which an individual challenges the accuracy of the information obtained from the background search. DPH may grant a waiver to an individual who identifies mitigating circumstances surrounding the disqualifying offense, including: (i) inaccuracy in the information obtained from the background search; (ii) lack of a relationship between the disqualifying offense and the position for which the individual has applied; (iii) evidence that the individual has pursued or achieved rehabilitation with regard to the disqualifying offense; or (iv) that substantial time has elapsed since committing the disqualifying offense.
- z. **Section 90: Review of Background Search Report by DPH and Notification to LTCF (effective 1/1/2012).** The Act provides that DPH shall, after completing its review, notify in writing the LTCF to which the individual has applied for employment or with which the individual seeks to enter into a contract or volunteer: (i) of any disqualifying offense and any information the individual provided to DPH regarding mitigating circumstances surrounding such offense, or of the lack of a disqualifying offense; and (ii) whether DPH granted a waiver.
- aa. **Section 90: LTCF Cannot Employ or Permit Volunteers Who Have a Disqualifying Offense (effective 1/1/2012).** The Act provides that a LTCF may not employ, contract with or allow to volunteer an individual who has a disqualifying offense for which DPH has not granted a waiver. A LTCF may, but is not obligated to, employ, enter into a contract with or allow to volunteer an individual who was granted a waiver.
- bb. **Section 90: No Employment or Volunteers Until DPH Report is Provided (effective 1/1/2012).** The Act provides that a LTCF shall not employ, enter into a contract with or allow to volunteer any individual required to submit to a background search until the LTCF receives notice from DPH regarding the results of the background search. A LTCF, however, may employ, enter into a contract with or allow to volunteer an individual required to submit to a background search on a conditional basis before the LTCF receives notice from DPH that such individual does not have a disqualifying offense, provided: (i) the employment or contractual or volunteer period on a conditional basis shall last not more than 60 days; (ii) the LTCF has begun the background search review process as prescribed by DPH and the individual has submitted to such review; (iii) the individual is subject to direct, on-site supervision during the course of such conditional employment or contractual or volunteer period; and (iv) the individual, in a signed statement (a) affirms that the individual has not committed a disqualifying offense; and (b) acknowledges that a disqualifying offense reported in the background search shall constitute good cause for termination and a LTCF may terminate the individual if a disqualifying offense is reported in the background search.

- cc. **Section 90: Timeline & Application (effective 1/1/2012).** The Act provides that DPH may phase in implementation of the LTCF Background Search Program by category of LTCF. No LTCF shall be required to comply with the provisions of the LTCF Background Search Program until the date published by DPH in the Connecticut Law Journal indicating that DPH is implementing the LTCF Background Search Program for the category of LTCF.
- dd. **Section 92: National Criminal History Record Checks for Homemaker-Companion Agencies (effective 1/1/2012).** The Act provides that for any person seeking a certificate of registration as a homemaker-companion agency shall, in addition to the current requirements, submit to state and national criminal history records checks in accordance with Conn. Gen. Stat. § 29-17a.
- ee. **Section 91: DCP’s New Definition of “Comprehensive Background Checks” (effective 1/1/2012).** The Act provides that a “Comprehensive Background Check” means a background investigation of a prospective employee performed by a homemaker-companion agency, that includes: (i) a review of any application materials prepared or requested by the agency and completed by the prospective employee; (ii) an in-person interview of the prospective employee; (iii) verification of the prospective employee’s Social Security number; (iv) if the position applied for within the agency requires licensure on the part of the prospective employee, verification that the required license is in good standing; (v) a check of the registry established and maintained pursuant to Conn. Gen. Stat. § 54-257; (vi) a review of criminal conviction information obtained through a search of current criminal matters of public record in this state based on the prospective employee’s name and date of birth; (vii) if the prospective employee has resided in this state less than 3 years prior to the date of the application with the agency, a review of criminal conviction information from the state or states where such prospective employee resided during such 3-year period; and (viii) a review of any other information that the agency deems necessary in order to evaluate the suitability of the prospective employee for the position.
- ff. **Section 93: DCP’s Requirement for Homemaker-Companion Agencies²³ to Conduct “Comprehensive Background Checks” (effective 1/1/2012).** The Act provides that DCP may revoke, suspend or refuse to issue or renew any certificate of registration as a homemaker-companion agency or place an agency on probation or issue a letter of reprimand for failing to perform a comprehensive background check of a prospective employee or maintain a copy of materials obtained during a comprehensive background check.
- gg. **Section 94: Comprehensive Background Checks for Prospective Employees of Homemaker-Companion Agencies (effective 1/1/2012).** The Act provides that each homemaker-companion agency, prior to extending an offer of employment or entering into a contract with a prospective employee, shall require such prospective employee to submit to a comprehensive background check. In addition, the homemaker-companion agency shall maintain a paper or electronic copy of any materials obtained during the comprehensive background check and shall make such records available for inspection upon request of DCP.

²³ “Homemaker-companion agency means (A) any public or private organization that employs one or more persons and is engaged in the business of providing companion services or homemaker services, or (B) any Registry. Homemaker-companion agency shall not include a home health care agency, as defined in subsection (d) of section 19a-490, or a homemaker-home health aide agency, as defined in subsection (e) of section 19a-490. “Registry” means any person or entity engaged in the business of supplying or referring an individual to or placing an individual with a consumer to provide homemaker or companion services provided by such individual, when the individual providing such services is either (A) directly compensated, in whole or in part, by the consumer, or (B) treated, referred to or considered by such person or entity as an independent contractor.”



hh. Section 95: Comprehensive Background Checks for Home Health Agencies²⁴ (effective 1/1/2012). The Act provides that “comprehensive background check” means a background investigation performed by a home health agency of an applicant for employment that includes, but is not limited to: (i) a review of any application materials prepared or requested by the agency and completed by the applicant; (ii) an in-person interview of the applicant; (iii) verification of the applicant’s Social Security number; (iv) if the position applied for within the agency requires licensure on the part of the applicant, verification that the required license is in good standing; (v) a check of the registry established and maintained pursuant to Conn. Gen. Stat. § 54-257; (vi) a review of criminal conviction information obtained through a search of current criminal matters of public record in this state based on the applicant’s name and date of birth; (vii) if the applicant has resided in this state less than three years prior to the date of the application for employment, a review of criminal conviction information from the state or states where such applicant resided during such three-year period; and (viii) a review of any other information that the agency deems necessary in order to evaluate the suitability of the applicant for the position.

ii. Section 95: Comprehensive Background Checks for a Home Health Agency’s Prospective Employees (effective 1/1/2012). The Act provides that each home health agency, prior to extending an offer of employment to an applicant, shall require such applicant to submit to a comprehensive background check (the “HHA Background Check Program”). In addition, each home health agency shall require that any such applicant complete and sign a form disclosing whether the applicant was subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction. Any applicant who makes a false statement regarding such prior disciplinary action with intent to mislead the home health agency shall be guilty of a Class A misdemeanor.

jj. Section 95: Discontinuation of HHA Background Check Program (effective 1/1/2012). The Act provides that the HHA Background Check Program shall end on the date DPH publishes notice in the Connecticut Law Journal of DPH’s implementation and application of the LTCF Background Search Program to home health agencies.

Questions or Assistance? If you have any further questions regarding the legislation outlined above, please feel free to contact one of the members of our Health Law Practice Group as listed on page 1 of this summary.

²⁴ Section 95 of Public Act 11-242 provides that “Home health agency” means an agency licensed as a home health care agency or a homemaker-home health aide agency.

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