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

2003 LEGISLATIVE SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

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2003 LEGISLATIVE SUMMARY

I. KEY BUDGET IMPLEMENTER LAW PROVISIONS

1. PUBLIC ACT 03-3: AN ACT CONCERNING PUBLIC HEALTH, HUMAN SERVICES AND OTHER MISCELLANEOUS IMPLEMENTER PROVISIONS

EFFECTIVE DATES: as noted.

A. NURSING HOME FIRE SPRINKLERS

§ 11-NURSING HOME FIRE SPRINKLERS. This provision requires the Connecticut Health and Educational Facilities Authority (CHEFA) to develop a plan for planning for and financing the installation of automatic fire sprinklers in chronic and convalescent nursing homes and rest homes with nursing supervision. CHEFA must do this in conjunction with the Departments of Public Safety, Social Services and Public Health. The plan must be submitted to the governor and the legislative committees of cognizance by February 1, 2004.

EFFECTIVE DATE: Upon passage

§ 92-NURSING HOME AUTOMATIC FIRE EXTINGUISHING SYSTEMS REQUIRED. This provision requires that each floor of each nursing home (chronic and convalescent nursing home and rest home with nursing supervision) have an automatic fire extinguishing system approved by the state fire marshal by July 1, 2005. It requires each home's owner or authorized agent, by July 1, 2004, to (1) submit plans for installing such a system, signed and sealed by a licensed professional engineer, to the local fire marshal and building official or to the state fire marshal, as the case may be, and (2) apply for a building permit to install the system.

Anyone who fails to install the required automatic fire extinguishing systems is subject to a civil penalty of up to $1,000 for each day the violation continues. This provision requires the attorney general, at the state fire marshal's request, to begin a civil action to recover the penalty.

This section applies to nursing homes as well as other buildings already required to have automatic fire extinguishing systems. These other buildings include:

1. new buildings with more than four stories built for human occupancy;
2. all residential buildings with more than four stories and occupied primarily by the elderly;
3. any residential building occupied primarily by, or designed primarily for, elderly occupants, if the building has more than 12 living units and is issued a building permit for new occupancy or is substantially renovated on or after January 1, 1997;

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4. any hotel or motel with more than five guest rooms that provides sleeping accommodations for more than 16 persons and is issued a building permit for new occupancy on or after Jan. 1, 1987;
5. hotels or motels with more than four stories; and
6. new educational buildings that are eligible for a school building project grant and put out to bid on or after July 1, 2004.

EFFECTIVE DATE: Upon passage

B. NURSING HOME ADMINISTRATOR LICENSURE CHANGES

§20 – The renewal period for Nursing Home Administrators' licenses is extended from annually to every two years, and the renewal fee is raised to $100 from $50. Forty hours of CEUs are required during each registration period, starting with the first date of renewal after October 1, 2004. Licensees must obtain a certificate of completion for CEUs and retain such certificate for a minimum of three years. The Department of Public Health may request that licensee submit the certificate to the department. First-time licensees are exempt, and the department may grant a waiver or extension for a licensee who has a medical disability or illness. Additional detail outlining acceptable courses, documentation requirements and entities that may offer or approve courses may be found in the summary for Public Act 03-118 (An Act Concerning Continuing Education for Professions Regulated by the Department of Public Health, page 16).
EFFECTIVE DATE: January 1, 2004

C. NURSING HOME FEES, RATES, RECEIVERSHIP & CLOSURE PROVISIONS

§ 28-HEALTH CARE INSTITUTION LICENSING, FEES, AND CODE COMPLIANCE

Licensing and Fees. This section extends the licensing period and increases the licensing fees for certain health care institutions, including residential care homes; it extends the licensing period for residential care homes from two to three years and the licensing fees from $300 to $450 per site and $3.00 to $4.50 per bed. In addition, for all health care institutions, DPH must charge $400 for technical assistance provided for design review and development of an institution's construction, sale or change in ownership.

Code Compliance. This section changes the requirement that the owner of real property on or in which a licensed health care institution in located biennially obtain a DPH certification of compliance. With the new law, instead of obtaining a DPH certificate, the property or building owners that are not the institution's license holder must submit a copy of the lease agreement to DPH indicating the person or entity responsible for maintenance and repair. The lease must be submitted whenever the institution's license is renewed and whenever the property owner changes.
EFFECTIVE DATE: January 1, 2004

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§ 50 - NURSING HOME RATES

The bill generally freezes Medicaid payments to nursing homes at their June 30, 2003 level for FY 2003-04 and the first half of FY 2004-05 and schedules a 1% increase for January 1, 2005. However, homes that would have received a lower rate on July 1, 2003 or 2004 than they had for the prior fiscal year because of their interim rate status or agreement with DSS will receive that lower rate until the January 1, 2005 increase, which also applies to them.

Also, the DSS commissioner is prohibited from adjusting a nursing home's annual rate for 2003-04 and 2004-05 for any reason other than to: (1) reflect the permitted percentage increase, (2) lower a rate, or (3) allow inclusion of extraordinary and unanticipated costs in accordance with existing law, which allows inclusion of these items if they are incurred to provide services to avoid an immediate negative impact on patients' health and safety.
EFFECTIVE DATE: Upon passage

D. NURSING HOME RECEIVERSHIP

§ 50 – RATES FOR NURSING HOMES IN RECEIVERSHIP UPON THEIR SALE. With this section, the interim rate DSS establishes to become effective upon sale of a nursing home that is in receivership cannot exceed the rate in effect for it when the receivership was imposed, subject to any annual increases allow in law. But if that rate is less than the median rate for the facility's peer grouping, the commissioner may, in her discretion, give the facility a higher rate up to the median rate. The commissioner can only exceed the median rate if the OPM secretary, after reviewing area nursing home bed availability and other pertinent factors, authorizes her to set a rate higher than the median.
EFFECTIVE DATE: Upon passage.

§ 76 - CHOICE OF NURSING HOME RECEIVERS. This section requires a court, in appointing a receiver for a nursing home, to choose only a responsible individual (1) whose name the DSS and DPH commissioners propose and (2) who is a Connecticut-licensed nursing home administrator with substantial experience in operating Connecticut nursing homes. The DSS commissioner must adopt regulations governing qualifications for proposed receivers consistent with this provision by July 1, 2004. Previously, the court could choose any responsible individual except a state employee, that nursing home's owner or administrator, or anyone else with a financial interest in the facility. The bill continues to prohibit any state employees or that nursing home's owner or administrator, or any other person with a financial interest in it from acting as a receiver for that nursing home. It also adds a prohibition on anyone who has been appointed a receiver having a financial interest in the home either currently or for five years after the receivership ends.

EFFECTIVE DATE: Upon passage

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§ 77-NURSING HOME RECEIVER POWERS. The bill requires a nursing home receiver, within 90 days after his appointment, to:

1. determine whether the facility can continue to operate and provide adequate care in substantial compliance with applicable federal and state law within the total of state payments as established by the DSS commissioner, income from self-pay residents, Medicare payments, and other current income;

2. report his determination to the court; and

3. seek facility purchase proposals.

If the receiver determines that the facility is unable to continue to operate in substantial compliance with these requirements, he must request an immediate order of the court to close the facility and make arrangements for the orderly transfer of residents under the law's existing procedures, unless he determines that the facility's transfer to a qualified purchaser is expected within 90 days. If such a transfer is not completed within 180 days after the receiver's appointment, the bill requires the receiver to request an immediate order of the court to close the facility and arrange for the residents' orderly transfer.
EFFECTIVE DATE: Upon passage

§ 78-NEED FOR PERMISSION FROM DSS FOR COURT-ORDERED NURSING HOME CLOSURES ELIMINATED. Prior law required nursing homes that transfer ownership or control before being initially licensed, add or expand services, terminate services, or substantially decrease bed capacity to request permission from DSS to implement the change. The bill makes an exception for facility closures ordered by the Superior Court, but it still requires the facility in receivership to notify the Office of the Long-Term Care Ombudsman when it is ordered closed by the Superior Court.
EFFECTIVE DATE: Upon passage

E. TRANSFER OF ASSETS, ELIGIBILITY & WAITING LIST PROVISIONS

§ 62-LONG-TERM CARE TRANSFER OF ASSETS CHANGES. This section makes several changes related to transfers of assets undertaken to achieve Medicaid eligibility and the waiver application DSS submitted to the federal Centers for Medicare and Medicaid Services (CMS) in 2002. CMS has not yet approved the application, which would change the start date of penalties for inappropriate asset transfers by people applying for Medicaid help in paying their nursing home costs, from the date the transfers occurred to the date the person otherwise would become eligible for Medicaid. It would also change the look-back period from three years to five years for real estate transfers, and exempt small amounts of transfers from the look-back and penalties.

This section:

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1. specifies that any transfer or assignment of assets resulting in the imposition of a penalty period will be presumed to be intentionally made to enable the transferor to become or remain eligible for Medicaid and allows this presumption to be rebutted only by clear and convincing evidence to the contrary;

2. specifies that such transfers that result in penalty periods also create a "debt" as defined in the Creditors' Collection Practices statute (CGS § 36a-645) that the transferor or transferee owes to DSS in a sum equal to the amount of medical assistance provided to or on behalf of the transferor on or after the transfer date, up to the assets' fair market value on the transfer date, and gives the DSS and DAS commissioners and the attorney general authority to seek administrative, legal, or equitable relief as provided in other statutes or common law;

3. allows the DSS commissioner, at a nursing home's request, to grant the home financial relief if the nursing home establishes that (a) it is experiencing severe financial hardship because of the asset transfer penalty period beginning in the month the patient is otherwise found Medicaid-eligible instead of in the month the transfer happened and (b) it has made every effort legally permissible to recover the transferred funds owed to it;

4. prohibits the nursing home from making a request for financial relief unless the patient has been in the home for at least 90 days without payment and, if DSS agrees to grant the financial relief to the home by providing Medicaid payments, requires DSS, by all means available to it under state and federal law, to recoup the money from the patient and the transferee;

5. allows the commissioner to waive the penalty period when the transferor (a) suffers from dementia at the time he applies for Medicaid and cannot explain the transfers, (b) suffered from dementia at the time of the transfer, or (c) was exploited into making the transfer. This provision specifies that waiving the penalty period does not prohibit the establishment of a debt as described above;

6. extends the look-back period for real estate transfers from three years to five years, except for transfers of real property that are exempt under DSS regulations. This longer look-back period can only take effect once the federal government approves Connecticut's existing application for a Medicaid waiver to allow this change; transfers that do not involve real property remain subject to the current look-back period contained in federal law, which is three years generally and five years for establishment of trusts;

7. allows the commissioner to establish threshold limits for the total amount of transfers that can be made in any year of the look-back period without resulting in imposition of a penalty period; and

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8. requires the commissioner to implement the policies and procedures needed to carry out these provisions while still in the process of adopting regulations, if she publishes the notice of intent to adopt regulations in the Connecticut Law Journal within 20 days after implementation (the bill makes such policies and procedures valid until final regulations take effect).

EFFECTIVE DATE: Upon passage

§ 57-PRESUMPTIVE ELIGIBILITY. This section eliminates a requirement that the commissioner, within available appropriations, contract with qualified entities that are authorized to make applicants for Medicaid presumptively eligible for assistance.

EFFECTIVE DATE: Upon passage

§ 63-DIVERSION OF INCOME FROM INSTITUTIONALIZED SPOUSE ON MEDICAID. The bill requires someone in a nursing home who is applying for Medicaid and who has a spouse still living in the community to divert the maximum allowable income to the community spouse to raise that spouse's income to the level of the federally required minimum monthly needs allowance. The bill requires this income diversion to occur before the community spouse is allowed to retain assets above the federally mandated community spouse protected amount. The bill also allows the DSS commissioner to implement this provision while still in the process of adopting regulations, as long as she prints the notice of intent to adopt regulations in the Connecticut Law Journal within 20 days of adopting the policy. The bill makes the policy valid until final regulations take effect.

EFFECTIVE DATE: Upon passage

§ 61-STATE SUPPLEMENT PROGRAM BENEFIT FREEZE. The bill continues for the next two fiscal years the freeze on the adult payment standard (need standard) in the State Supplement Program. But it authorizes the DSS commissioner to increase the personal needs allowance component of the standard as necessary to meet federal maintenance of effort requirements.

EFFECTIVE DATE: Upon passage

§ 74-NURSING HOME WAITING LISTS. This section allows a nursing home to admit an applicant seeking to transfer from a nursing home that is closing without regard to the order of the home's waiting list, regardless of other statutory provisions.

EFFECTIVE DATE: Upon passage

F. RESIDENTIAL CARE HOME CON REQUIREMENTS, PROPERTY COST

§§ 30 & 90-EXEMPTING RESIDENTIAL CARE HOMES FROM CON REVIEW. This section exempts all residential care homes from the Office of Health Care Access' (OHCA) certificate of need (CON) review and eliminates OHCA oversight of these facilities. Previously, RCHs were exempt from the CON process unless created, acquired, operated, or in any way related to,

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affiliated with, or under the complete or partial ownership of a facility, institution, or affiliate subject to CON review. Thus, the bill removes the CON requirement for any homes not already exempt. It further eliminates the requirement that exempt residential care homes provide OHCA with information about capital projects, expansion or relocation, service changes or termination, change of ownership, or reduction in bed capacity. Previously, they were required to do this between 10 and 60 calendar days before any change or, if they were in operation on June 5, 1998, within 60 days afterward. The bill also eliminates the requirement that these homes annually renew their exemption by filing current information with OHCA. *EFFECTIVE DATE: Upon passage*

§ 50-ALLOWING ACTUAL DEBT SERVICE IN LIEU OF PROPERTY COSTS. The Department of Social Services may allow actual debt service (principal, interest and a repair and replacement reserve on the loan) in lieu of allowed property costs for loans issued to RCHs by the Connecticut Housing Finance Authority if the Commissioner determines the loan is reasonable in relation to the useful life and property cost.
EFFECTIVE DATE: Upon passage

G. PHARMACY, CONNPACE & OTHER PROVISIONS

§ 82-PHARMACISTS PROCEDURE UNDER PRIOR AUTHORIZATION. This language requires pharmacists, when filling prescriptions under Medicaid, ConnPACE and other state programs, to use the most cost-efficient dosage, consistent with the prescribing practitioner's instructions unless the pharmacist receives permission to do otherwise under the state's new prior authorization plan (which began July 16, 2003).
EFFECTIVE DATE: Upon passage

§ 83-MEDICAID PHARMACEUTICAL AND THERAPEUTICS COMMITTEE AND PREFERRED DRUG LIST. This section changes the composition of the Medicaid Pharmaceutical and Therapeutics Committee created in legislation last year (PA 02-1). This bill adds two members, for a total of fourteen, and adjusts the composition of the committee across professions. The Committee may seek participation of state agencies on an ad hoc basis. For example, one member of the Committee must be a geriatrician. The Commissioner of DSS (or her designee) must convene the committee, and DSS' administrative staff will staff the Committee.

Existing law requires DSS to adopt a preferred drug list for its medical assistance programs by July 1, 2003 in consultation with the Medicaid and Pharmaceutical Therapeutics Committee. The bill specifies that the preferred drug list is for use in the Medicaid and ConnPACE programs and that the preferred drug list and the committee's functions also apply to the SAGA program.

By law, one of the committee's functions is to make recommendations to DSS regarding the prior authorization of prescribed drugs. The bill specifies that these

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recommendations must be in accordance with the prior authorization plan already developed and implemented under existing law.
EFFECTIVE DATE: Upon passage

§ 84-PRIOR AUTHORIZATION-BRAND NAME VS. GENERIC DRUGS. Current law generally requires prior authorization for pharmacists to dispense brand name drugs under Medicaid, ConnPACE, SAGA and other state programs, if a chemically equivalent generic drug is available at lower cost. The bill requires that in cases where the brand name drug is less costly than the generic drug (factoring in manufacturers' rebates), the pharmacist must dispense the brand name drug.
EFFECTIVE DATE: Upon passage

§ 69-DENYING PRESCRIPTIONS FOR FAILURE TO PAY CO-PAYMENTS. The DSS commissioner is required by September 30, 2003 to submit a Medicaid state plan amendment to allow pharmacies to refuse to fill Medicaid prescriptions for program beneficiaries who demonstrate a documented and continuous failure to pay co-payments in spite of their ability to make these payments. The language defines "continuous failure" as failure to (1) make required co-payments within six months from when a prescription is filled or (2) make required co-payments on six or more prescriptions when these prescriptions are filled during any six-month period.

The amendment must allow for a resumption of drug benefits once the beneficiary pays all of his outstanding co-payments. The state plan amendment shall not apply to prescriptions for psychotropic drug therapies.
EFFECTIVE DATE: Upon passage

§ 52-PHARMACY REIMBURSEMENT CUT. This provision reduces pharmacies' per-prescription dispensing fee by 30 cents from $3.60 to $3.30 starting October 1, 2003 in the Medicaid, ConnPACE, SAGA, the Connecticut AIDS Drug Assistance Program and other state programs. The new language allows DSS to provide an enhanced dispensing fee to a pharmacy enrolled in the federal Office of Pharmacy Affairs Section 340B drug discount program or a pharmacy under contract to provide services under that program.
EFFECTIVE DATE: Upon passage

§ 58-CONNPACE ASSET TEST. This section imposes an asset test on ConnPACE participants. It sets the asset limit at $100,000 in liquid assets for single participants and $125,000 for married couples. It specifies that available assets are those that are considered available under the Connecticut Home Care for Elders Program (which excludes the value of a home and certain other property).
EFFECTIVE DATE: October 1, 2003

§ 59-CONNPACE ESTATE RECOVERY, PUBLIC ASSISTANCE, AND ANNUITY RECOVERIES. This language gives the state a claim starting

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September 1, 2003 on the estates of deceased ConnPACE beneficiaries to recoup the money the state has paid to help them with their prescription expenses. The change applies to deaths on or after September 1, 2003 and allows recoupment only of ConnPACE benefits the deceased person actually received on or after July 1, 2003.

For estate recovery purposes, the bill also makes all annuity sums due on or after July 1, 2003 to anyone after the death of a public assistance recipient part of the deceased person's estate and consequently accessible to the state for repayment of public assistance benefits, irrespective of any provision of law, if the annuity contract was purchased at any time with the public assistance recipient's assets. It makes the annuity beneficiary solely liable to the state for repayment of public assistance granted to the deceased person up to the amount of the payments the annuity beneficiary received.
EFFECTIVE DATE: Upon passage

§ 43, § 96 – STATE ADMINISTERED GENERAL ASSISTANCE DRUG CO-PAYMENT RAISED. The law includes several changes in the State Administered General Assistance (SAGA), which is available to certain individuals ineligible for Medicaid. State law was changed in February 2003, from permitting to requiring the Commissioner of Social Services to impose cost-sharing requirements on recipients of medical assistance and setting co-payment rates. Among other changes enacted during the June special session, the law specifies reorganization of the medical assistance program to a statewide program and raised the co-payment on prescription drugs. Co-payments for SAGA beneficiaries are now:

Prescription drugs: $1.50/prescription

Outpatient medical services: $1.00/service
EFFECTIVE DATE: Upon passage

§ 53-FEE SCHEDULES FOR DURABLE MEDICAL EQUIPMENT, OTHER SERVICES AND DEVICES. This section permits the DSS commissioner to modify the state medical assistance fee schedules for durable medical equipment, medical surgical supply, oxygen, orthotic and prosthetic devices, and hearing aids, as well as applicable regulations, policies, procedures, or purchase of service contracts to achieve expenditure reductions adopted in the recently passed budget (PA 03-1, June 30 Special Session). If such modifications require revisions to state regulations, the bill allows the commissioner to make the modifications while in the process of adopting them in regulation form as long as she publishes notice of the modifications in the *Connecticut Law Journal* within 20 days of their implementation. The bill allows these modifications to include, but does not limit them to:

1. a change in the reimbursement for customized manually priced devices to a formula based on a percentage of list or acquisition costs;

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2. a percentage reduction in payments to all other durable medical equipment, medical surgical supply, oxygen, orthotic and prosthetic devices, and hearing aid providers;

3. the application of any rental costs for durable medical equipment when DSS purchases equipment for a beneficiary of the same type that has previously been rented for him; and

4. selection of a vendor or vendors to provide such equipment, services, and devices through a competitive bidding process.

The bill also prohibits estimated expenditure reductions for the modifications the commissioner implements from being less than those adopted in the recent budget.
EFFECTIVE DATE: Upon passage

2. PUBLIC ACT 03-6: AN ACT CONCERNING GENERAL BUDGET AND REVENUE IMPLEMENTATION PROVISIONS
EFFECTIVE DATE: Upon passage

§§ 40 & 41-PROPERTY TAX EXEMPTION FOR THE DISABLED. For the October 1, 2002 and 2003 assessment years, this section of the bill suspends (1) a mandatory local property tax exemption for up to $ 1,000 worth of property owned by at state resident who is permanently and totally disabled and (2) state reimbursements to towns for lost revenues attributable to the exemption. The bill restores the exemption and the state reimbursement for the October 1, 2004 and subsequent assessment years. To receive the exemption, a property owner must be eligible for Social Security or other comparable federal, state, or local government disability benefits.
EFFECTIVE DATE: Upon passage and applicable to assessment years beginning on or after October 1, 2002.

§§ 51-52-FINANCIALLY DISTRESSED PROPERTY/AFFORDABLE HOUSING. This section gives a housing authority, with the Department of Economic and Community Development commissioner's (DECD) approval, permission to transfer a financially distressed property to the Connecticut Housing and Finance Authority (CHFA) under certain conditions. It defines "financially distressed property" as a housing development owned by a housing authority and subject to an asset transferred from DECD to CHFA.

The bill also adds financing of affordable housing to the list of activities that, by law, make certain businesses eligible to enter a contract for state financial assistance.

By law, nonprofits, municipalities, housing authorities, or businesses that have as one of their main purposes the (1) construction, (2) acquisition, (3) rehabilitation, or (4) operation of affordable housing, or any combination of these activities, are eligible to enter a contract for state financial assistance.

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Conditions for Transfer

Under this bill, to approve the transfer of a financially distressed property, the DECD commissioner must find:

1. a housing authority is financially unable to maintain it,
2. there is no reasonable prospect that the housing authority will be able to maintain it in the future,
3. the housing authority requests the transfer, and
4. CHFA is prepared to accept the transfer.

EFFECTIVE DATE: Upon passage for transfers and October 1, 2003 for the financing provision.

§ 187-PAYMENT FOR BRANFORD HOSPICE. This section entitles Branford to $100,000 annually to offset the property tax revenue lost due to the tax-exempt status of Connecticut Hospice. The funding must come from the annual General Fund appropriation for reimbursement to towns for loss of taxes on private tax-exempt property. The town does not have to file the property's assessed value with the Office of Policy and Management, as the law requires for towns seeking reimbursement for lost tax revenues from hospitals and colleges.
EFFECTIVE DATE: Upon passage

§ 197 & 198-HOME HEALTH SERVICES FEE SCHEDULE AND PSYCHIATRIC NURSE VISITS. PA 03-2 required the DSS home health fee schedule, which lists what the state will pay for various home health services for its medical assistance programs, to include a fee for a nurse who makes a home visit solely to administer medications. It allowed such medication administration to include blood pressure checks, glucometer readings, pulse rate checks, and similar health status indicators. The act required the fee to include administration of medications while the nurse is present, pre-pouring additional doses for the client to self-administer at a later time, and teaching self-administration. The act explicitly prohibited DSS from paying for medication administration when other nursing services are provided at the same visit. It allowed DSS to establish prior authorization requirements for this service. It required the DSS commissioner, before implementing the change, to consult with the chairmen of the Public Health and Human Services committees.

Section 197 specifies that the home health services fee schedule established under PA 03-2's provisions for nurse medication administration visits must include rates for psychiatric nurse visits.

Section 198 requires these nurse medication administration visit rates to be established after the DSS commissioner consults with the chairmen of the Appropriations Committee. The bill requires the commissioner to submit the rates

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to the chairmen for their review and comment by December 15, 2003 and requires that the rates take effect by January 1, 2004.
EFFECTIVE DATE: Upon passage

§ 199-TRANSFER OF DECD FUNDS. The bill takes a portion of the funds appropriated in the budget bill (June 30 Special Session, PA 03-1 - HB 6802) to the Department of Economic and Community Development (DECD) for the Subsidized Assisted Living Demonstration (SALD) account and transfers them to the Housing Assistance and Counseling account in both FY 2003-04 and FY 2004-05. It transfers (1) $140,986 from a total SALD appropriation of $970,300 in FY 2003-04 and (2) $160,000 from a total SALD appropriation of $2,014,300 in FY 2004-05.
EFFECTIVE DATE: Upon passage

§ 204-HOSPICE AUTHORIZATION. This section makes the authorization for a licensed or certified hospice to operate a residence for the terminally ill permanent, rather than terminating this authority on October 1, 2006.
EFFECTIVE DATE: Upon passage

§ 208-DPH APPROPRIATIONS. The bill appropriates $7.1 million to DPH in both FYs 2003-04 and 2004-05 for immunization services.
EFFECTIVE DATE: Upon passage

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II. VARIOUS SPECIFIC LAWS OF INTEREST

1. PUBLIC ACT 03-275: AN ACT CONCERNING A DEMONSTRATION PROJECT FOR LONG-TERM ACUTE CARE GENERAL HOSPITALS

EFFECTIVE DATE: October 1, 2003

Under this law, The Office of Health Care Access (OHCA), in consultation with the departments of Public Health (DPH) and Social Services (DSS), can authorize up to four demonstration projects allowing chronic disease hospitals to establish and operate new long-term acute care hospitals or satellite facilities. The purpose of the demonstration projects is to study quality of service, patient outcomes, and cost effectiveness from using such hospitals or facilities. The demonstrations must be designed to serve people who need long-term hospitalization in an acute care setting, need 24 hour on-site physician availability, and are not suited for skilled nursing facility placement.

Chronic disease hospitals interested in the demonstration project can apply to OHCA by January 1, 2005 for a certificate of need (CON). Each authorized project must collect and report data on its cost effectiveness and effect on quality and patient outcomes. Data must include (1) length and cost of stay, (2) number of intensive care days per patient, (3) type of discharge, and (4) other data requested by OHCA. OHCA determines how the data is reported.

OHCA must report, by January 1, 2007, to the Public Health and Human Services committees on findings and recommendations concerning the demonstration projects. It must consult with DPH and DSS on the report. The bill also allows DPH to waive certain licensure and regulatory requirements. DPH also establishes state payment standards for services provided by these facilities under the demonstration project. As amended and passed, the bill includes additional requirements for the demonstration projects; allows for establishing satellite facilities; sets a deadline for CON applications; establishes requirements for payment; and allows DPH to waive certain requirements.

The law defines "chronic disease hospital" as a nonprofit facility licensed as a chronic disease hospital by DPH on or before January 1, 2003. A "satellite facility" is a long-term acute care facility operated as part of a long-term acute care hospital under Medicare. Under the law, new long-term acute care hospitals and satellite facilities may be eligible to operate as demonstration projects if they are (1) located within a licensed short-term acute care general or children's hospital, (2) under the common ownership and control of a chronic disease hospital, and (3) certified, or become certified, for Medicare participation as a long-term acute care hospital.

The law allows DPH, at its discretion, to waive licensure and regulatory requirements otherwise applicable to chronic disease hospitals for new long-term acute care hospitals or satellite facilities. The law specifies that DPH does not have to adopt or amend regulations for these demonstration projects.

The law specifies that payments to hospitals based on DSS-established inpatient hospital rates must include any inpatient service days provided in a new long-term acute care hospital or satellite facility established as a demonstration project.

For rate setting and cost per discharge settlement purposes, the law specifies that the inpatient stay of a Medicaid-eligible patient must include both short and long-term acute care hospital days provided in a new long-term acute care hospital or satellite facility established as a demonstration project.

The law allows a short-term acute care hospital to enter into an agreement with a chronic disease hospital that establishes a new long-term acute care hospital or satellite facility under the demonstration project to distribute state payments received for services provided by the long-term acute care hospital or satellite facility.

2. PUBLIC ACT 03-267: AN ACT CONCERNING REPORTS OF SUSPECTED ABUSE, NEGLECT, EXPLOITATION OR ABANDONMENT OF ELDERLY PERSONS OR PERSONS IN LONG-TERM CARE FACILITIES

EFFECTIVE DATE: October 1, 2003

This law creates new crimes and penalties for repeated acts or omissions that injure an elderly, blind, disabled, or mentally retarded person. It directs the appropriate state's attorney or assistant state's attorney to report convictions to the Department of Public Health (DPH) when the abuser has an occupational license issued by DPH, and permits DPH to suspend or revoke the license or take other disciplinary action based on this information. Depending on the particular circumstances, the acts and omissions identified as criminal abuse under the bill may constitute misdemeanor or felony offenses under current law.

The law makes intentionally failing to report elder abuse a crime, rather than a violation, and shortens the time that mandated elder abuse reporters have to notify the Department of Social Services (DSS) commissioner about a suspected case of abuse. It also authorizes legal remedies for anyone subjected to discrimination or retaliation for, in good faith, (1) reporting elder abuse or (2) complaining to DSS about a nursing or board-and-care home or similar adult care homes. This law further specifies that an elderly person's refusal of treatment for religious reasons is not of itself grounds for implementing protective services through DSS's Elderly Protective Services Unit.

Actors who may be convicted of the new crimes are: natural persons, corporations, partnerships, limited liability companies, unincorporated businesses, and other business entities. Under the law, "abuse" is an act or omission that occurs at least twice and causes physical injury to an elderly, blind, disabled, or mentally retarded person. Acts or omissions that are part of the person's treatment or care and are in furtherance of his health and safety are excluded, as are those based on his instructions, wishes, consent, or revoked consent.

The law adopts current penal code definitions governing an actor's state of mind

and the extent of the victim's injuries.

First-Degree Abuse
An actor commits 1st degree abuse when he intentionally commits abuse and causes serious physical injury. As under current law, a person acts intentionally when his conscious objective is to cause a particular result or to engage in particular conduct. A serious physical injury is one that (1) creates a substantial risk of death, (2) causes serious disfigurement, or (3) seriously impairs the health or the function of a bodily organ.

The law makes first-degree abuse a class C felony, punishable by imprisonment for one to 10 years, a fine of up to $ 10,000, or both.

Second-Degree Abuse
An actor commits second-degree abuse when he (1) intentionally commits the abuse and causes a physical injury or (2) knowingly commits abuse and causes a serious physical injury. As under current law, a person acts knowingly when he is aware that his conduct is of a particular nature or that particular circumstances exist. A physical injury is one that impairs a person's physical condition or causes pain.

Second-degree abuse is a class D felony, punishable by imprisonment for one to five years, a fine of up to $ 5,000, or both.

Third-Degree Abuse
An actor commits third-degree abuse when he knowingly or recklessly commits abuse and causes a physical injury. As under current law, a person acts recklessly when he is aware of and consciously disregards a substantial and unjustifiable risk that a particular result will occur or that a particular circumstance exists. The risk must be of a nature or degree that disregarding it constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.

Third-degree abuse is a class A misdemeanor, punishable by imprisonment for up to one year, a fine of up to $ 2,000, or both.

This law requires prosecutors to notify DPH whenever a person holding a DPH-regulated license, certificate, or permit to engage in a profession is convicted of the new abuse crimes or of a criminal offense involving the failure to report elder abuse. It authorizes DPH, in its sole discretion, to (1) suspend temporarily or revoke the convicted person's license, certificate, or permit for such time as it deems appropriate; (2) revoke permanently the convicted person's license, certificate, or permit; or (3) take any other disciplinary action permitted under current law.

In addition to suspending or revoking a practitioner's occupational license, current law allows DPH to censure, reprimand, and place practitioners on probation. It can act summarily against a practitioner's license or permit when it receives proof that the holder has a felony conviction.

By law, mandated reporters must notify DSS when they have reasonable cause to suspect or believe that someone age 60 or over (1) has been abused, neglected, exploited, or abandoned, or is in a condition caused by one of these or (2) is in need of protective services (services designed to protect elderly individuals from such harm). The previous requirement that they must make the report of suspected abuse within five calendar days has been changed to three days of first suspecting it. Under the law, intentionally failing to do so is a class C misdemeanor for first offenses, punishable by imprisonment for up to three months, a fine of up to $500, or both. Subsequent offenses are class A misdemeanors, punishable by imprisonment for up to one year, a fine of up to $2,000, or both. An unintentional failure to report remains punishable by the fine described above.

The law also requires DSS to refer substantiated abuse cases involving long-term care residents to prosecutors. It must already do this in protective services cases. The law requires that both types of referrals go to the chief state's attorney or his designee. Currently, protective service referrals go to the appropriate office of the state's attorney. Under the law, the chief state's attorney or his designee, rather than state's attorneys, investigates and makes prosecution decisions in these cases.

The law specifies that any person discharged or discriminated or retaliated against for reporting elder abuse or complaining to DSS about a long-term care facility in good faith is entitled to all legal remedies available, including treble damages, job reinstatement, back pay and benefits, court costs, and attorney's fees.

3. PUBLIC ACT 03-118: AN ACT CONCERNING CONTINUING EDUCATION FOR PROFESSIONS REGULATED BY THE DEPARTMENT OF PUBLIC HEALTH

EFFECTIVE DATE: October 1, 2003 for license renewals commencing October 1, 2004.

This law establishes continuing education requirements for nursing home administrators and other holders of licenses through Department of Public Health (DPH). The law defines acceptable continuing education courses and activities for these professions, requires participants to document their continuing education and maintain records for a set period, and gives DPH authority to discipline individuals not complying with these requirements. The law provides that continuing education requirements shall be waived for licensees applying for licensure renewal for the first time. DPH can grant continuing education waivers or extensions under certain circumstances.

As amended by Public Act 03-3 and beginning October 1, 2004, nursing home administrator licensees must complete at least 40 hours of continuing education during each registration period, in areas related to their practice. Continuing education activities can include courses offered or approved by CANPFA, the Connecticut Association of Healthcare Facilities, the Connecticut Chapter of the American College of Health Care Administrators, accredited colleges, or programs presented or approved by the National Continuing Education Review

Service of the National Association of Boards of Examiners of Long Term Care Administrators, or by state and federal agencies.

Additional provisions extending the license renewal period to two years, raising the fee and requiring continuing education are in § 20 of Public Act 03-03 (An Act Concerning Public Health, Human Services and Other Miscellaneous Implementer Provisions, page 2).

4. PUBLIC ACT 03-92: AN ACT CONCERNING NURSING HOME INSPECTIONS

EFFECTIVE DATE: Upon passage (June 3, 2003)

This law prohibits prior disclosure of the time of Department of Public Health (DPH) dual nursing home inspections. It also requires the inspections to be conducted randomly as to date and time of day. Under existing law, which this provision did not change, DPH, whenever possible, must conduct both state and federally required inspections at the same time (1) when required for state licensing and for federal Medicaid or Medicare certification and (2) in at least 70% of the facilities.

5. PUBLIC ACT 03-272: AN ACT CONCERNING RECOMMENDATIONS FOR ROOM TEMPERATURES IN NURSING HOME FACILITIES, WHISTLEBLOWING BY HEALTH CARE FACILITY EMPLOYEES AND REPORTS BY EMPLOYERS REGARDING HEALTH EMERGENCIES, DISEASES OR HAZARDS IN A WORKPLACE.

EFFECTIVE DATE: October 1, 2003

This law consists of three different nursing home provisions. The first requires the Department of Public Health (DPH) to adopt recommendations for minimum and maximum temperatures for areas in nursing homes and rest homes. They may be based on standards set by national public or private entities after research into appropriate temperature settings to ensure residents' health and safety. DPH must make these recommendations available to nursing homes, rest homes, and the public, and post them on its website.

The second provides protections against discriminatory treatment of, or retaliation against, employees of a health care facility who submit a complaint, or initiate or cooperate in a government investigation or proceeding related to conditions, care, or service issues at that facility. The law defines "discriminatory treatment" as discharge, demotion, suspension, or any other detrimental changes in employment terms or conditions, or the threat of any such actions. A "health care facility" is any facility or institution primarily providing services for the prevention, diagnosis, or treatment of human health conditions.

The law requires a health care facility that discriminates or retaliates against an employee to reinstate him and reimburse him for lost wages, lost work benefits, and any reasonable legal costs he incurs. It specifies that its provisions and remedies are not exclusive and are in addition to others available in statute or

common law.

Finally, the law provides that upon notice from an employer about a health emergency, disease cluster, or imminent hazard, DPH and the Department of Labor (DOL) may initiate surveillance activities such as site-specific hazard evaluations and industry-wide epidemiological studies. Based on the results of the studies, DPH and DOL must recommend to an employer measures to reduce risk of death, disability, injury or harm. If such recommendations are made, employers must immediately notify employees at potential risk from a health emergency, disease cluster, or imminent hazard. Notice must also be sent to the commissioners and include information on (1) the nature of the health emergency, disease cluster, or imminent hazard; (2) the level at which exposure is determined hazardous, if known; (3) potential acute and chronic effects of exposure at hazardous levels; (4) symptoms of those effects; (5) appropriate emergency treatment; (6) employer precautions; and (7) precautions employees should take.

The law specifies that notification made according to these provisions is not admissible as evidence of the facts stated in any lawsuit or action under workers' compensation against the employer making the notification.

An employer failing to make a required notification, or who knowingly gives false information, can be assessed a civil penalty of up to $ 1,000 per violation.

III. PHARMACY-RELATED LAWS

1. PUBLIC ACT 03-116: AN ACT IMPROVING PHARMACY CARE TO RESIDENTS OF LONG-TERM CARE FACILITIES

EFFECTIVE DATE: Upon passage for the drug return program provisions (June 18, 2003) and July 1, 2003, for the pharmacy service reimbursements.

This law requires the Department of Social Services (DSS) commissioner to update and expand the list of drugs included in the Nursing Home Drug Return Program by June 30, 2003, and annually thereafter. The law requires the list to include the 50 drugs with the highest average wholesale price that meet the program's requirements. DSS must do this in consultation with the Pharmacy Review Panel, which advises DSS on the operation of its pharmacy benefit programs, including cost savings initiatives.

The law also allows the commissioner, within available appropriations, to reimburse pharmacies or pharmacists for services they provide to residents in long-term care facilities, (including nursing homes, rest homes, residential care homes, residential facilities for mentally retarded people, and facilities served by assisted living services agencies), in addition to other reimbursements and dispensing fees already allowed under the state's medical assistance programs, if the services improve the residents' quality of care and save the state money, as determined by the commissioner. These services may include emergency and delivery services offered on all medications, including intravenous therapy, 24 hours a day, seven days a week.

As established under prior law, nursing homes that violate the requirement to return drugs meeting the specific criteria for return are subject to a $30,000 fine for each incident of noncompliance. The DSS commissioner can deduct the fine from a facility's Medicaid reimbursement. Fines collected must be deposited in the General Fund and credited to the Medicaid account.

2. PUBLIC ACT 03-164: AN ACT CONCERNING COLLABORATIVE PRACTICE BETWEEN PHYSICIANS AND PHARMACISTS

EFFECTIVE DATE: October 1, 2003

This law adds pharmacists working in nursing homes to those pharmacists who can establish collaborative agreements with physicians to manage the drug therapy of patients. Prior law allowed physicians and hospital pharmacists to enter into collaborative agreements to manage the drug therapy of individuals receiving inpatient hospital services.

This law allows pharmacists employed by or under contract with a nursing home to enter into collaborative drug therapy management agreements with physicians. The agreements must be based on written protocols for purposes of managing the drug therapy of individual patients in nursing homes, and are subject to the nursing home's approval. Each patient's collaborative drug therapy management must be based on a written protocol specific to that patient and developed by the treating physician in consultation with the pharmacist. The protocol must be

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reviewed and approved by the nursing home's active organized medical staff.

Under the law, the nursing home that employs the pharmacist must determine that he is competent to participate in each collaborative agreement. The nursing home must file a copy of the criteria it uses to judge competence with the Commission of Pharmacy.

The law specifies that records collected or maintained under the prescription drug error reporting program do not have to be disclosed for a six-month period from the date the records were created. Also, these records are not subject to subpoena, discovery, or introduction into evidence in any judicial proceeding except as otherwise specifically provided by law.

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IV. DENTAL-RELATED LAWS

1. PUBLIC ACT 03-155: AN ACT CONCERNING THE DELIVERY OF DENTAL SERVICES UNDER THE MEDICAID PROGRAM

EFFECTIVE DATE: Upon passage, except for the requirement that the commissioner review elimination of prior authorization and the provisions concerning regulations, which took effect July 1, 2003.

This law bill requires the Commissioner of Social Services to revise the Connecticut Medical Assistance Program Provider Manual to incorporate measures that enhance and expedite dental services delivery to individuals eligible for Medicaid. Revisions include simplifying the application process for dental providers and streamlining the renewal form for current providers whose information has not changed in the preceding two years.

The law further requires the Commissioner amend the state's federal waiver no later than July 1, 2004 and before implementing a statewide dental plan. In addition, before implementing such a statewide dental plan, the law requires the Commissioner to review eliminating prior authorization requirements for basic and routine dental services. If the Commissioner adopts regulations to eliminate prior authorization, the bill allows her to implement the policies and procedures while the regulation change is in process as long as she prints notice of the intention to adopt regulations in the Connecticut Law Journal within 20 days of implementing the policies and procedures.

2. PUBLIC ACT 03-124: AN ACT CONCERNING RETIRED DENTISTS

EFFECTIVE DATE: October 1, 2003

This law establishes a reduced annual license fee ($100) for dentists who practice *pro bono* and for at least 100 hours per year at a public health facility, but do not otherwise practice dentistry. (The regular annual license fee for a practicing dentist is $450.) "Public health facility" includes nursing homes, residential care homes, home health care agencies and other organizations.

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V. NON-PROFIT RELATED LAWS

1. PUBLIC ACT 03-270: AN ACT CONCERNING A PROPERTY TAX EXEMPTION FOR CHARITABLE HOUSING

EFFECTIVE DATE: Upon passage (July 9, 2003) and applicable to assessment years beginning on or after October 1, 2003.

This law outlines specific types of nonprofit organizations that may be exempt from real property taxes. It specifies that the tax exemption applies to temporary housing owned by, or held in trust for, a federally tax-exempt, exclusively charitable organization and used primarily as one or more of the following:

1. an orphanage;
2. a drug or alcohol treatment facility;
3. housing for homeless, retarded, or handicapped people or battered or abused women and children; or
4. housing for ex-offenders or participants in Judicial Branch- or Department of Correction-sponsored programs
5. short-term housing where the average stay is less than six months.

2. PUBLIC ACT 03-178: AN ACT CONCERNING CHARITABLE BINGO AND SEALED TICKET SALES

Effective date: October 1, 2003

This law establishes a new type of permit allowing certain non-profit organizations to sell sealed tickets at fund-raising events. Such organizations must have been organized for at least two years before applying for the permit; the annual cost of the permit is $50. It also increases to $600 the total value of all the $51 to $200 prizes that a bingo permittee may award on any day, and makes other changes to the awarding of prizes for bingo permittees.

VI. MISCELLANEOUS PROFESSIONAL PRACTICE-RELATED LAWS

1. PUBLIC ACT 03-8: AN ACT CONCERNING ADVANCED NURSING PRACTICE

EFFECTIVE DATE: October 1, 2003

This law specifies that advance practice registered nurses can direct registered nurses.

2. PUBLIC ACT 03-209: AN ACT CONCERNING THE PRACTICE OF PHYSICAL THERAPY

EFFECTIVE DATE: October 1, 200

This law defines "wellness care" as "services related to conditioning, strength training, fitness, workplace ergonomics or injury prevention" and specifies wellness care as within the scope of practice of physical therapy. New language states that physical therapists are not prohibited from providing wellness care to individuals who are asymptomatic and who are not referred by a physician or other licensed individual allowed to make referrals for physical therapy. Employers or insurers are not required to pay for physical therapy for asymptomatic persons without a referral.

Also, as of October 1, 2003, licensed physical therapists are required to complete at least 20 hours of continuing education during each license registration period. Such continuing education must relate to the individual's practice. License holders must obtain a certificate of completion for each continuing education program they attend and maintain such documentation for at least three years following the applicable licensure renewal date. First-time renewals are exempt from the continuing education requirements. The Department of Public Health also has discretion to waive these requirements due to medical disability or illness, grant a waiver for a specific period of time or grant an extension of time for the continuing education requirements.

3. PUBLIC ACT 03-252: AN ACT CONCERNING REVISIONS TO CERTAIN DEPARTMENT OF PUBLIC HEALTH STATUTES

EFFECTIVE DATE: October 1, 2003

Among other provisions, this law allows the Department of Public Health (DPH) to issue a license by endorsement to professionals who can document existing licensure in other states where the licensure requirements meet or exceed those in Connecticut. This applies to naturopathic physicians (Sec. 7), physicians and surgeons (Sec. 8 subdivision 5, with a time limit of 30 days of practice without a Connecticut license), occupational therapists and occupational therapy assistants (Sec. 9).

VII. EMPLOYER-RELATED LAWS

1. PUBLIC ACT 03-45: AN ACT CONCERNING SECONDHAND SMOKE IN WORK PLACES

EFFECTIVE DATE: October 1, 2003

The law states that no person shall smoke "in any area of a health care institution". It amends existing law to require any employer with fewer than five employees to establish one or more work areas as non-smoking. It also prohibits smoking in any workplace with more than five employees, unless designated smoking rooms are established. Such smoking rooms must meet specific requirements. Employers are not prohibited from designating an "entire business facility" as non-smoking.

2. PUBLIC ACT 03-5: AN ACT CONCERNING EMPLOYEE ACCESS TO ELECTRONICALLY RECORDED PERSONNEL FILES

EFFECTIVE DATE: October 1, 2003

This law expands the definition of "personnel file" to include e-mails and faxes. The law now defines "personnel file" as "papers, documents and reports, including electronic mail and facsimiles, pertaining to a particular employee that are used or have been used by an employer to determine such employee's eligibility for employment, promotion, additional compensation, transfer, termination, disciplinary or other adverse personnel action including employee evaluations or reports relating to such employee's character, credit and work habits."

3. PUBLIC ACT 03-18: AN ACT CONCERNING CONFIDENTIALITY OF EMPLOYEE ASSISTANCE PROGRAM CLIENT COMMUNICATIONS

EFFECTIVE DATE: October 1, 2003

This law defines "employee assistance program" and "employee assistance professional." It provides specific protection of the confidentiality of information regarding an employee's use of such a program or records pertaining to such program. Employee assistance programs and their agents or representatives are prohibited from disclosing any information or records concerning or confirming an employee's participation, except where disclosure is necessary to prevent harm to the employee or others.

VIII. POLICY-RELATED LAWS

1. PUBLIC ACT 03-236: AN ACT CONCERNING PUBLIC HEALTH EMERGENCY RESPONSE AUTHORITY

EFFECTIVE DATE: From date of passage

This law strengthens the governor's, the Department of Public Health (DPH) commissioner's, and local health directors' powers to respond to public health emergencies. It authorizes the governor to declare a public health emergency and order the DPH commissioner to take certain actions, but also provides for legislative leaders to override such a declaration. It authorizes the commissioner to quarantine, isolate, and vaccinate people during a public health emergency. This law specifically allows people to refuse vaccination for any reason, and allows those who do so to be quarantined or isolated. DPH is required to develop a public health emergency response plan, with a newly established Public Health Preparedness Advisory Committee. That committee must report annually beginning January 1, 2004.

Other provisions relate to local health directors' quarantine authority; the authority of the governor to seize anti-toxins and pharmaceutical or other biologic products when there is a shortage of these during a public health or civil preparedness emergency; protection of state and local officials against liability for damages from their actions or inactions during a public health emergency; temporary suspension of license requirements for out-of-state health professionals who work in Connecticut during a public health emergency; and the ability of DPH to authorize people to register death certificates and carry out related duties during an emergency.

This law allows DPH to authorize nursing homes and other providers to provide potassium iodide to their clients and staff and others in case of a public health emergency, as long as certain consent requirements are met.

2. PUBLIC ACT 03-88: AN ACT CONCERNING THE OFFICE OF PROTECTION AND ADVOCACY FOR PERSONS WITH DISABILITIES

EFFECTIVE DATE: October 1, 2003

This law specifies that all aspects of the operations of the Office of Protection and Advocacy for Persons with Disabilities conform to federal requirements for program independence and authority. Among other requirements, the Office must be structurally independently from other agencies that provide services; have the authority to pursue legal and administrative remedies on behalf of persons with disabilities; be authorized to investigate allegations of abuse and neglect of persons who receive care, treatment or services; and have the authority to access residents of facilities or clients of service systems and, with appropriate consent, to access such individuals' records concerning care, treatment or services.