



## ACTS AFFECTING HEALTH PROFESSIONS



2015-R-0162

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## **NOTICE TO READERS**

This report provides summaries of new laws (Public Acts and Special Acts) affecting health professions enacted during the 2015 regular session and June Special Session. Each summary indicates the Public Act (PA) or Special Act (SA) number. The report does not cover acts that were vetoed.

Not all provisions of the acts are included. Complete summaries of Public Acts are or will soon be available on OLR's webpage:  
<http://www.cga.ct.gov.oler/OLRPASums.asp>.

The summaries are divided into categories for ease of reference; some provisions may fall into multiple categories.

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, House Clerk's Office, or General Assembly's website:  
<http://www.cga.ct.gov>.

All provisions summarized here are effective October 1, 2015, unless otherwise noted.

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## **AMBULATORY SURGICAL CENTER TAX**

[PA 15-244](#), § 172, as amended by [PA 15-5, June Special Session](#), § 130, imposes a new tax on ambulatory surgical centers (ASCs), including Department of Public Health (DPH)-licensed outpatient surgical centers and other Medicare-certified ASCs. The tax is 6% of the ASC's gross receipts, excluding the first \$1 million of the ASC's gross receipts in the given year. The act also excludes the net patient revenue of a hospital subject to the hospital tax.

ASCs must remit the tax quarterly, beginning by January 1, 2016 for the last calendar quarter of 2015.

## **BEHAVIORAL HEALTH SERVICES**

### ***Animal-Assisted Therapy***

[PA 15-208](#) makes several changes in the law concerning animal-assisted therapy services. For example, it requires the Department of Children and Families (DCF) commissioner, in consultation with the agriculture commissioner and within available appropriations, to develop a protocol to identify and mobilize animal-assisted critical incident response teams statewide, instead of identify a canine crisis response team as required under prior law. It extends the deadline for this requirement by two years, from January 1, 2014 to January 1, 2016.

EFFECTIVE DATE: Upon passage

## ***Behavioral Health Partnership Oversight Council***

[PA 15-242](#), § 30, adds two nonvoting, ex-officio members to the Behavioral Health Partnership Oversight Council: one each appointed by the DPH commissioner and health care advocate, to represent their department or office respectively. The council advises the DCF, social services, and mental health and addiction services commissioners on the planning and implementation of the Behavioral Health Partnership (an integrated behavioral health system for Medicaid patients).

## ***Department of Mental Health and Addiction Services (DMHAS) Statutes***

[PA 15-120](#) makes several changes in the DMHAS statutes, such as specifying that all private agencies treating psychiatric disabilities or substance abuse, regardless of whether they are state-funded, must comply with the commissioner's data collection requirements.

EFFECTIVE DATE: Most provisions effective October 1, 2015.

## ***DMHAS Acute Care and Emergency Behavioral Services Grant Program***

[PA 15-5, June Special Session](#), § 355, establishes a grant program in DMHAS to provide funds to organizations providing acute care and emergency behavioral health services. The grants are for providing

community-based behavioral health services, including (1) care coordination and (2) access to information on and referrals to available health care and social service programs.

EFFECTIVE DATE: July 1, 2015

### ***Insurance Department Data Collection Working Group***

[PA 15-5, June Special Session](#), § 353, requires the insurance commissioner to convene a working group to develop recommendations for uniformly collecting behavioral health utilization and quality measures data from various entities, such as (1) insurers and (2) state agencies that pay health care claims. By January 1, 2016, the commissioner must submit the recommendations to the governor and the Children's, Human Services, Insurance and Real Estate, and Public Health committees.

EFFECTIVE DATE: Upon passage

### ***Youth Suicide Prevention Training***

[PA 15-242](#), § 52, requires DCF's Youth Suicide Advisory Board, within available appropriations, to periodically offer youth suicide prevention training for health care providers, among others.

### **CERTIFICATE OF NEED (CON)**

#### ***Exemption for Certain Scanners***

[PA 15-146](#), § 39, eliminates the CON requirement for the acquisition of certain types of scanners if they are

replacements for scanners previously approved through the CON process. This applies to MRI, CT, PET, and PET/CT scanners.

EFFECTIVE DATE: July 1, 2015

### ***Large Group Practice Sales***

[PA 15-146](#), § 37, expands which ownership transfers of a large group practice (eight or more full-time equivalent physicians) are subject to the CON requirement. Prior law exempted transfers to a physician or group of physicians. Under the act, the exemption for transfers to a physician group applies only if that group is organized in a partnership, professional corporation, or limited liability company formed to render professional services and its physicians are not employed by or an affiliate of a hospital, medical foundation, insurance company, or similar entity.

EFFECTIVE DATE: July 1, 2015

### ***Service Termination***

By law, if a health care facility proposes to terminate all of its services and those services were originally authorized by a CON, it must (1) notify the Office of Health Care Access (OHCA) at least 60 days before doing so and (2) surrender its CON within 30 days after taking such action. Additionally, a facility that proposes to stop operating or providing a service for which a CON was not originally obtained must give OHCA at least 60 days' notice.



[PA 15-242](#), § 27, specifies that health care facilities must comply with these requirements only if they are not otherwise required, under existing law, to file a CON application.

### **CHILDHOOD IMMUNIZATIONS**

Existing law exempts from school immunization requirements any child who presents a statement from the parents or guardian that the immunization is contrary to the child's religious beliefs. [PA 15-174](#), as amended by [PA 15-242](#), §§ 68 & 71, additionally exempts children who present a statement that the immunization is contrary to the parents' or guardian's religious beliefs. It requires any such statement to be officially acknowledged (e.g., by a notary public).

The act extends the above requirement to children attending child day care centers and group or family day care homes. (Existing regulations require the submission of a religious exemption statement but do not require it to be acknowledged.)

The parents or guardians must submit the religious exemption statement (1) once for children attending day care and (2) before a student enrolls in seventh grade, in addition to when he or she initially enrolls in school, as existing law requires.

EFFECTIVE DATE: July 1, 2015

### **COMMUNITY HEALTH CENTERS**

[PA 15-5, June Special Session](#), § 520, repeals a statutory provision authorizing DPH, within available appropriations, to establish and administer a program to provide financial assistance to community health centers. But the act, § 402, requires that \$422,327 per year appropriated to the General Fund's community health services account in the FY 16-17 biennium be used by the DPH commissioner to provide grants to community health centers.

EFFECTIVE DATE: Upon passage, except the repealer is effective July 1, 2015.

### **DEPARTMENT OF PUBLIC HEALTH AUTHORITY**

#### ***Decisions in Matters Before Professional Licensing Boards***

[PA 15-5, June Special Session](#), § 493, authorizes the DPH commissioner, or her designee, to issue final decisions in certain proceedings brought by or before the professional licensing boards and commissions directly overseen by the department. The act requires these boards and commissions to notify the department when they (1) receive complaints or (2) receive petitions for declaratory rulings or initiate proceedings for declaratory rulings under the Uniform Administrative Procedure Act.

The act authorizes the commissioner, within 15 days after receiving any such notice, to notify the board or commission that (1) its decision will be a proposed decision and (2) the commissioner will render the final decision (subject to the existing right to appeal).

EFFECTIVE DATE: Upon passage

### ***Disciplinary Action Based on Foreign Agency Action***

[PA 15-242](#), § 16, allows DPH and its professional licensing boards and commissions to take disciplinary action against a practitioner's license or permit as a result of the practitioner being subject to disciplinary action by a federal agency.

### ***Disciplinary Authority over Clinical Laboratories***

[PA 15-242](#), §§ 14 & 15, makes various changes concerning DPH's disciplinary authority over clinical laboratories. For example, it provides that each day a laboratory does not comply with the law or DPH regulations is a separate violation for purpose of civil penalties. It also (1) allows DPH to impose its standard range of disciplinary actions, not just license suspension or revocation, for violations of specified laws and (2) grants to the department similar investigative authority over clinical laboratories as it already has over licensed health care institutions.

### ***Technical Assistance Fee***

By law, DPH charges a fee for technical assistance the department provides for the design, review, and development of a health care institution's construction, renovation, sale, or ownership change. For projects costing more than \$1 million, [PA 15-242](#), § 1, the act provides that the fee (one-quarter of 1%) is based on total construction costs rather than total project costs.

### ***Voluntary Surrender of a License***

[PA 15-242](#), § 17, specifies that DPH may deny an application to reinstate the license of a person who voluntarily surrendered or agreed not to renew or reinstate it for specified reasons (e.g., the applicant failed to comply with state laws or regulations or was subject to disciplinary action elsewhere).

## **DEVELOPMENTAL DISABILITIES**

### ***Behavioral Services Program***

[PA 15-5, June Special Session](#), §§ 357-358, renames the Department of Developmental Services' (DDS) "Voluntary Services Program" as the "Behavioral Services Program" to reflect current practice. The program serves children and adolescents with intellectual disabilities and behavioral or mental health needs.

EFFECTIVE DATE: July 1, 2015

### ***Birth-to-Three Program***

[PA 15-5, June Special Session](#), §§ 259-261, shifts oversight over the Birth-to-Three program from DDS to the Office of Early Childhood (OEC). The program provides early intervention services to families with infants and toddlers who have developmental delays or disabilities.

The act, § 262, also establishes an October 1, 2015 deadline for the OEC commissioner to require, as part of the program, that notice of the availability of hearing tests be given to parents and guardians of children receiving program services who are exhibiting delayed speech, language, or hearing development. (The act repeals [PA 15-81](#), which contains similar provisions but refers to DDS rather than OEC.)

EFFECTIVE DATE: July 1, 2015

### ***DDS Commissioner's Designated Services and Interventions***

[PA 15-5, June Special Session](#), § 351, requires the DDS commissioner, in consultation with the Autism Spectrum Disorder Advisory Council, to designate services and interventions that demonstrate, in accordance with best practices, empirical effectiveness for treating autism spectrum disorder (ASD).

EFFECTIVE DATE: Upon passage

### ***DDS Report on Autism Services***

[PA 15-209](#) requires DDS, beginning by February 1, 2016, to report annually

to the Public Health Committee on the activities of the (1) department's Division of Autism Spectrum Disorder Services and (2) Autism Spectrum Disorder Advisory Council.

EFFECTIVE DATE: July 1, 2015

### ***Developmental Screenings for Children***

[PA 15-157](#) requires a health care provider, when completing the state's (1) early childhood health assessment record form or (2) public school health assessment form for a child age five or younger, to indicate on the form whether he or she performed a developmental screening during the related examination.

EFFECTIVE DATE: July 1, 2015

### ***ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION TECHNOLOGY***

#### ***Health Information Access and Blocking***

[PA 15-146](#), § 20, provides that electronic health records, to the fullest extent practicable, must (1) follow and be accessible to the patient and (2) be shared and exchanged in a timely manner with providers who the patients choose.

The act makes "health information blocking" an unfair trade practice. This includes knowingly interfering with the ability of patients, providers, or other authorized persons to access, exchange, or use electronic health records.

The act also makes it an unfair trade practice for a seller of an electronic health record system to make a deceptive representation that the system is federally certified.

### ***Hospital Electronic Health Records***

[PA 15-146](#), § 24, requires each licensed hospital, to the fullest extent practicable, to use its electronic health records system to enable the secure exchange of patient electronic health records between the hospital and any other licensed providers who have a system that can exchange these records. A hospital is deemed to have satisfied this requirement if it connects to and actively participates in the State Health Information Exchange established by the act (see below).

The act specifies that this does not require a hospital to pay for any new or additional information technology, equipment, hardware, or software. It also provides that a hospital's failure to take all reasonable steps to comply constitutes evidence of health information blocking.

[PA 15-1, June Special Session](#), §§ 2 & 21, authorizes \$41 million in general obligation (GO) bonds (\$25 million in FY 16 and \$16 million in FY 17) for the Office of Policy and Management (OPM) to buy and implement an integrated electronic medical records system at UConn Health Center.

EFFECTIVE DATE: October 1, 2015, except the bonding authorization is effective July 1, 2015 and July 1, 2016.

### ***State Health Information Technology Advisory Council***

[PA 15-146](#), § 25, as amended by [PA 15-242](#), § 59, creates a 28-member State Health Information Technology Advisory Council. Among other things, the council must advise the social services (DSS) commissioner on developing priorities and policy recommendations to advance the state's health information technology and health information exchange efforts and goals.

EFFECTIVE DATE: July 1, 2015

### ***Statewide Health Information Exchange***

[PA 15-146](#), § 21, establishes a Statewide Health Information Exchange and gives DSS administrative authority over it. The exchange's goals include allowing real-time, secure access to patient health information and complete medical records across all provider settings.

Under the act, § 22, within a year after the exchange's launch, each licensed hospital and clinical laboratory must (1) maintain an electronic health record system capable of participating in the exchange and (2) apply to begin the process of doing so. Within two years after the launch, each licensed health care provider with such a system capable of participating in the exchange

must apply to begin the process to do so.

[PA 15-1, June Special Session](#), §§ 2 & 21, authorizes \$15 million per year in GO bonds in FY 16 and FY 17 to OPM to develop and maintain the exchange.

EFFECTIVE DATE: Upon passage, except the bonding authorization is effective July 1, 2015 and July 1, 2016.

### ***Statewide Health Information Technology Plan and Related DSS Responsibilities***

By law, the DSS commissioner must implement and periodically revise the statewide health information technology plan. [PA 15-146](#), §§ 23, 26, & 41, makes various changes affecting the plan. For example, it broadens the plan's applicability by requiring the plan to include electronic data standards to facilitate a statewide electronic health information system for state-licensed providers and institutions, instead of just state-funded providers and institutions as under prior law.

It makes other changes to DSS responsibilities over health information technology and related topics. For example, within existing resources, it requires the DSS commissioner, in consultation with the new advisory council, to coordinate the state's health information technology and health information exchange efforts.

EFFECTIVE DATE: July 1, 2015, except a repealer and a conforming change take effect October 1, 2015.

### **EMERGENCY MEDICAL SERVICES (EMS)**

#### ***Ambulance Service Billing***

[PA 15-110](#) requires an ambulance service to make a good faith effort to determine whether a person has health insurance before attempting to collect payment from the person. If the company determines that the person is insured, the act prohibits it from trying to collect payment, other than a coinsurance, copayment, or deductible, from the person for covered medical services, before receiving notice from the insurer that it is not paying for the services.

If the insurer has not paid for the service or provided notice that it declines to do so within 60 days after receiving the bill, the ambulance service may attempt to collect payment from the person.

#### ***DPH Ambulance Rate-Setting***

[PA 15-5, June Special Session](#), § 367, allows the DPH commissioner to increase the maximum allowable rates she sets for licensed and certified ambulance services, effective on or before July 15, 2015.

EFFECTIVE DATE: Upon passage

## ***DSS Reimbursement***

Beginning with FY 16, [PA 15-5, June Special Session](#), § 389, requires DSS, subject to federal approval, to revise the Medicaid payment methodology for ambulance services to apply a relative value unit (RVU) system similar to the payment methodology used in the Medicare program. RVU means a numeric value relative to the value of a base level ambulance service.

For emergency medical transportation for people eligible for both Medicaid and Medicare, the act, § 388, limits reimbursement for Medicare coinsurance and deductibles to ensure that the combined Medicaid and Medicare provider payment does not exceed the maximum allowable under Medicaid.

EFFECTIVE DATE: July 1, 2015

## ***EMS Call Volume Reports***

By law, DPH regulations must specify that ambulance or paramedic intercept services that do not apply for a rate increase in a given year beyond the medical care services consumer price index, or that accept the maximum allowable rates in a voluntary statewide rate schedule, must file certain information. [PA 15-242](#), § 10, extends the filing deadline from July 15 to the last business day of August.

## ***EMS Vehicle Inspections***

PA 14-231 made various changes concerning required biennial inspections

of EMS vehicles, such as allowing the inspections to be performed by state or municipal employees, or Department of Motor Vehicles-licensed motor vehicle repairers or dealers, qualified under federal regulations. Under [PA 15-242](#), §§ 11 & 12, these provisions apply only to ambulances and invalid coaches, but not to intercept vehicles staffed by advanced emergency technicians or paramedics.

In addition to this inspection, the act specifies that all such ambulances, invalid coaches, and intercept vehicles must also be inspected by DPH, to verify their compliance with minimum standards for vehicle design and equipment. The act also allows the DPH commissioner to inspect any rescue vehicle used by an EMS organization, for compliance with minimum equipment standards.

## ***Infectious Disease Notification to EMS Responders***

Existing law requires hospitals to notify EMS responders, through designated officers, that may have been exposed to infectious pulmonary tuberculosis when treating or transporting a victim of an emergency. [PA 15-242](#), § 51, expands the notification requirement to include possible exposure to various other airborne infectious diseases.

Among other things, the act also (1) requires hospitals to designate a contact person to communicate with designated officers and (2) allows DPH to discipline

hospitals, hospital contact persons, or designated officers who fail to comply with the notification law.

### ***Mandated Reporters of Elder Abuse***

[PA 15-236](#) and [PA 15-242](#), § 9, add the following EMS providers to the list of mandated reporters of elder abuse: paramedics; emergency medical responders, technicians, advanced technicians, and technician-paramedics; service instructors; and any of these professionals who are members of a municipal fire department.

### ***Primary Service Area Responder (PSAR) Address Changes***

[PA 15-242](#), § 8, allows certain PSARs to apply to DPH, on a short form application, to change the address of their principal or branch locations within the primary service area, without necessarily going through the standard hearing process. A hearing is required if requested by another PSAR in the municipality or an adjacent municipality.

### ***Supplemental First Responders***

[SA 15-8](#) requires DPH to issue a certificate of authorization for a supplemental first responder to an EMS provider who meets certain requirements and operates only in a municipality with a population between 105,000 and 115,000 (i.e., Waterbury).

The act also specifies that if a PSAR and a supplemental first responder are

both on the scene of an emergency medical call, the PSAR controls and directs emergency activities at the scene.

EFFECTIVE DATE: Upon passage

### ***Various Revisions***

[PA 15-223](#) makes various changes in the EMS laws. For example, it:

1. establishes a hierarchy for determining which EMS provider is responsible for making patient care decisions at the scene of an emergency call, giving decision-making authority to the provider holding the highest classification of licensure or certification and
2. establishes a civil penalty of up to \$100 per day for an EMS organization's failure to report data as required, in addition to existing penalties.

## **HEALTH CARE PROVIDERS' AND CARRIERS' INFORMATION FOR CONSUMERS**

### ***Pricing and Related Information***

[PA 15-146](#) contains several provisions on health care pricing and related information available to consumers. The act, §§ 2 & 3, establishes notice requirements for nonemergency care pricing information. Beginning January 1, 2016, it requires all licensed providers, before any scheduled nonemergency admission, procedure, or service, to determine whether the patient is insured. If the

patient is uninsured or the provider is out-of-network, the provider must notify the patient of the charges and certain other information. The act creates additional notification requirements for hospitals beginning January 1, 2017.

The act, §§ 1 & 2, as amended by [PA 15-242](#), § 58, requires the Connecticut Health Insurance Exchange, starting July 1, 2016 and within available resources, to establish and maintain a consumer health information website with information comparing the quality, price, and cost of health care services.

Among other things, the act, §§ 4-7, also:

1. requires each health carrier to maintain a website and toll-free telephone number that allow consumers to request and obtain information on in-network and out-of-network costs and related information;
2. requires carriers to make specified information available to consumers, including giving them a way to accurately determine whether specific providers are in the policy's provider network;
3. requires (a) providers to notify the applicable carrier within 30 days after they stop accepting patients enrolled in an insurance plan and (b) carriers to update

their provider directories at least monthly; and

4. on and after January 1, 2016, prohibits contracts between providers and carriers from restricting the disclosure of (a) billed or allowed amounts, reimbursement rates, or out-of-pocket costs or (b) any data to the all payer claims database.

### ***Referrals to Affiliated Providers***

[PA 15-146](#), § 15, requires health care providers to notify patients when they refer them to an affiliated provider who is not a member of the same partnership, professional corporation, or limited liability company as the referring provider. The notification must be in writing and (1) inform them that they do not have to see the affiliated provider and may seek care from a provider they choose and (2) provide them with the website and toll-free telephone number of their health carrier to obtain information on in-network providers and estimated out-of-pocket costs for the services. The act exempts healthcare providers who provide a substantially similar notice under federal law.



## **HOSPITALS AND HEALTH SYSTEMS**

### ***Dementia Training***

[PA 15-129](#) requires hospitals, starting October 1, 2015, to train direct care staff in the symptoms of dementia as part of their regular staff training.

EFFECTIVE DATE: July 1, 2015

### ***Facility Fees***

By law, a “facility fee” is any fee a hospital or health system charges for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate from the provider’s professional fee.

[PA 15-146](#), §§ 13 & 14, makes various changes affecting facility fees. On and after January 1, 2017, it prohibits facility fees for outpatient services that (1) use a current procedural terminology evaluation and management code and (2) are provided at a hospital-based facility, other than an emergency department, that is not on a hospital campus. For uninsured patients, it prohibits facility fees for outpatient services, other than those provided in off-site emergency departments, that exceed the Medicare facility fee rate. A violation is an unfair trade practice. If an insurance contract in effect on July 1, 2016 provides reimbursement for facility fees that are prohibited by these provisions, the facility may continue to collect such

reimbursement from insurers until the contract expires.

Under the act, on and after January 1, 2016, if a transaction materially changes the business or corporate structure of a physician group practice and establishes a hospital-based facility where facility fees will likely be billed, the purchaser must provide certain information to each patient the practice served over the previous three years, within 30 days after the transaction. The act prohibits the facility from collecting a facility fee from the transaction date until at least 30 days after the required notice is mailed to the patient or a copy is filed with OHCA, whichever is later. A violation is an unfair trade practice.

The act also:

1. requires billing statements that include a facility fee to contain certain information (e.g., it must clearly identify the fee as separate from the provider’s professional fee, if any), except for Medicare or Medicaid patients or those receiving services under a workers’ compensation plan;
2. beginning by July 1, 2016, requires each hospital and health system to annually report to the DPH commissioner specified information on the facility fees it charged the prior year at hospital-based facilities outside a hospital campus; and

3. generally prohibits carriers that reimburse for facility fees for outpatient services provided off-site from a hospital campus, from imposing a separate copayment for these fees, for plans issued or continued on or after January 1, 2016.

### ***Hospital Affiliations***

[PA 15-146](#), § 27, requires the parties to a transaction that results in an affiliation between one hospital or hospital system and another to notify the attorney general (AG) in writing at least 30 days before the transaction takes effect. The notice must identify each party and include certain information about the affiliation.

Starting by December 31, 2015, the act requires each hospital and hospital system to annually file a written report with the AG and DPH commissioner describing its affiliation with any other hospital or hospital system.

### ***Hospital and Health System Reporting***

By law, general and children's hospitals must annually report certain information on salaries to OHCA, including (1) salaries and fringe benefits for the 10 highest paid positions and (2) salaries paid to hospital employees by each joint venture, partnership, subsidiary, and corporation related to the hospital. [PA 15-146](#), § 33, requires hospitals to also report this information for health system employees.

For such hospitals that are parties to an ownership transfer approved under the CON law, the act requires the hospital to report information on financial gain realized by the hospital's officers, directors, board members, and senior managers as a result of the transaction, as part of its annual report to OHCA.

Existing law requires hospitals to annually file with OHCA their audited financial statements. [PA 15-146](#), § 40, and [PA 15-242](#), § 70, allow a health system to submit one report with the audited financial statements for all of its hospitals.

EFFECTIVE DATE: July 1, 2015

### ***Hospital Sales***

[PA 15-146](#), §§ 28, 30-32, & 35, creates additional requirements for CON applications or determination letters filed after December 1, 2015 seeking CON approval to transfer ownership of a hospital. For example, it:

1. adds to the factors that OHCA must consider when reviewing a CON application for a hospital ownership transfer;
2. allows OHCA to place conditions on the approval of a CON application involving a hospital ownership transfer, subject to certain requirements, such as that OHCA must weigh the conditions' value in promoting the law's purposes against the

burden on the parties and hospital (the law already specifically authorizes conditions for hospital conversions to for-profit status); and

3. requires the applicant to submit a plan demonstrating how the new hospital will provide health care services for the first three years after the ownership transfer, including any service reduction or expansion.

The act, § 28, requires OHCA to hire an independent consultant to serve as a post-transfer compliance reporter for three years after the transfer if the purchaser is an in- or out-of-state hospital or a hospital system that (1) had more than \$1.5 billion in net patient revenue in FY 2013 or (2) is organized or operated for profit. The purchaser must pay the cost of hiring the reporter, up to \$200,000 annually. If the reporter determines that the purchaser has breached a condition of the CON approval, OHCA may implement a performance improvement plan and extend the reporting period for up to one year after the conditions have been resolved.

The act, §§ 29 & 35, also requires OHCA, through an independent consultant, to conduct a cost and market impact review (CMIR) of CON applications that propose to transfer a hospital's ownership if the purchaser meets the conditions set forth above on revenue or for-profit status. After its

review, OHCA must refer its final report to the AG for investigation if a transacting party currently or, after the proposed transfer, will likely (1) have a dominant market share and (2) (a) charge materially higher prices than the median prices charged by all other providers of the same services in the same market or (b) have a health status adjusted total medical expense materially higher than the median total medical expense for such other providers.

EFFECTIVE DATE: July 1, 2015

### ***Hospital Tax***

[PA 15-244](#), as amended by [PA 15-5, June Special Session](#), (1) increases the hospital tax rate from 5.5% of inpatient revenue and 3.83% of outpatient revenue to 6% of all net patient revenue and (2) updates the base year for the tax from 2009 to 2013 total net patient revenue (§ 56, reflected in health provider tax revenue estimates).

For calendar quarters beginning on or after July 1, 2015, [PA 15-244](#), § 89, imposes a 50.01% limit on the amount of hospital tax liability that hospitals may reduce by using tax credits.

EFFECTIVE DATE: July 1, 2015

### ***Infant Safe Sleep Practices Information***

[PA 15-39](#) requires hospitals, through their maternity programs, to provide newborn infants' parents or legal guardians with written information on the American Academy of Pediatrics' recommendations for safe sleep practices when the infants are discharged.

### ***Language Interpreters for Acute Care Hospitals***

[PA 15-34](#) requires acute care hospitals to ensure that interpreter services are available to non-English speaking patients whose primary language is spoken by at least 5% of the population in the hospital's geographic service area. Prior law required hospitals to do so only to the extent possible.

### ***Medicaid Reimbursement***

[PA 15-5, June Special Session](#), § 393, changes requirements for how DSS reimburses hospitals for services provided to Medicaid recipients. It establishes a four-year time frame for DSS to broaden hospital-specific diagnosis related groups used to calculate rates for acute care hospitals. It also makes changes in the Medicare Ambulatory Payment Classification (MAPC) system used to calculate rates for outpatient and emergency room care. It specifies how these rates are calculated before DSS implements the modified MAPC system and limits how they are calculated after

implementation. The act also requires DSS to meet several existing requirements concerning Medicaid reimbursement to hospitals within available appropriations.

EFFECTIVE DATE: July 1, 2015

### ***Medical Records***

[PA 15-242](#), § 2, requires chronic disease hospitals to maintain their medical records on-site in an accessible manner. It also requires this for children's hospitals, except for nurses' notes.

It requires both chronic disease and children's hospitals to keep a patient's medical records on-site for at least 10 years after the patient's discharge, except they may destroy the original records sooner if they preserve a copy through a process consistent with current hospital standards. It also requires chronic disease hospitals to complete a patient's medical records within 30 days after the person's discharge, except in unusual circumstances as specified in the hospital's medical staff rules.

### ***Newborn Screening Program Fee***

[PA 15-5, June Special Session](#), § 346, increases, from \$56 to \$98 per infant, the fee DPH charges hospitals for administering its newborn screening program.

EFFECTIVE DATE: July 1, 2015

## ***Nurse Staffing Plans***

[PA 15-91](#) requires hospitals to report annually to DPH on their prospective nurse staffing plans, rather than make the plans available to DPH upon request. It expands, in two stages, the information that must be included in the plans, such as the (1) ratio of patients to certain nursing staff and (2) differences between the prospective staffing levels and actual levels.

It also requires the DPH commissioner to annually report to the Public Health Committee on hospital compliance with staffing plan reporting requirements and recommendations for any additional reporting requirements.

EFFECTIVE DATE: July 1, 2015

## ***Patient-Designated Caregivers***

[PA 15-32](#) requires a hospital, when discharging a patient to his or her home, to:

1. allow the patient to designate a caregiver at or before the time the patient receives a written copy of his or her discharge plan,
2. document the designated caregiver in the discharge plan,
3. attempt to notify the designated caregiver of the patient's discharge, and

4. instruct the caregiver on post-discharge tasks with which he or she will assist the patient at home.

Under the act, a hospital or its employees, contractors, or consultants are not liable for services a caregiver provides or fails to provide to the patient in his or her home.

## ***Property Tax on Certain Health System Property***

[PA 15-5, June Special Session](#), §§ 238-240, generally imposes the property tax on (1) real property that a health system acquires on or after October 1, 2015 that is subject to the tax at the time of the acquisition and (2) any personal property related to health care services delivered at the property. It applies to health systems that had, for the 2013 fiscal year (ending September 30, 2013), at least \$1.5 billion in net patient revenue from in-state facilities. The act excludes property within such an entity's campus.

The act validates, for property tax purposes, the acts and proceedings of a municipality's officers and officials concerning the tax treatment of health system property on the 2014 grand list and prior lists. It requires the municipality to continue to tax or exempt such property, as applicable, in subsequent tax years.

Existing law allows a municipality to fix the real property tax assessment increase resulting from improvements made to real property used for specified purposes. The act expands the types of projects that qualify for the fixed assessments to include property improvements used by or on behalf of health systems.

EFFECTIVE DATE: Upon passage; the provision subjecting certain health system property to property taxes is applicable to assessment years beginning on or after October 1, 2015.

### ***Sales Tax Exemption for Certain Acute Care Hospitals***

[PA 15-5, June Special Session](#), § 512, makes permanent a sales tax exemption for sales of tangible personal property or services to and by an acute care hospital, operating as a "sole community hospital" in the state as defined by federal law, exclusively for its purposes (i.e., Sharon Hospital). The exemption previously applied through FY 17.

EFFECTIVE DATE: July 1, 2015

### ***Supplemental Inpatient Pool***

Prior law required the DSS commissioner, within available appropriations to establish a supplemental inpatient pool for low-cost hospitals. [PA 15-5, June Special Session](#), § 382, eliminates this pool and instead allows him, within available

appropriations, to establish a supplemental inpatient pool for certain hospitals.

The act does not specify which hospitals will be eligible for the supplemental pool. In practice, the pool will be dedicated to certain small hospitals that are not part of a hospital group.

EFFECTIVE DATE: July 1, 2015

### ***Workers' Compensation Hospital Charges***

[PA 14-167](#) required the Workers' Compensation Commission chairman to establish a fee schedule for workers' compensation-related hospital services. It required charges for services rendered before then (April 1, 2015) to be the hospital's actual costs of treating an injured worker, as determined by a workers' compensation commissioner. [PA 15-5, June Special Session](#), § 459, requires these pre-schedule charges to be determined exclusively under this requirement, and not the OHCA statutes. (In 2012, a compensation commissioner ruled that a workers' compensation payor must pay a hospital's billed charges because the workers' compensation law's requirement to pay actual costs had been superseded by hospital deregulation laws in the OHCA statutes.)

The act also requires disputes over a hospital's workers' compensation-related charges to be filed within one year after the initial payment was remitted, regardless of the service date, unless an applicable law or rule requires a shorter timeframe.

EFFECTIVE DATE: Upon passage

## **INSURANCE**

### ***Behavioral Health and Autism Spectrum Disorder Services***

[PA 15-5, June Special Session](#), §§ 347-350, expands certain individual and group health insurance policies' required coverage of ASD services and treatment. For example, it requires individual policies to conform to several coverage and limitation provisions that existing law requires of group policies.

The act also (1) expands existing law's group policy behavioral therapy coverage requirements for people with ASD and also applies it to individual policies and (2) eliminates maximum coverage limits on the Birth-To-Three program.

EFFECTIVE DATE: January 1, 2016

### ***Conferences Between Health Care Professionals and Clinical Peers***

[PA 15-139](#) requires, rather than allows, health carriers, after notifying a covered person or his or her authorized representative or health care professional of certain initial adverse determinations, to offer the health care

professional the opportunity to confer with the carrier's clinical peer. As under prior law, they must do so provided the covered person, representative, or health care professional does not file a grievance of the adverse determination before the conference. The act requires carriers to offer the conference on the request of the health care professional.

### ***Emergency Services***

[PA 15-146](#), § 9, prohibits health carriers from requiring prior authorization for emergency services. It prohibits carriers from charging out-of-pocket expenses for emergency services performed by an out-of-network provider that is greater than that charged by an in-network provider.

It requires carriers to reimburse out-of-network providers who perform emergency services for insureds the greatest of the (1) amount the health care plan would pay if the services were rendered by an in-network provider; (2) usual, customary, and reasonable rate; or (3) amount Medicare reimburses for those services. A carrier and an out-of-network provider may agree to a greater reimbursement amount. The health care provider may bill the carrier directly.

EFFECTIVE DATE: July 1, 2016

## ***Mental and Nervous Conditions***

[PA 15-226](#), as amended by [PA 15-5, June Special Session](#), §§ 43-46 & 515, expands the services certain health insurance policies must cover for mental and nervous conditions. By law, a policy must cover the diagnosis and treatment of such conditions on the same basis as medical, surgical, or other physical conditions. The act requires policies to cover, among other things:

1. medically necessary acute treatment and clinical stabilization services;
2. general inpatient hospitalization, including at state-operated facilities; and
3. programs to improve health outcomes for mothers, children, and families.

Among other things, the act also provides that a policy may not prohibit an insured from receiving, or a provider from being reimbursed for, multiple screening services as part of a single-day visit to a provider or multicare institution.

EFFECTIVE DATE: most provisions are effective January 1, 2016; certain provisions are effective January 1, 2017.

## ***Network Status Notification***

[PA 15-146](#), §§ 9 & 10, requires each health carrier to tell a covered

person or his or her health care professional, when the person or professional requests a prospective or concurrent benefit review:

1. the professional's network status under the person's health benefit plan;
2. the estimated amount the carrier will reimburse the professional; and
3. how that amount compares to the usual, customary, and reasonable charge, as determined by the federal Center for Medicare and Medicaid Services (CMS).

Under the act, if an out-of-network provider renders services to an insured and the carrier did not inform the insured of the provider's network status, if required, the carrier is prohibited from imposing an out-of-pocket expense that is more than what would be imposed if an in-network provider rendered services.

EFFECTIVE DATE: July 1, 2016

## ***Optometrists***

[PA 15-122](#) generally prohibits a provider contract between an insurer and an optometrist entered into, renewed, or amended on or after January 1, 2016 from requiring the optometrist to accept as payment an amount the insurer sets for services that are not covered benefits under an insurance policy or benefit plan.



The act prohibits an optometrist from charging patients more than his or her usual and customary rate for services not covered by an insurance policy or benefit plan. It also requires optometrists to post, in a conspicuous place, a notice stating that services or procedures that are not covered benefits might not be offered at a discounted rate.

EFFECTIVE DATE: January 1, 2016

### ***Surprise Bills***

Under [PA 15-146](#), §§ 9 & 10, if an insured receives a surprise bill, he or she is required to pay only the out-of-pocket expense that would apply if the services had been rendered by an in-network provider. A carrier must reimburse an out-of-network provider or insured for the services at the in-network rate as payment in full, unless the carrier and provider agree otherwise.

Under the act, a “surprise bill” is a bill for non-emergency health care services rendered by an out-of-network provider at an in-network facility for a service or procedure performed by an in-network provider or previously approved by the carrier, and the insured did not knowingly elect to receive the services from the out-of-network provider.

EFFECTIVE DATE: July 1, 2016

## **LONG-TERM CARE**

### ***Continuing Care Retirement Communities (CCRCs)***

[PA 15-115](#) makes several changes affecting CCRCs. Among other things, it:

1. requires providers to give residents advance notice of major construction projects, ownership changes, and monthly service fee increases;
2. decreases the amount of funds providers must keep in escrow and, in certain cases, changes how providers must compute required reserve amounts for the escrow account; and
3. makes changes to the information providers must (a) file with DSS and (b) include in the disclosure statement given to residents upon admission.

### ***Facility Closure Rates***

[PA 15-5, June Special Session](#), § 392, allows the DSS commissioner, at his discretion, to revise the rate of a nursing home, residential care home (RCH), or intermediate care facility for intellectual disabilities (ICF-ID) that is closing down. An interim rate during the facility’s closure must be based on certain factors, such as a review of the facility’s costs and the anticipated impact on Medicaid costs.

EFFECTIVE DATE: July 1, 2015

## **Facility Employee Salary Increases**

Starting July 1, 2015, [PA 15-5, June Special Session](#), § 377, requires DSS, within available appropriations, to adjust facility rates in accordance with standard accounting principles for each nursing home, RCH, and ICF-ID. The adjustment must provide a pro-rata increase based on employee salaries reported in the facility's 2014 annual cost report, and adjusted to reflect certain factors.

Among other things, the act provides that of the total amount appropriated for these increases, up to \$9 million may go to increases based on reasonable costs mandated by collective bargaining agreements.

EFFECTIVE DATE: July 1, 2015

## **ICF-ID Rates**

[PA 15-5, June Special Session](#), § 378, generally caps at FY 15 levels the Medicaid rates DSS pays ICF-IDs in FYs 16 and 17. The act also extends DSS' authority for the next two years to pay a fair rent increase to an ICF-ID that has (1) undergone a material change in circumstances related to fair rent and (2) an approved certificate of need for the change.

EFFECTIVE DATE: July 1, 2015

## **Nursing Home Bed Moratorium**

[PA 15-5, June Special Session](#), § 391, indefinitely extends DSS' moratorium on accepting or approving

requests for a CON to add new nursing home beds. It also eliminates, modifies, and adds exemptions to the moratorium.

EFFECTIVE DATE: July 1, 2015

## **Nursing Home Medicaid Reimbursement Rates**

[PA 15-5, June Special Session](#), §§ 377 & 394, makes several changes affecting Medicaid reimbursement rates for nursing homes. Among other things, it:

1. caps the rates at FY 15 levels, for the next two fiscal years, with certain exceptions for facilities that would have been issued a lower rate due to an agreement with DSS;
2. extends, for the next two fiscal years, the DSS commissioner's authority, within available appropriations, to provide pro rata fair rent increases; and
3. allows the commissioner to implement an acuity-based method for reimbursing Medicaid nursing home services.

EFFECTIVE DATE: July 1, 2015, except that the provision on acuity-based reimbursements took effect upon passage.

### ***Nursing Home Resident Community Transition***

Under [PA 15-5, June Special Session](#), § 404, if a nursing home has reason to know that a resident is likely to become financially eligible for Medicaid within 180 days, it must notify DSS and the resident or the resident's representative. DSS may (1) assess the resident to determine if he or she prefers and is able to live appropriately at home or in another community-based setting and (2) develop a care plan and help the resident transition to the community.

EFFECTIVE DATE: July 1, 2015

### ***Personal Care Attendant (PCA) Training Contract***

[PA 15-5, June Special Session](#), § 473, allows the state and the union representing state-funded PCAs to contract directly with a nonprofit labor management trust to provide training and related services to the PCAs at cost. The training contract must be authorized under the collective bargaining agreement between the state and the PCA union, and the trust providing the training services must be authorized to receive payments from an employer under federal labor law.

EFFECTIVE DATE: July 1, 2015

### ***Residential Care Home (RCH) Rates***

[PA 15-5, June Special Session](#), § 380 caps at FY 15 levels the Medicaid

rates DSS pays RCHs in FYs 16 and 17, except that the commissioner may provide pro rata fair rent increases under limited circumstances.

Starting with FY 16, the act requires DSS to provide fair rent reimbursement to RCHs, at the greater of \$3.10 per day or the allowable accumulated fair rent reimbursement associated with real property additions and land as calculated on a per day basis.

EFFECTIVE DATE: July 1, 2015

### ***Residents' Medicare or Medicaid Applications***

[PA 15-50](#) entitles residents of nursing homes, RCHs, and chronic disease hospitals, or their representatives, to receive a copy of any Medicare or Medicaid application a facility completes on their behalf. It adds this right to the state's nursing home patients' bill of rights.

EFFECTIVE DATE: July 1, 2015

### ***Safeguarding RCH Residents' Personal Funds***

[PA 15-130](#) extends to RCHs statutory requirements for nursing homes regarding the management of residents' personal funds, and associated penalties for mismanagement.

EFFECTIVE DATE: July 1, 2015

## ***State Payments for Reserved Beds***

By law, DSS may pay State Supplement Program benefits directly to licensed RCHs or rated housing facilities on behalf of a recipient, even when the recipient is temporarily absent. [PA 15-102](#) prohibits such payments when the recipient's bed is not otherwise available during his or her absence (e.g., if the facility experiences structural damage).

EFFECTIVE DATE: July 1, 2015

## **MEDICAID (OTHER)**

### ***Chiropractic Services***

[PA 15-5, June Special Session](#), § 520, eliminates a provision allowing DSS to spend up to \$250,000 annually to provide chiropractic services to Medicaid recipients.

EFFECTIVE DATE: July 1, 2015

### ***Elimination of Case Management Requirements***

[PA 15-5, June Special Session](#), §§ 395-398, eliminates specific requirements related to the provision of intensive case management (ICM) services to certain Medicaid recipients. For example, it eliminates provisions requiring Medicaid administrative service organizations (ASOs), beginning July 1, 2016, to provide ICM services that include (1) identifying hospital emergency departments with high numbers of frequent users and (2)

creating regional ICM teams to work with emergency department doctors.

The act instead allows DSS to contract with the behavioral health ASO to provide intensive care management.

EFFECTIVE DATE: July 1, 2016

### ***Federally Qualified Health Center (FQHC) Payments***

Under prior law, DSS had to distribute funding to FQHCs, within available appropriations, based on cost reports the centers submitted to DSS, until the Human Services and Appropriations committees approved an alternative payment methodology.

[PA 15-5, June Special Session](#), § 403, instead allows DSS to develop an alternate payment methodology to replace the encounter-based reimbursement system. The same legislative committees must approve the methodology. Until the methodology is implemented, DSS must distribute supplemental funding, within available appropriations, to FQHCs based on cost, volume, and quality measures the DSS commissioner determines.

EFFECTIVE DATE: July 1, 2015

### ***Medicaid Cost Effectiveness and CON Applications***

By law, one factor OHCA must consider when evaluating a CON application is whether the applicant has satisfactorily shown how the proposal will improve the quality, accessibility,

and cost effectiveness of health care delivery in the region. [PA 15-146](#), § 28, eliminates a requirement for this to include the impact on the cost effectiveness of providing access to Medicaid services.

EFFECTIVE DATE: July 1, 2015

### ***Medicaid Fraud***

[PA 15-211](#), § 10, excludes from participation in accelerated rehabilitation (AR) health care providers or vendors participating in the state's Medicaid program who are charged with (1) 1<sup>st</sup> degree larceny or (2) 2<sup>nd</sup> degree larceny involving defrauding a public community of \$2,000 or less. (Under the AR program, certain criminal defendants may avoid prosecution and incarceration by successfully completing court-sanctioned, community-based treatment programs before trial.)

### ***Medication Administration***

Under certain conditions, the law permits a registered nurse to delegate the administration of medications that are not injected into patients to homemaker-home health aides who obtain certification for medication administration.

[PA 15-5, June Special Session](#), § 387, requires the DSS commissioner to monitor Medicaid home health savings achieved since the law's implementation three years ago. If, by January 1, 2016, the commissioner determines that the savings are less than the amount assumed in the 2016-17 biennial

budget, DSS may reduce home health care Medicaid rates for medication administration to the amount necessary to achieve the assumed savings. If DSS determines it is necessary to reduce the rates, it must examine the possibility of establishing a separate supplemental rate or a pay-for-performance program for the providers who have successfully delegated medication administration to homemaker-home health aides.

EFFECTIVE DATE: July 1, 2015

### ***Orthodonture Coverage***

Under [PA 15-5, June Special Session](#), § 390, DSS must cover orthodontic services for a Medicaid recipient under age 21 when the Salzmann Handicapping Malocclusion Index (SHMI) indicates that the recipient's correct assessment score is 26 points or greater, subject to prior authorization. (The SHMI measures teeth misalignment by using weighted measurements of various factors.) If a recipient's SHMI score is less than 26 points, DSS must consider certain additional substantive information when determining the need for orthodontic services.

EFFECTIVE DATE: Upon passage

## **Provider Audits**

[PA 15-5, June Special Session](#), § 400, makes several changes in the DSS Medicaid provider audit process. For example, it:

1. modifies the circumstances in which DSS may make findings of over- or under-payment using extrapolation of audited provider claims;
2. prohibits DSS from extrapolating an overpayment or attempting to recover an extrapolated overpayment beyond the payment's original dollar amount if the provider presents credible evidence that a DSS error caused the overpayment; and
3. prohibits DSS from recouping a contested provider overpayment based on extrapolation until a final decision is issued after the hearing.

EFFECTIVE DATE: July 1, 2015

## **MISCELLANEOUS**

### ***Advanced Notice of Facility Inspections and Investigations***

The law prohibits regional long-term care ombudsmen and DPH and DSS employees from giving nursing or residential care homes (1) advanced notice of an investigation or inspection or (2) information about a complaint filed by a mandated reporter of elder abuse unless they are specifically required to do so by state or federal

regulations. [PA 15-242](#), § 18, extends the prohibition to cover all licensed health care institutions and specifies that it does not apply to inspections related to an institution's initial licensure.

### ***Birth Certificate Amendments to Reflect Gender Change***

[PA 15-132](#) allows people who have undergone surgical, hormonal, or other clinically appropriate treatment for gender transition to change the sex designation and name on their birth certificate. Previously, state regulations prohibited transgender people from doing so unless they completed gender assignment surgery and supplied an affidavit from a specified mental health professional attesting that they were socially, psychologically, and mentally the designated sex.

The act requires the DPH commissioner to issue a new birth certificate to a transgender person who, among other things, provides a notarized affidavit from a licensed physician, advanced practice registered nurse (APRN), or psychologist stating that he or she has undergone surgical, hormonal, or other clinically appropriate treatment for gender transition.

### ***Certified Dietician-Nutritionists***

[PA 15-242](#), §§ 54-56, allows certified dietician-nutritionists (CDNs) to directly order diet or nutritional support, including therapeutic diets, for patients in health care institutions. Prior law only

allowed CDNs to convey a physician's verbal order.

Under the act, the CDN must document the order in the patient's medical record and a physician must countersign it within 72 hours unless state or federal law requires otherwise.

### ***Cytomegalovirus (CMV) Screening***

Starting January 1, 2016, [PA 15-10](#) requires all health care institutions caring for newborn infants to test those who fail a newborn hearing screening for CMV. It requires the testing to be done (1) within available appropriations and (2) as soon as is medically appropriate, unless, as allowed by law, their parents object on religious grounds. The act also requires health care institutions to report CMV cases confirmed by the screening to DPH.

EFFECTIVE DATE: July 1, 2015

### ***E-Cigarettes***

[PA 15-206](#) imposes restrictions on the use of "electronic nicotine delivery systems" and "vapor products" ("e-cigarettes") in certain establishments and public areas that are similar to existing restrictions on smoking tobacco products in such areas. It also requires the Public Health Committee to hold a hearing to determine whether any state legislation is needed after the federal Food and Drug Administration (FDA) finalizes a rule that could impose federal regulations on e-cigarettes.

### ***Hair Follicle Drug Testing***

[PA 15-72](#) requires a clinical laboratory to administer a hair follicle drug test if (1) the laboratory offers that test as a diagnostic testing service and (2) it is ordered by a licensed physician, physician assistant (PA), or APRN.

### ***Lead Poisoning Prevention***

[PA 15-172](#) lowers the blood lead level threshold at which local health directors must inform parents or guardians about (1) a child's potential eligibility for the state's Birth-to-Three program and (2) lead poisoning dangers, ways to reduce risks, and lead abatement laws.

### ***Mandated Reporters of Child Abuse***

[PA 15-205](#) makes several changes affecting mandated reporters of child abuse. For example, it increases, from a class A misdemeanor to a class E felony, the penalty for a mandated reporter who fails to report suspected child abuse or neglect to DCF if the (1) violation is a subsequent violation; (2) violation is willful, intentional, or due to gross negligence; or (3) mandated reporter had actual knowledge of the abuse, neglect, or sexual assault.

EFFECTIVE DATE: Most provisions are effective October 1, 2015.

### **Medical Spas**

[PA 15-242](#), § 19, specifies that the statutory definition of a medical spa does not include hospitals or other licensed health care facilities. The law defines a medical spa as an establishment where cosmetic medical procedures are performed.

By law, a physician, PA, or APRN must perform an initial physical assessment of a person before he or she can undergo a cosmetic medical procedure at the spa. The act requires the assessment to be performed in-person.

### **Motor Vehicle Operator's License Medical Advisory Board**

By law, this board advises the DMV commissioner on the medical aspects and concerns of licensing motor vehicle operators. [PA 15-5, June Special Session](#), §§ 205 & 206, allows PAs and APRNs to (1) serve on the board and (2) complete physicals and medical reports requested by the board for licensing purposes. Under prior law, only physicians and optometrists could perform these functions.

Among other things, the act (1) allows such physicals and medical reports to be completed by medical professionals licensed outside of Connecticut and (2) adds occupational medicine to the list of specialties required on the board.

EFFECTIVE DATE: Upon passage

### **Newborn Screening Test for Adrenoleukodystrophy (ALD)**

[PA 15-5, June Special Session](#), § 506, requires the DPH commissioner, by October 1, 2015, to execute an agreement with the New York State Department of Health to conduct a newborn screening test for ALD and develop a quality assurance testing method for the screening test.

The act eliminates a provision requiring health care institutions to begin testing infants for ALD after certain events occur, such as the development of a reliable screening method.

### **Notification of Group Practice Transactions**

By law, parties engaging in any transaction that materially changes a group practice must notify the AG at least 30 days before the transaction's effective date. [PA 15-146](#), § 27, requires the (1) parties to also notify the DPH commissioner and (2) commissioner to post a link to the notice on the department's website.

### **Optical Selling Permits**

By law, a licensed optician or an establishment with an optical department must obtain a DPH permit to sell retail optical glasses and instruments. [PA 15-242](#), § 26, exempts from the permit requirement a regionally accredited college or university that operates an optical



establishment to provide practical training to students enrolled in its optician training program.

EFFECTIVE DATE: Upon passage

### ***PANDAS/PANS Advisory Council***

[PA 15-242](#), § 25, adds the Insurance Committee chairpersons, or their designees, to the Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute Neuropsychiatric Syndrome (PANS), thus increasing the membership from 14 to 16.

### ***Physician Assistant Orders***

[PA 15-242](#), § 3, requires all orders written by a PA to include his or her signature and printed name. (The signature requirement was inadvertently removed by PA 14-231.)

### ***School-Based Health Center Definition***

[PA 15-59](#) establishes a statutory definition for a "school-based health center" (SBHC) and permits DPH to adopt regulations to establish minimum quality standards for these centers. It prohibits anyone from using the term SBHC to describe a facility or any words or abbreviations that may be reasonably confused with this term, unless the facility meets the act's definition.

Additionally, the act establishes a statutory definition for an "expanded school health site" and extends to these

sites certain statutory provisions regarding SBHCs (e.g., exemption from DPH's CON requirements).

### ***Sedation and General Anesthesia in Dentistry***

[PA 15-163](#) updates the statutory definitions of sedation and general anesthesia related to dentistry to reflect industry standards. Among other things, it:

1. eliminates the definition of "conscious sedation" in the dentistry statutes, replacing it with new definitions for "minimal sedation," "moderate sedation," and "deep sedation" and
2. exempts dentists using minimal sedation from existing permitting requirements.

### ***Sexual Assault Forensic Examiners at Higher Education Institutions***

[PA 15-16](#) allows sexual assault forensic examiners (SAFEs) to treat sexual assault victims who are patients in a health care facility operated by a higher education institution if the facility meets certain licensure and accreditation requirements.

The act requires SAFE services to be (1) aligned with the policies and accreditation standards of the respective health care facility and (2) provided under a written agreement between the health care facility, DPH,

and the Office of Victim Services, about the facility's participation in the SAFE program.

EFFECTIVE DATE: July 1, 2015

### ***Stem Cell Research***

[PA 15-242](#), §§ 4 & 5, eliminates DPH's authority to enforce specified laws on stem cell research and related topics. Among other things, it eliminates the requirement for a researcher to provide certain documentation to DPH before someone may perform this research. (This research continues to be overseen by an embryonic stem cell research oversight committee established under national guidelines.)

Under the act, the Regenerative Medicine Research Advisory Committee must require research grant applicants to submit a form attesting to compliance with the law's requirements for embryonic stem cell research and related topics, if the research involves these cells.

### ***Training about Elderly Exploitation and Abandonment***

[PA 15-236](#) and [PA 15-242](#), § 9, expand the training that organizations and facilities employing individuals to care for someone age 60 or older must provide their employees. The acts require this training to cover detecting elderly exploitation and abandonment, in addition to the existing topics of detecting elderly abuse and neglect and

informing employees of their mandated reporting responsibilities.

### ***Workplace Violence Reporting***

Starting January 1, 2016, [PA 15-91](#) requires certain health care employers to annually report to DPH, rather than report upon the department's request, on the number of workplace violence incidents occurring on the employer's premises and the specific area or department where they occurred.

## **PHARMACISTS AND MEDICATIONS**

### ***Counterfeit Drugs and Devices***

[PA 15-49](#) expands existing prohibitions on counterfeit drugs and devices to include knowingly dispensing, importing, or reimporting them into the state. The law already prohibits knowingly purchasing for resale, selling, offering for sale, or delivering these items.

The act subjects violators to both criminal and civil penalties and disciplinary action by the Department of Consumer Protection (DCP). It also provides that any prescribing practitioner who violates the act or existing law as noted above is subject to DPH disciplinary action.

## **DSS Reimbursements to Pharmacies**

[PA 15-5, June Special Session](#), § 381, reduces, from \$1.70 to \$1.40, the dispensing fee that DSS pays to pharmacists for each prescription they fill for beneficiaries of DSS medical assistance programs (e.g., Medicaid).

It also lowers the drug reimbursement rate by increasing, from 16% to 16.5%, the discount off the average wholesale price (AWP) DSS pays pharmacies for filling brand name prescriptions. By law, DSS must pay the lesser of (1) the rate established by CMS, (2) the discounted AWP rate, or (3) an equivalent percentage established under the state's Medicaid plan.

By law, DSS must reimburse providers for all prescription drugs provided under its medical assistance programs and pay licensed pharmacies a professional fee for each prescription dispensed. For certain otherwise eligible prescriptions, the act, § 399, requires DSS to pay for the original prescription and as many refills a licensed authorized practitioner orders within 12 months.

EFFECTIVE DATE: July 1, 2015 for the provisions reducing reimbursement rates and August 1, 2015 for the other provisions.

## **Generic Drugs**

[PA 15-219](#) expands the information pharmacists must provide with a

generic name prescription drug. For drugs sold only by generic name, it requires them to include the (1) manufacturer's name and (2) website and toll-free telephone number for MedWatch, the FDA's drug safety and reporting program.

The act requires a pharmacist who substitutes a generic name drug for a brand name drug to include on the container's label the name of the (1) generic drug and (2) brand name drug prescribed.

EFFECTIVE DATE: January 1, 2015

## **Manufacturer Payments to APRNs**

Legislation enacted in 2014 requires manufacturers of covered drugs, devices, biologicals, and medical supplies to report to DCP on payments or other transfers of value they make to APRNs practicing in Connecticut. Among other things, [PA 15-4](#):

1. extends, by two years, the due date of the first report, from July 1, 2015 to July 1, 2017;
2. limits the reporting requirement to payments made to APRNs not practicing in collaboration with a physician; and
3. excludes from the reporting requirement the same payments excluded under the federal law on reporting payments to physicians.

EFFECTIVE DATE: Upon passage

### **Medicaid Over-The-Counter (OTC) Drug Coverage Expansion**

[PA 15-165](#) expands the types of OTC drugs and products covered under Medicaid to include those the DSS commissioner determines to be appropriate based on their clinical efficacy, safety, and cost effectiveness.

Existing law otherwise bans DSS from paying for OTC drugs, with certain exceptions (e.g., drugs covered as an essential health benefit under the federal Affordable Care Act).

EFFECTIVE DATE: July 1, 2015

### **Off-Label Prescription Drugs**

[PA 15-5, June Special Session](#), §§ 469 & 470, expands coverage under certain health insurance policies for off-label use of FDA-approved drugs. It does so by:

1. including peer reviewed medical literature in the list of sources that can recognize an off-label drug for treatment of a condition and thus require it to be covered;
2. requiring coverage for medically necessary services associated with the administration of such a drug; and
3. prohibiting denial of coverage based on medical necessity, except for reasons unrelated to the legal status of the drug.

It also exempts certain types of research trial drugs from the required coverage.

EFFECTIVE DATE: January 1, 2016

### **Prescription Drug Abuse Prevention**

[PA 15-198](#) makes various changes affecting prescription drugs, drug abuse prevention, and related topics. Among other things, it:

1. requires practitioners, before prescribing more than a 72-hour supply of a controlled substance, to check the patient's record in the prescription drug monitoring program;
2. allows pharmacists to prescribe opioid antagonists, used to treat drug overdoses, if they receive special training and certification to do so, and expands the existing immunity for all prescribers when prescribing, dispensing, or administering opioid antagonists; and
3. requires physicians, APRNs, dentists, and PAs to take continuing education in pain management and prescribing controlled substances.

[PA 15-5, June Special Session](#), § 354, requires pharmacists and other controlled substance dispensers, by July 1, 2016, to report to the monitoring program immediately after dispensing

controlled substances but no later than 24 hours after doing so, rather than at least weekly as under prior law.

EFFECTIVE DATE: Upon passage, except the provisions on the prescription drug monitoring program and continuing education are effective October 1, 2015.

### ***Prescription Quantity***

[PA 15-116](#) allows a pharmacist to refill a prescription for a drug, other than a controlled drug, in an amount greater than the initial prescribed quantity under specified circumstances, such as when the (1) refill does not exceed a 90-day supply and (2) patient's insurer will cover the refill quantity at no out-of-pocket cost to the patient.

EFFECTIVE DATE: July 1, 2015

## **PROFESSIONAL LICENSING**

### ***Acupuncturists' Professional Liability Insurance***

[PA 15-242](#), §§ 22-24, requires acupuncturists to maintain professional liability insurance or other indemnity against liability for professional malpractice that is at least \$250,000 per person, per occurrence, and at least \$1 million in the aggregate.

### ***Central Service Technicians***

[PA 15-11](#) generally requires anyone who begins practicing as a central service technician (CST) after January 1, 2016 to pass a national examination

and be certified. A certified person who has not passed the examination may perform CST functions if he or she obtained the certification within two years after the date of hire. A CST is someone who decontaminates, inspects, assembles, packages, and sterilizes reusable medical instruments or devices in certain health care facilities.

The act exempts licensed health care providers and certain others from its requirements. It requires CSTs to annually take 10 hours of continuing education. It also requires the facility that employs or contracts with a CST to submit to DPH, upon request, documentation demonstrating that a CST is in compliance with the act.

EFFECTIVE DATE: January 1, 2016

### ***Continuing Education on Veterans' Mental Health Conditions***

[PA 15-242](#), §§ 60-67, requires certain health care professionals, starting January 1, 2016, to take at least two contact hours of training or education on mental health conditions common to veterans and their family members, during the first renewal period in which continuing education is required and once every six years thereafter. The requirement applies to APRNs, alcohol and drug counselors, chiropractors, marital and family therapists, professional counselors, psychologists, and social workers.

### ***DPH License Renewal Fees***

[PA 15-244](#), §§ 112-137, as amended by [PA 15-5, June Special Session](#), §§ 474-479, (1) increases by \$5 license renewal fees for various DPH-licensed professionals, for licenses or certificates expiring on or after October 1, 2015 and (2) directs the revenue generated to a newly established account to fund the professional assistance program for health professionals.

EFFECTIVE DATE: October 1, 2015, except for a provision in PA 15-5, June Special Session changing the effective date of the fee increases, which took effect June 30, 2015.

### ***Genetic Counselor Licensing***

Subject to certain exemptions, [PA 15-5, June Special Session](#), §§ 360-366, requires anyone practicing genetic counseling to be licensed by DPH. Among others exempt from the licensure requirement are physicians, PAs, APRNs, and nurse-midwives.

The act allows DPH to issue nonrenewable temporary permits to licensure applicants under certain conditions.

EFFECTIVE DATE: October 1, 2015, except the provisions on licensure applications, qualifications, and renewals are effective upon passage.

### ***Hairdresser and Cosmetician Licensure Without Examination***

By law, an applicant currently licensed as a hairdresser and cosmetician in another state who has successfully passed a written examination in that state may obtain a Connecticut license without examination. [PA 15-242](#), § 29, additionally waives the examination requirement for an applicant from a state that did not require an examination as a condition of licensure, if the applicant (1) legally practiced cosmetology for at least five years in another state and (2) submits to the DPH commissioner specified evidence of his or her education and experience.

### ***Massage Therapists***

[PA 15-3](#) requires an applicant for a massage therapist license to successfully complete a DPH-prescribed examination instead of the National Certification Examination for Therapeutic Massage and Bodywork, which is no longer offered.

[PA 15-242](#), § 7, specifically allows DPH to discipline a licensed massage therapist for fraud or deceit in obtaining the license.

EFFECTIVE DATE: Upon passage, except the provision on disciplinary action is effective October 1, 2015.

### ***Nuclear Medicine Technologists***

[PA 15-242](#), § 28, adds a second organization from which a nuclear medicine technologist may be certified, to be exempt from radiographer licensure for specified activities.

### ***Nurses From Other States***

[PA 15-242](#), § 6, allows a qualified registered nurse or licensed practical nurse from another state to care for a patient in Connecticut for up to 72 hours without receiving a temporary DPH permit.

### **REPORTING OF IMPAIRED HEALTH CARE PROFESSIONALS**

By law, physicians, PAs, and hospitals must notify DPH if a physician or PA is or may be unable to practice with skill and safety due to impairment. The law also establishes procedures for DPH to follow when it receives such notice. [PA 15-5, June Special Session](#), § 480, expands the reporting requirement to cover all licensed or permitted health care professionals and establishes similar procedures for DPH to follow when it receives such notice.

Under certain circumstances, the act allows a health care professional or hospital to satisfy the act's reporting requirements by referring the impaired professional for intervention to the professional assistance program for DPH-regulated professionals.

### **TASK FORCES AND STUDIES**

#### ***Certified Behavioral Analysts Licensing Study***

[PA 15-242](#), § 32, requires the education commissioner, in consultation with the DPH commissioner, to study the (1) potential advantages of licensing board certified behavior analysts and assistant behavior analysts credentialed by the Behavior Analyst Certification Board and (2) inclusion of board certified behavior analysts and assistant behavior analysts in school special education planning and placement teams. It requires the education commissioner, by January 1, 2016, to report to the Public Health and Education committees on these studies.

EFFECTIVE DATE: Upon passage

#### ***Chronic Obstructive Pulmonary Disease (COPD) Study***

[PA 15-203](#) requires the DPH commissioner to study COPD, in consultation with the DSS commissioner and representatives of (1) the Connecticut Hospital Association and (2) any other national patient organization with expertise in COPD. The act requires her to report on the study's results to the Public Health Committee by February 1, 2016. It also requires her to post certain information about COPD on the department's website.

EFFECTIVE DATE: Upon passage

### ***Community-Based Health Care Services Study***

[PA 15-5, June Special Session](#), § 359, requires the DSS and DPH commissioners to study the effectiveness of providing community-based health care services in the state. They must submit a preliminary report by February 1, 2016 and a final report by June 1, 2016, to the Human Services and Public Health committees.

Among other things, the study must include a review of the need for, and feasibility of, EMS personnel providing home visits to people at a high risk of being frequent, repeat users of the emergency department, to help them manage chronic diseases and adhere to medication plans.

EFFECTIVE DATE: Upon passage

### ***DPH Report on Con Requirements***

[PA 15-146](#), § 34, requires the DPH commissioner, by January 1, 2016 and within available appropriations, to report to the Public Health Committee on OHCA's CON requirements for health care facilities. The report must include recommendations (1) to eliminate CON requirements or create an expedited approval process for certain matters that currently require CON approval and (2) on an expedited automatic approval of certain CON applications.

EFFECTIVE DATE: July 1, 2015

### ***Financing Options for Hospital Improvements Study***

[PA 15-146](#), § 38, requires the chairperson of the Connecticut Health and Education Facilities Authority (CHEFA) board, in consultation with OHCA and the economic and community development commissioner, to study financing options for community hospitals for various purposes. The CHEFA chairperson must report by January 1, 2016 to the Public Health and Commerce committees on the study.

Under the act, a "community hospital" means a nonprofit hospital that (1) is not a teaching hospital and has 25 or fewer full-time equivalent interns or residents for every 100 inpatient beds; (2) charges less than the state median price for services; and (3) is not part of a hospital system.

EFFECTIVE DATE: Upon passage

### ***Food-Borne Disease Outbreak Study***

[PA 15-242](#), § 33, requires DPH to study food-borne disease outbreaks originating from public eating places, including the type of information communicated to the public after confirmed outbreaks and how it is communicated. By July 1, 2016, the commissioner must report on the study to the Public Health Committee.



### ***Health Care Cabinet Study of Cost Containment Models***

[PA 15-146](#), §§ 17 & 18, renames the 28-member “Sustinet Health Care Cabinet” the “Health Care Cabinet” to conform to current practice. The act expands the cabinet’s duties to include studying health care cost containment models in select other states to identify successful practices and programs that may be implemented in Connecticut. The cabinet must report to the legislature on the study by December 1, 2016, including recommendations on various matters.

EFFECTIVE DATE: Upon passage, except technical and conforming changes took effect July 1, 2015.

### ***Minors’ Exposure to Family Violence Task Force***

[SA 15-10](#) establishes a task force to study the statewide response to minors exposed to family violence. The task force must examine existing policies and procedures on this issue, and develop a statewide model policy, for use by various agencies and groups, including health care professionals. The task force must report on its findings and recommendations to the Children’s and Human Services committees by January 15, 2016.

EFFECTIVE DATE: Upon passage

### ***Psychiatric Services Study***

[PA 15-5, June Special Session](#), § 356, requires the DMHAS commissioner,

in consultation with certain officials and groups, to study the current adequacy of psychiatric services (e.g., how many psychiatric beds are needed in each region of the state). The commissioner must report on this study to the Appropriations, Human Services, and Public Health committees by January 1, 2017.

EFFECTIVE DATE: July 1, 2015

### ***Rare Disease Task Force***

[PA 15-242](#), § 35, establishes a 16-member task force to study rare diseases. The task force must (1) examine rare disease research, diagnoses, treatment, and education and (2) make recommendations for the establishment of a permanent group of experts to advise DPH on rare diseases. The task force must report its findings and recommendations to the Public Health Committee by January 1, 2016.

EFFECTIVE DATE: Upon passage

### ***Rising Health Care Costs Study***

[PA 15-146](#), § 19, requires the insurance commissioner, within available appropriations, to convene a working group that includes the state comptroller, healthcare advocate, and DPH commissioner, to study rising health care costs and related issues. The insurance commissioner must report to the legislature by January 1, 2016 on the study’s findings and legislative recommendations.

EFFECTIVE DATE: July 1, 2015

## **TELEHEALTH**

[PA 15-88](#) establishes requirements for providers who provide health care services through the use of “telehealth.” Among other things, a telehealth provider (1) must obtain a patient’s informed consent, at the first telehealth interaction, to provide telehealth services; (2) must not prescribe schedule I, II, or III controlled substances through the use of telehealth; and (3) must not charge a facility fee for telehealth services.

The act also requires certain health insurance policies to cover medical services provided through telehealth to the extent that they cover the services through in-person visits.

EFFECTIVE DATE: October 1, 2015, except for the insurance coverage provisions, which are effective January 1, 2016.

## **UNFAIR BILLING PRACTICES**

[PA 15-146](#), §§ 11 & 12, expands what constitutes an unfair trade practice by a health care provider. Under prior law, it was an unfair trade practice for a provider to request payment from a managed care plan enrollee for covered services, except for a copayment or deductible. The act instead makes it an unfair trade practice for a provider to request payment from a health care plan enrollee, except for a copayment, deductible, coinsurance, or other out-of-pocket expense, for (1) covered health care services or facility fees, (2)

covered emergency services rendered by an out-of-network provider, or (3) a surprise bill.

The act also makes it an unfair trade practice for a health care provider to report to a credit reporting agency an enrollee’s failure to pay a bill for the above-listed items when a carrier has primary responsibility for paying. Under prior law, it was an unfair trade practice to report to a credit reporting agency an enrollee’s failure to pay a bill for medical services that a managed care organization had primary responsibility for paying.

The act requires contracts between HMOs and participating providers to reflect what constitutes an unfair trade practice, as described above.

EFFECTIVE DATE: July 1, 2016

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