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UPDATE
Health Law Pulse

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Health Law Legislative Update Part 2

The following, part 2 of our two-part legislative update, is a general summary of certain significant legislation enacted during the 2011 Connecticut legislative session.

PUBLIC ACT 11-183: An Act Requiring Certificate of Need Approval for the Termination of Inpatient and Outpatient Services by a Hospital.

Effective as of July 13, 2011.

This new law requires hospitals to obtain a certificate of need (CON) to terminate inpatient or outpatient services. In addition, outpatient surgical facilities and any facility that provides outpatient surgical services as part of an outpatient surgery department of a short-term acute care general hospital must also obtain a CON to terminate outpatient services unless (1) termination is due to insufficient patient volume or (2) the facility is terminating a subspecialty surgical service. Health care facilities proposing to terminate a service authorized by a CON but not covered by these new requirements are still required to file a modification request with the Office of Health Care Access (OHCA).

PUBLIC ACT 11-175: An Act Concerning Workplace Violence Prevention and Response in Health Care Settings.

This new law contains several provisions related to the prevention of violence in health care settings.

The following provisions are effective as of July 1, 2011.

- Health care employers must establish a workplace safety committee no later than October 1, 2011. The term "health care employer" includes hospitals, outpatient surgical facilities, mental health facilities, and other institutions with 50 or more full- or part-time employees. The committee must include members of the facility's

administration, direct patient care staff, and security personnel, with at least 50 percent of the members being nonmanagement employees.

- Health care employers must undertake a risk assessment of the factors that put health care employees at risk for workplace violence. "Health care employees" are individuals directly or indirectly employed by, or volunteering for, health care employers who (1) are directly involved in patient care or (2) have direct contact with patients or their families when performing information collection or process functions, or escorting or directing patients or their families on the health care employer's premises. This risk assessment must be prepared no later than October 1, 2011, and annually thereafter. Each health care employer must then, in collaboration with its workplace safety committee, develop and implement a written workplace violence prevention and response plan no later than January 1, 2012, and annually thereafter. Hospitals may use an existing committee to assist in preparing the plan as long as at least 50 percent of the committee is comprised of nonmanagement employees. In addition, any health care employer may use existing policies and procedures to satisfy the requirement to have a workplace violence prevention plan if the risk assessment determines that such policies and procedures are sufficient.

- To the extent practicable, health care employers must adjust patient care assignments so that no health care employees who request adjustments to their patient care assignments are required to treat or provide services to patients who the employer knows to have intentionally physically abused or threatened the employees. However, behavior that is a direct manifestation of a patient's condition or disability is not considered to be physical abuse or threatening for purposes of this law. If the employer determines that it is not practical to reassign a patient, an employee can request that a second health care employee be present while treating the patient.

The following provisions are effective as of October 1, 2011.

- Health care employers must maintain records of workplace violence incidents. The records must include the specific area or department of the employer's premises where the incident occurred. Upon request from the Department of Public Health (DPH), a health care employer must report the number of workplace violence incidents occurring on its premises, as well as the specific area or department where the incidents occurred. Incidents involving persons with disabilities are excluded from this requirement if the conduct was a clear manifestation of such disability.

- Health care employers must report to local law enforcement any act against health care employees who are performing their duties when such act may constitute an assault or related offense. The report must be made no later than 24 hours following its occurrence.

- An assault of a health care employee is now a class C felony. However, if the defendant is a person with a disability, then a defense can be that the defendant's conduct was a clear and direct manifestation of such disability.

PUBLIC ACT 11-44: An Act Concerning the Bureau of Rehabilitative Services and Implementation of Provisions of the Budget Concerning Human Services and Public Health.

The following provision is effective as of June 13, 2011.

- The Department of Social Services (DSS) is now authorized to establish medical homes as models for delivering care to state medical assistance program beneficiaries. DSS may also establish a demonstration project to allow pediatric medical providers to organize accountable care organizations.

The following provisions are effective as of July 1, 2011.

- This new law maintains fiscal year 2011 payment rates through fiscal years 2012 and 2013 for nursing homes (including rest homes with nursing supervision), chronic disease hospitals associated with nursing homes, licensed residential care homes, and residential facilities for people with intellectual disabilities. However, any facility that would have been issued payments at a lower rate due to interim rate status or an agreement with DSS will receive payments at such lower rate. In addition, DSS may (1) increase rates to licensed chronic and convalescent nursing homes and rest homes with nursing supervision, provided such increases are within available appropriations and (2) increase rates to account for a facility's costs of complying with Connecticut law regarding certification of unlicensed personnel who administer medication in residential care homes. DSS may also increase the fair rent value credited to any such facility that has undergone a material change in circumstances related to fair rent and that has an approved CON.

- Currently, state reimbursement for prescription drugs covered by medical assistance programs administered by DSS is an amount equal to the lesser of (1) the federal acquisition cost, (2) the average wholesale price minus 14 percent, or (3) an equivalent percentage under the state Medicaid plan. This new law increases the percentage under option (2) to 16 percent. In addition, it reduces the professional fee paid by the state to licensed pharmacies from $2.90 to $2.00 for prescriptions of medical assistance program beneficiaries.

- DPH will establish and contract for a program to assist victims of sexual assault with payment for postexposure drugs for the prevention of human immunodeficiency virus. The program will be administered by using federal AIDS Services funding, totaling $25,000 annually. Priority will be given to individuals who are uninsured or underinsured, and for whom the program is a payer of last resort. DPH will issue a request for proposal for the administration of the program, to which any qualified organization may apply.

- OHCA's annual review of a hospital's provision of uncompensated care no longer requires hospitals to obtain and file an independent audit of the level of charges, payments, and discharges by primary payer that are related to Medicare, medical assistance, CHAMPUS or TriCare, nongovernmental payers, or the amount of uncompensated care, including emergency assistance provided to families. Instead, by February 28 of each year, hospitals must now file audited financial statements, which must include, in a format that OHCA specifies, verification of a hospital's net revenue for the most recently completed fiscal year.

PUBLIC ACT 11-137: An Act Concerning Administrative Hearings Under the Medicaid Electronic Health Record Incentive Program and Return Receipts for Agency Notices.

Effective as of July 8, 2011.

This new law requires DSS to establish a Medicaid electronic health record incentive program for eligible hospitals and other eligible health care providers that adopt and meaningfully use electronic health records (Medicaid Meaningful Use Program). Under the Medicaid Meaningful Use Program, eligible hospitals and health care providers may request review by the Commissioner of Social Services of certain adverse decisions, including eligibility for incentive payments, incentive payment amounts, and fulfillment of meaningful use criteria. In addition, if not satisfied with the Commissioner's review, eligible hospitals and health care providers may request an administrative hearing to contest the Commissioner's determination.

PUBLIC ACT 11-209: An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions.

Effective as of July 1, 2011.

This new law establishes a process through which a health care profession that seeks to establish a new scope of practice or change the scope of practice can have such request reviewed by DPH prior to consideration by the General Assembly. Any health care profession that may be directly affected by another health care profession's scope of practice request may submit a written impact statement to DPH identifying the nature of the impact, to which the original requestor must respond. A health care profession may request an exemption from the request process for reasons that include exigent circumstances or the lack of dispute concerning the request.

PUBLIC ACT 11-225: An Act Concerning Insurance Coverage for the Screening and Treatment of Prostate Cancer and Prohibiting Differential Payment Rates to Health Care Providers for Colonoscopy or Endoscopic Services based on Site of Service.

The following provision is effective as of October 1, 2011.

Insurers and other entities that contract directly with physicians, physician groups, or physician organizations (Contracting Physician) to provide medical services under individual or group insurance policies must now, at the Contracting Physician's request, establish a payment amount for the physician's professional component of colonoscopy or endoscopic services that is (1) the same regardless of where the physician's professional services are performed and (2) not less than the amount that would be paid to the Contracting Physician if the services were not performed at an outpatient surgical facility. This new law permits Contracting Physicians to agree to a different payment method for such services.

PUBLIC ACT 11-228: An Act Concerning Misrepresentation as a Board Certified Behavior Analyst.

Effective as of October 1, 2011.

This new law makes it a crime to use the words "board certified behavior analyst," "certified behavior analyst," "board certified assistant behavior analyst," or "certified assistant behavior analyst," or any abbreviation thereof, in connection with a name or business unless otherwise certified by the Behavior Analyst Certification Board. A violation of this law is punishable by a fine of up to $500, imprisonment up to five years, or both.

PUBLIC ACT 11-236: An Act Concerning the Transfer and Discharge of Nursing Facility Residents and Audits of Certain Long-Term Care Facilities.

The following provisions are effective as of July 13, 2011.

- This new law changes the discharge and transfer procedures for nursing facilities, nursing homes, and rest homes with nursing supervision. It allows residents to obtain a hearing in connection with an appeal of a discharge or transfer. Facilities subject to this new law must include in their discharge and transfer notices the date by which such an appeal must be filed for residents to preserve their right to such a hearing and the fact that there may be an exception to this deadline for good cause. Previously, such notices only needed to include the day by which the resident must file to stay the proposed transfer or discharge. If DSS receives a request for a hearing, and the facility's notice to the requesting resident did not comply with statutory requirements, the Commissioner of Social Services will order the discharge or transfer stayed and will require the facility to issue a revised notice. However, this provision will not apply in emergencies or in situations where the resident is not physically present in the facility.

- Under this new law, if DSS notifies a resident that he or she is no longer in need of the level of care provided by a facility, and that coverage for care will therefore end, the resident may request a hearing by the Commissioner of Social Services. If the resident requests a hearing prior to the date that Medicaid coverage is scheduled to end, such coverage will continue pending the outcome of the hearing.

- If the Commissioner of Social Services finds that a resident has been improperly refused readmission to a facility after hospitalization (or, with respect to recipients of state medical assistance, authorized home leave), the resident has the right to be readmitted to such facility regardless of whether he or she accepted placement in a different facility while waiting for a bed to become available.

- This new law establishes a consultation procedure for facilities concerned about readmitting residents after hospitalization, due to the facility's ability to meet the resident's care needs or concerns about whether the resident is a danger to himself or others. In such event, the facility may request a consultation with the hospital no later

than 24 hours after the hospital notifies the facility that the resident is ready for discharge. Through the consultation, which must begin no later than three business days after the facility's request, the facility and hospital will develop a care plan for the resident that takes into consideration his or her wishes and the hospital's recommendations. The facility must reserve the resident's bed until the consultation process is complete. A facility may only refuse to admit a resident if (1) the facility cannot meet his or her needs, (2) the resident's health has improved such that he or she no longer needs the facility's services, or (3) readmission would endanger the health and safety of other individuals in the facility. No later than 24 hours after the decision not to readmit a resident, the facility must notify the hospital, the resident, and the resident's guardian or conservator of its decision. The notice must contain several provisions, including the reason for the refusal, the right to appeal, and the deadline for initiating an appeal. In addition, a resident may file a complaint against the facility for its refusal to readmit him or her. If a resident also files an appeal, then an investigation of the complaint will be stayed, pending a determination from the hearing.

- Finally, this new law requires that when a hospital refers a patient to a nursing home as part of its discharge planning process such hospital must make a copy of the patient's hospital record available to the nursing home and provide the nursing home with access to the patient for purposes of planning and consultation.

PUBLIC ACT 11-242: An Act Concerning Various Revisions to Public Health Related Statutes.

The following provisions are effective as of July 1, 2011.

- With few exceptions, health care practitioner licensing boards, commissions, or DPH may take disciplinary action against a practitioner's license or permit if such practitioner has been or becomes subject to disciplinary action, similar to an action that may be taken under Connecticut law, by a duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction. In taking disciplinary action, such licensing board, commission, or DPH may rely upon the findings and conclusions made by a duly authorized professional disciplinary agency of another jurisdiction.

- Under the existing law, hospitals are authorized to designate a licensed health care provider or a certified ultrasound or nuclear medicine technologist to perform oxygen-related patient care activities (for example, connecting or disconnecting an oxygen supply, or transporting a portable oxygen source), provided that such designated individual meets certain education and training requirements. This revised law clarifies that hospitals, under such authorization, are not prohibited from designating persons who are authorized to transport patients with portable oxygen sources to perform oxygen-related patient care activities in the hospital.

- DPH may now restrict, suspend, or limit the license or permit of any person subject to regulation or licensing by DPH who has entered into an interim consent order during the pendency of an investigation into complaints regarding such person.

- The board of the Health Information Technology Exchange of Connecticut will establish an advisory committee on patient privacy and security to (1) monitor developments in federal law concerning patient privacy and security relating to health information technology and (2) report to the board on national and regional trends, federal policies, and relevant guidance. Members of the advisory committee will be appointed by the chairperson of the board, and will include, but not be limited to (1) a representative from a nonprofit research and educational organization dedicated to improving access to health care, (2) a representative from a patient advocacy group, (3) an ethicist, (4) an attorney with expertise in health information technology and the protections set forth in the Health Insurance Portability and Accountability Act of 1996, (5) the chief information officer of a hospital, (6) an insurer or representative of a health plan, and (7) a primary care physician who utilizes electronic health records.

- This new law increases the dentistry residency or fellowship training requirement to three years for foreign-educated applicants.

- This revised law establishes measures by which the federal Vaccines for Children immunization program, administered by DPH, will be implemented. The Vaccines for Children program provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Beginning October 1, 2011, DPH will provide certain vaccines at no cost to certain health care providers in Bridgeport, New Haven, and Hartford who participate in the Vaccines for Children immunization program so that such health care providers can administer such vaccines to children. Unless the program yields adverse results in child immunization rates or to the health and safety of children, DPH will expand the distribution of free vaccines to all health care providers who participate in the federal Vaccines for Children immunization program, commencing July 1, 2012.

- This law increases late fees on annual assessments to be paid by hospitals to OHCA and authorizes DPH to require such payment to be paid by electronic funds transfer. Under the prior law, annual assessments due by hospitals were subject to a late fee of $10, plus interest charged at 1.25 percent per month. Under this revised law, such assessments not paid when due are subject to a fee equal to (1) 2 percent of the assessment if a hospital's payment is up to 5 days late, (2) 5 percent of the assessment if such payment is more than 5 days but less than 15 days late, or (3) 10 percent of the assessment if such payment is more than 15 days late. If a hospital fails to pay any assessment for more than 30 days after the due date, DPH may impose a civil penalty of up to $1,000 per day for each day past the initial 30 days that the assessment is not paid. If payment is required by electronic funds transfer, but is made by some other method, the hospital is subject to a penalty equal to 10 percent of the assessment.

- Prior to July 1, 2011, chiropractors were prohibited from practicing under any name other than the name of the chiropractor owning the practice or a corporate name that included the name or names of the chiropractor owners of the practice. The revised law deletes this prohibition. DPH will not initiate disciplinary actions against licensed chiropractors who are alleged to have been practicing under a prohibited name.

The following provisions are effective as of July 13, 2011.

- The definition of the practice of nursing by a licensed practical nurse has been revised to refer to persons acting under the direction of a registered nurse or advanced practice registered nurse who are executing the orders of a physician, physician assistant, podiatrist, optometrist, or dentist. The definition was previously limited to persons carrying out the orders of a physician or dentist.

- This new law authorizes the Department of Consumer Protection (DCP) to establish a pilot program to permit a hospital pharmacist to supervise, via audio and video communication, pharmacy technicians at such hospital's satellite or remote locations in the preparation of intravenous admixtures. Any hospital participating in the pilot program must undertake periodic quality assurance evaluations to assess any error in medication administration that occurs under the pilot program. The pilot program will begin on or after July 1, 2011, and end no later than December 31, 2012.

- This revised law requires a state-operated hospital, facility, or institution to apply for a CON from OHCA prior to the termination of inpatient or outpatient services eligible for reimbursement under Medicare or Medicaid.

The following provisions are effective as of October 1, 2011.

- Hospitals must file a report with DPH for any foundling, which is defined as any child of unknown parentage or an infant voluntarily surrendered.

- This revised law allows a person's appointed conservator to access and obtain the birth and fetal death records of such person.

- Prescribing practitioners who diagnose a patient with chlamydia or gonorrhea may prescribe and dispense oral antibiotic drugs to such patient and the patient's partner or partners without a physical examination of such partner or partners. A prescribing practitioner who prescribes or dispenses oral antibiotic drugs to the partner or partners of a patient will not be deemed to have violated the standard of care for the prescribing or dispensing of drugs.

- All licensed chiropractors applying for license renewal must participate in continuing education programs. On or before October 1, 2011, DPH will issue a list of no more than five mandatory topics for continuing education activities required for the registration period beginning in October 2012 and for the two subsequent registration periods. New lists of mandatory continuing education topics will be issued biennially.

- Under this revised law, the independent decision-making authority of the Deputy Commissioner of Public Health is limited to CON decisions. The Deputy Commissioner's authority previously extended over all matters related to CON determinations, orders, decisions, and settlements. In addition, this law modifies the requirement that applicants for a CON publish notice of such application in a local newspaper. Such notice must be published at least 20 days before the application is filed, and the application must be filed within 90 days of published notice.

- Under this revised law, DPH no longer charges maternity homes, which are operated for the purpose of caring for women during pregnancy and for women and their infants following pregnancy, with per site or per bed licensing fees; however, outpatient clinics that provide medical or mental health service and well-child clinics, except those operated by municipal health departments, health districts, or licensed nonprofit nursing or community health agencies, are still required to pay a licensing fee of $1,000.

- DPH no longer provides to unserved or underserved female populations a 60-day follow-up pap test for victims of sexual assault. The age requirement of unserved or underserved female populations is redefined as women age 21 to 64, instead of age 19 to 64.

- Any communications privileged by a doctor-patient relationship or therapist-patient relationship are now exempt from the disclosure requirements of the Freedom of Information Act. In addition, all confidential records obtained during the inspection, investigation, examination, and audit activities of an institution, pursuant to a contract between DPH and the United States Department of Health and Human Services relating to the Medicare and Medicaid programs, are also exempt from disclosure.

- DPH now permits the use of saliva-based drug screening or urinalysis when conducting drug screenings of persons who abuse substances other than alcohol at facilities licensed by DPH.

- The revised statute makes changes to the training requirements for physicians who use fluoroscopy for diagnostic and therapeutic procedures. Under the revised requirements, such physicians must (1) complete 40 hours of didactic instruction relevant to fluoroscopy, (2) complete a minimum of 40 hours of supervised clinical experience, and (3) pass an examination prescribed by DPH.

- The definition of "the practice of acupuncture" has been revised to refer to the system of restoring and maintaining health by the classical and modern Oriental medicine principles and methods of assessment, treatment, and prevention of diseases, disorders, and dysfunctions of the body, injury, pain, and other conditions. This revised definition also sets forth specific practices included in the practice of acupuncture.

- This revised law authorizes DPH to impose a directed plan of action, in addition to existing disciplinary measures, upon a health care institution in the event DPH determines that such institution has substantially failed to comply with the Public Health Code or licensing regulations. Currently, DPH may suspend or revoke licensure; issue censures, reprimands, or orders compelling compliance; restrict the acquisition of other facilities; or place a licensee or certificate holder on probationary status.

The following provisions are effective as of January 1, 2012:

- By July 1, 2012, DPH will create and implement a criminal history and patient abuse background search program that facilitates the performance, processing, and analysis of criminal history and patient abuse background searches of prospective employees, contractors, or volunteers who have direct access to patients or residents of a long-term care facility. For the purposes of this law, long-term care facilities include, but are

not limited to, nursing homes and home health agencies. Generally, a long-term care facility may not enter into an agreement with such employee, contractor or volunteer until the facility has received a report from DPH regarding such person's history. Until such time that the program has been implemented, home health agencies must perform a comprehensive background check on prospective employees, contractors, and volunteers. In addition, each home health agency must require that prospective employees sign a form disclosing whether they were subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction.

- This revised law also requires that prospective employees of homemaker-companion agencies submit to comprehensive background checks. DCP may revoke, suspend, or refuse to issue or renew the certificate of registration of a homemaker-companion agency that has failed to comply with the applicable background check requirements for employees of such agency.

PUBLIC ACT 11-58: An Act Concerning Health Care Reform.

The following provisions are effective as of July 1, 2011.

- Short-term acute care general and children's hospitals are now required to submit patient-identifiable discharge and emergency department data to OHCA at such time and in such format as specified by OHCA.

- This revised law also creates new requirements regarding submission of outpatient data to OHCA that apply to outpatient surgical facilities, short-term acute care general or children's hospitals, and facilities that provide outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital. The data submitted must include at such dates specified by OHCA (1) the name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed, and scans performed in a calendar year.

- Any patient-identifiable data received by OHCA is kept confidential and is not subject to disclosure under the Freedom of Information Act. OHCA may release de-identified patient data or aggregate patient data, which must exclude provider, physician, and payer organization names or codes. As of October 1, 2011, the Comptroller will have access to reportable data.

- OHCA is required to convene representatives of outpatient surgical facilities and hospitals, and other necessary individuals, to address obstacles to, and develop proposed requirements for, patient-identifiable reporting in the outpatient setting. Furthermore, prior to July 1, 2012, the Connecticut Association of Ambulatory Surgery Centers will provide annual progress reports to DPH on the implementation of systems that allow for the reporting of outpatient data as required by DPH.

PUBLIC ACT 11-132: An Act Concerning Most Favored Nation Clauses in Health Care Provider Contracts.

Effective October 1, 2011.

This revised law prohibits managed care organizations and preferred provider networks (original contracting health organization) from including certain clauses, covenants, or agreements in participating provider contracts, contracts with dentists, or contracts with hospitals entered into, renewed or amended after October 1, 2011.

The prohibited contract provisions are as follows:

- Any clause requiring disclosure of payment or reimbursement rates from any other contracting health organization that the provider, dentist, or hospital has contracted with or with which it may contract.
- Any clause requiring services to be provided at a rate equal to, or lower than, the lowest rate that the provider, dentist, or hospital has contracted for, or may contract for, with another contracting health organization.
- Any clause requiring a provider, dentist, or hospital to certify that it has not contracted with any other contracting health organization to provide services or procedures at a rate lower than the contracted rate with the original contracting health organization.
- Any clause, covenant, or agreement that prohibits or limits a provider, dentist, or hospital from contracting with any other contracting health organization to provide services or procedures at a rate lower than the contracted rates with the original contracting health organization.
- Any clause that allows the original contracting health organization to terminate or renegotiate the contract if the provider, dentist, or hospital contracts with another contracting health organization to provide services or procedures at a lower rate than the contracted rates with the original contracting health organization.

Any such clause in a contract with an effective date prior to October 1, 2011, will be void and unenforceable on the date the contract is next renewed, or on January 1, 2014, whichever is earlier. Contracting health organizations may enforce such clauses prior to invalidation. Invalidation does not affect other provisions of the contract.

If you have questions about any of these new laws, contact a member of our Health Law Group.

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