

## Connecticut Health Law Legislative Update

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Following the close of the Connecticut General Assembly's 2016 legislative session, Governor Dannel P. Malloy signed into law a number of bills that affect health care providers in Connecticut. Below is a summary of significant, newly enacted health care laws.

### **Public Act 16-95: An Act Concerning Matters Affecting Physicians, Health Care Facilities And Medical Foundations.**

#### **PHYSICIAN NONCOMPETES**

*Effective July 1, 2016*

As [previously published](#) in the *Pulse*, Public Act 16-95 (P.A. 16-95) places significant restrictions on covenants not to compete that involve physicians.

#### **MEDICAL FOUNDATIONS**

*Effective October 1, 2016*

Current law permits a hospital, health system, or medical school to organize and become a member of a medical foundation, which can practice medicine through its employees or agents who are physicians, chiropractors, optometrists, or podiatrists (collectively, providers). Current law prohibits a medical foundation from operating as a for-profit entity.

P.A. 16-95 authorizes independent practice associations (IPAs) and certain "other business entities" to organize and join for-profit or nonprofit medical foundations. IPAs are organizations (1) that have only independent providers as owners or members or that are owned by a tax-exempt, state-wide professional medical membership association and controlled by independent providers and (2) that provide services to and on behalf of its members or owners. Only Connecticut-licensed physicians may own, control, or be a member in an IPA.

The "other business entities" permitted to join or form a medical foundation must be registered to do business and have their principal place of business in Connecticut and have at least 60 percent of its ownership or control held, individually or jointly, by (1) an IPA; (2) a provider; or (3) a professional medical partnership, professional corporation (PC), or limited liability company (LLC) (other than a "captive professional entity" as defined below) in which all partners, shareholders, or members are Connecticut-licensed physicians. The inclusion of the term "provider" in the definition of other business entities arguably creates a conflict with Connecticut's corporate practice of medicine doctrine. It remains to be seen how courts will resolve this potential conflict.

An IPA or other business entity forming a medical foundation cannot be owned or controlled by a hospital, health system, medical school, or medical foundation organized by a hospital, health system, or medical school. P.A. 16-95 prohibits employees and representatives of hospitals, health systems medical schools, or any entity controlling the foregoing from serving on the board of a medical foundation formed by an IPA or other business entity. This legislation also restricts anyone from simultaneously serving on the board of more than one medical foundation.

Medical foundations formed or joined by hospitals, health systems, or medical schools must continue to be organized as nonprofit entities.

Current law requires all medical foundations to annually report certain information to the Office of Health Care Access. This legislation expands the reporting obligations to include (1) the names and addresses of the medical foundation's organizing members; (2) the name and employer of each board member; (3) the name, specialty, practice location, and description of services provided at such location for each physician employee or agent of the medical foundation; and (4) a copy of the medical foundation's governing documents and bylaws.

#### **OTHER RELEVANT PROVISIONS OF P.A. 16-95**

- This legislation expands the definition of "captive professional entity" for purposes of the medical foundation law described above and physician group practice reporting requirements. Under the revised definition, a captive professional entity is a partnership, PC, LLC, or other professional services entity in which a physician is a beneficial owner and is directly or indirectly employed by, controlled by, or subject to the direction of (1) a hospital, health system, medical school, or medical foundation or (2) an entity that controls, is controlled by, or is under common control with any such organization. *Effective October 1, 2016*
- When a health care provider refers a patient to an affiliated health care provider that is not a member of the referring provider's partnership, PC, or LLC, existing law requires the health care provider to provide the patient with certain information. Under this legislation, health care providers must notify the patient that the referred-to providers are affiliated providers and that the patient may seek care from an alternate provider of his choice. The provider must also advise the patient to contact his health carrier to receive information concerning in-network services. *Effective July 1, 2016*
- Under P.A. 16-95, hospitals must include its cost-to-charge ratio on all bills to patients and third-party payors. *Effective October 1, 2016*

#### **Public Act 16-39: An Act Concerning The Authority And Responsibilities Of Advanced Practice Registered Nurses.**

*Effective October 1, 2016, except as noted otherwise below*

Public Act 16-39 (P.A. 16-39) extends to advance practice registered nurses (APRNs) authority that, under current law, is generally held only by physicians. Highlights of certain significant sections of P.A. 16-39 are as follows:

- P.A. 16-39 revises the patients' bill of rights for residents of nursing homes, residential care homes, and chronic disease hospitals by, among other things, (1) granting patients the right to choose not only their physician but also their APRN, (2) allowing APRNs to order physical or chemical restraints of patients, (3) permitting APRNs to order administration of psychopharmacologic drugs, and (4) allowing the patient's APRN to consult with the facility regarding certain proposals to transfer a patient to another room.

- This legislation allows APRNs to document the basis for transferring or discharging a resident from a Medicaid-certified nursing facility, Medicare-certified skilled nursing facility, chronic or convalescent nursing home, or a rest home with nursing supervision. Under the new law, APRNs may also develop a resident's discharge plan prior to transfer or discharge. Current law allows only the resident's personal physician or the facility's medical director, in conjunction with a social worker, nursing director, or other health care provider, to develop a resident's discharge plan.
- Current law requires the attending physician to make reasonable efforts to notify a patient's health care representative, next of kin, legal guardian, conservator, or other designated person within a reasonable time prior to withholding or removing the patient's life support system. This legislation places the foregoing notification obligations on either the attending physician or APRN.
- P.A. 16-39 provides APRNs with the same civil and criminal immunity afforded to physicians for removing a patient's life support. As with physicians, to qualify for this immunity, APRNs must exercise their best medical judgment, the patient must be in a terminal condition, and APRNs must consider the patient's wishes. APRNs must also comply with federal regulations concerning removal of life support from infants.
- This legislation permits APRNs to issue "do not resuscitate" orders.
- P.A. 16-39 authorizes APRNs to direct the care of and issue written protocols for respiratory care.
- This legislation allows APRNs to authorize paramedics to administer drugs and intravenous solutions and to order paramedics to administer controlled substances.
- P.A. 16-39 authorizes APRNs to issue written certifications to qualifying patients (except those with glaucoma as the qualifying condition) authorizing the palliative use of marijuana. This legislation also provides APRNs with the same civil, criminal, and disciplinary liability protections as physicians related to providing certifications for the palliative use of marijuana. The new law also permits the Department of Consumer Protection (DCP) to issue APRNs licenses to possess and supply marijuana to treat chemotherapy side effects. These medical marijuana-related provisions of P.A. 16-39 are effective January 1, 2017.

## **Public Act 16-25: An Act Concerning Telehealth Providers.**

*Effective October 1, 2016*

Current law permits physicians, physician assistants, advance practice registered nurses, and numerous other categories of health care providers to provide health care services using telehealth. Under Public Act 16-25 (P.A. 16-25), licensed speech and language pathologists, respiratory care practitioners, and audiologists are added to the list of health care providers permitted to provide telehealth services.

The existing telehealth rules do not restrict "health care providers" from providing on-call coverage, consulting with other providers regarding a patient's care, and issuing orders for hospital patients. P.A. 16-25 expands the definition

of “health care providers” for these purposes to include a number of new categories of providers, including, but not limited to, licensed speech and language pathologists, respiratory care practitioners, and audiologists.

## **Public Act 16-77: An Act Concerning Patient Notices, Designation Of A Health Information Technology Officer, Assets Purchased For The State-Wide Health Information Exchange And Membership Of The State Health Information Technology Advisory Council.**

*Effective upon passage*

This legislation (P.A. 16-77) makes substantive and technical changes related to Public Act [15-146](#), a major public health and health care bill passed by the Connecticut legislature during its 2015 legislative session.

### **CONNECTICUT HEALTH INSURANCE EXCHANGE CONSUMER INFORMATION WEBSITE**

Under current law, Connecticut’s Health Insurance Exchange (HIX) is required, within available resources, to establish and maintain a consumer health information website by July 1, 2016. The HIX website must include price and cost information for the most common inpatient diagnoses and procedures, outpatient procedures, and surgical and imaging procedures, listed by health care provider and categorized by third-party payer, based on a list published by the Department of Public Health (DPH) and the Insurance Department (CID) on their websites (Joint Report). Current law provides that, starting January 1, 2017, hospitals will be required to inform a patient of the patient’s right to request cost and quality information at the time of scheduling a diagnosis or procedure for nonemergency care listed on the Joint Report. If the patient requests such information regarding the diagnosis or procedure, a hospital must, within three business days, provide the patient information on (1) the amount the patient will be charged if uninsured, including the amount of a facility fee; (2) the Medicare reimbursement amount; (3) if the patient is insured, the allowed amount and the insurer’s contact information so that the patient may obtain additional information regarding charges and out-of-pocket costs; (4) the hospital’s Joint Commission composite accountability rating and Medicare star rating; and (5) the website addresses for the Joint Commission and Medicare hospital compare tool. If the patient is insured and the hospital is out-of-network under the insurance policy, the hospital’s notice must also state that out-of-network rates may apply.

P.A. 16-77 delays the implementation date for requiring hospitals to provide patients with notice of their right to request cost and quality information. Under this legislation, hospitals will not be required to provide such notices until 180 days after the CID and the DPH issue the Joint Report on their websites. Additionally, in the event a patient’s diagnosis or procedure has no corresponding Medicare reimbursement amount, this legislation requires a hospital to instead notify the patient of either the approximate amount or the percentage of the hospital’s charges that Medicare would have paid for the services. P.A. 16-77 also clarifies that the location or setting of scheduled nonemergency care is immaterial for purposes of implicating the notice requirement.

### **FACILITY FEE NOTIFICATION**

Currently, billing statements that include a facility fee must clearly identify the facility fee and provide certain additional information, including the Medicare facility fee reimbursement rate for the same service and notice to patients of their right to request a reduction in the facility fee or any other portion of their bill. Under P.A. 16-77, the requirement to provide this information is limited to the initial billing statement. In addition, if there is no corresponding

Medicare facility fee for the service, the hospital must provide either the approximate amount, or the percentage of the hospital's charges, that Medicare would have paid the hospital for the facility fee. This legislation also clarifies that hospitals are required to notify patients of their right to request a reduction in the facility fee or any other portion of their bill without regard to whether such patient qualifies for, or is likely to be granted, a reduction.

Under current law, hospitals, health systems, and hospital-based facilities are prohibited, as of January 1, 2017, from collecting a facility fee for (1) outpatient services provided at an off-campus hospital-based facility, other than a hospital emergency department, that uses a current procedural terminology evaluation and management code, or (2) from uninsured patients in excess of the Medicare rate for outpatient services unless such services were provided in an emergency department not located on a hospital campus; however, if a contract providing for payment of facility fees was in effect on July 1, 2016, between a health insurer and a hospital, health system, or hospital-based facility, then such a provider may continue to collect reimbursement for facility fees from the health insurer until the expiration of such contract. P.A. 16-77 exempts application of these facility fee prohibitions if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation medical plan.

#### **HEALTH INSURER CONSUMER INFORMATION WEBSITES**

Current law requires health insurance carriers in Connecticut to maintain a website and toll-free telephone number to allow consumers to obtain insurance cost and network information related to specific procedures and providers by July 1, 2016. P.A. 16-77 delays the deadline for establishing this website until January 1, 2017, and also exempts all health insurance carriers with less than 40,000 covered lives in Connecticut from having to maintain such a website.

#### **Public Act 16-43: An Act Concerning Opioids And Access To Overdose Reversal Drugs.**

Public Act 16-43 (P.A. 16-43) implements new restrictions on the prescription of opioid drugs and makes certain revisions to Connecticut's controlled substance laws as part of Connecticut's efforts to curb opioid drug abuse. The provisions of P.A. 16-43 are effective as of the dates noted below.

#### **OPIOID DRUG PRESCRIBING RESTRICTIONS**

*Effective July 1, 2016*

P.A. 16-43 implements new restrictions on the prescription of opioid drugs. This legislation specifically includes the following.

- In accordance with the recommendations set forth in the National Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain, prescribing practitioners issuing an opioid prescription for the first time to an adult patient for outpatient use are prohibited from issuing a prescription for more than a seven-day supply of such drug except in limited circumstances.
- Prescribing practitioners are prohibited from issuing a prescription to a minor patient for more than a seven-day supply of an opioid drug at any time except in limited circumstances. If a practitioner prescribes less than a seven-day supply of an opioid drug to a minor patient, then at the time of prescribing the practitioner must discuss the prescription with the minor patient and, if present, the patient's custodial parent, guardian, or other person having legal custody of the minor. This discussion must cover the reasons why the

prescription is necessary, risks associated with opioid drug use (including addiction and overdose), and the dangers of taking opioids with alcohol, benzodiazepines, and other central nervous system depressants.

- The seven-day supply restrictions described above do not apply if, in the professional medical judgment of the prescribing practitioner, more than a seven-day supply is required to treat a patient's acute medical condition or is necessary for treatment of the patient's chronic pain, pain associated with a cancer diagnosis, or pain related to palliative care. In such event, the triggering condition must be documented in the patient's medical record, and the practitioner must indicate that an alternative to the opioid drug was not appropriate to address the patient's condition.

P.A. 16-43 defines "opioid drug" by reference to federal controlled substance regulations, which define opioid drug as "any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability." This legislation also stipulates that the opioid prescribing and documentation requirements set forth above do not apply to medications designed for treatment of abuse of, or dependence on, an opioid drug, including without limitation opioid agonists and opioid antagonists. "Opioid antagonist" is defined to include naloxone hydrochloride (a/k/a Narcan) or any "similarly acting and equally safe" drug approved by the Food and Drug Administration (FDA) for treatment of a drug overdose, and "opioid agonist" refers to any medication that binds to opiate receptors and provides relief for opioid abuse or dependence.

## **ADMINISTRATION OF OPIOID ANTAGONISTS BY LICENSED HEALTH CARE PROFESSIONALS**

### *Effective upon passage*

Under current law, only a licensed health care professional who is legally authorized to prescribe an opioid antagonist is permitted to administer an opioid antagonist to treat or prevent a drug overdose. Under P.A. 16-43, all licensed health care professionals are permitted to administer an opioid antagonist to treat or prevent an opioid-related drug overdose; however, the legislation does not expand the types of health care professionals authorized to prescribe or dispense opioid antagonists. Consistent with existing law, this legislation states that all licensed health care professionals who administer opioid antagonists to prevent or treat an overdose are immune from criminal or civil liability or professional discipline under such circumstances.

## **HIPAA NONCOMPLIANCE GROUNDS FOR DISCIPLINARY ACTION AGAINST CONTROLLED SUBSTANCE REGISTRANTS**

### *Effective October 1, 2016*

Current law allows DCP to take certain disciplinary actions, including suspension, revocation or nonrenewal of a registration, or imposition of civil penalties, against registered practitioners who distribute, administer, or dispense controlled substances in the event of certain prohibited occurrences. P.A. 16-43 expands the bases on which disciplinary action may be imposed against a registrant to include (1) failure to establish and implement administrative safeguards for the protection of electronic protected health information in accordance with the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and (2) breach of any such safeguards by a prescribing practitioner's authorized agent.

## **REVISIONS TO ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM**

*Effective July 1, 2016*

Current law requires DCP to operate an electronic prescription drug monitoring program to collect prescription information regarding dispensing of controlled substances in schedules II, III, IV, and V. As of July 1, 2016, every pharmacy and dispenser of controlled substances is required to report certain information regarding prescriptions of such controlled substances to DCP via the electronic prescription drug monitoring program no later than 24 hours after dispensing such a prescription. P.A. 16-43 revises that deadline to provide that pharmacies and dispensers must make such a report to DCP by the end of the next business day after dispensing a schedule II to V controlled substance. Moreover, if the prescription drug monitoring program is not operational, the pharmacy or dispenser is required to report the necessary information by the next business day after regaining access to the program.

Under current law, DCP may provide controlled substance prescription information to a prescribing practitioner with whom a patient has made contact for the purpose of seeking medical treatment as long as the patient consents in writing. This legislation permits DCP to also release controlled substance prescription information to the authorized agent of a prescribing practitioner with whom a patient has made contact for the purpose of seeking medical treatment as long as such request is accompanied by the patient's written consent.

Current law requires prescribing practitioners, or their authorized agent (who is also a licensed health care professional), to review a patient's records in the electronic prescription drug monitoring program before prescribing more than a 72-hour supply of any controlled substance to such patient. Current law also requires prescribing practitioners or their authorized agent (who is also a licensed health care professional) to review a patient's records in the electronic prescription drug program at least every 90 days following prescription of a controlled substance as part of the continuous or prolonged treatment of a patient. This legislation removes the requirement that a prescribing practitioner's authorized agent be a licensed health care professional. P.A. 16-43 also clarifies that, where a schedule V nonnarcotic controlled substance is prescribed for the continuous or prolonged treatment of any patient, prescribing practitioners, or their authorized agent, are only required to review the electronic prescription drug monitoring program at least annually. In connection with these changes, this legislation also revises the current definition of "agent" as used in Connecticut's controlled substance laws to expressly provide that an agent may act on behalf of, or at the direction of, a prescribing practitioner in addition to acting on behalf of, or at the direction of, a manufacturer, distributor, or dispenser.

Additionally, this legislation expressly permits prescribing practitioners to designate an authorized agent to review electronic prescription drug monitoring programs and patient controlled substance prescription information on behalf of the prescribing practitioner. The prescribing practitioner must ensure that an authorized agent's access to the program and information protects patient confidentiality and is limited to permitted purposes. This legislation also provides that such access is subject to, and must comply with, HIPAA and that a prescribing practitioner is subject to disciplinary action for the acts of the authorized agent.

P.A. 16-43 provides that, where a prescribing practitioner is employed by or provides professional services to a hospital, prior to designating an authorized agent, the prescribing practitioner is required to submit a request to DCP that designates one or more authorized agents along with a written protocol for oversight of the authorized agent(s), which DCP must then approve. The written protocol must designate the hospital's medical director, a hospital

department head (who is a prescribing practitioner), or another prescribing practitioner as the overseer of the authorized agent(s). The individual responsible for oversight of the agents must ensure that an agent's access to the electronic prescription drug program and information is limited to permitted purposes and protects patient confidentiality. The individual responsible for oversight of the authorized agent(s) is also subject to disciplinary action for the acts of the authorized agent(s).

## **FIRST RESPONDERS TO BE TRAINED ON AND EQUIPPED WITH OPIOID ANTAGONISTS**

*Effective upon passage*

P.A. 16-43 requires each municipality in Connecticut to amend its local emergency services plan by October 1, 2016, to ensure that emergency first responders are equipped with opioid antagonists and have received DPH-approved training in the administration of such opioid antagonists.

## **PROHIBITION ON PRIOR AUTHORIZATION REQUIREMENT FOR OPIOID ANTAGONISTS**

*Effective January 1, 2017*

This legislation prohibits certain health insurance policies from requiring prior authorization for the opioid antagonist naloxone hydrochloride (a/k/a Narcan) or any other similarly acting and equally safe drug that has received FDA approval for the treatment of drug overdose. This prohibition applies to individual and group health insurance policies that include prescription drug coverage of Narcan in addition to the following: (1) basic hospital expense coverage, (2) basic medical-surgical expense coverage, (3) major medical expense coverage, (4) hospital or medical service plan contracts, (5) hospital and medical coverage provided to subscribers of a health care center, and (6) single service ancillary health coverage.

## **SCOPE OF PRACTICE FOR ALCOHOL AND DRUG COUNSELORS**

*Effective October 1, 2016*

Finally, P.A. 16-43 clarifies that the scope of practice of alcohol and drug counseling by licensed or certified alcohol and drug counselors may include (1) conducting a psychosocial history to determine an individual's risk for substance abuse, (2) developing a preliminary diagnosis based on such evaluation or screening, (3) determining the individual's risk of abuse of prescription or illegal drugs or alcohol, (4) developing a treatment plan and referral options for the individual, and (5) submitting a consultation report on opioid use to the individual's primary care provider for review and inclusion in the individual's medical record.

## **Public Act 16-66: An Act Concerning Various Revisions To The Public Health Statutes.**

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

*Effective October 1, 2016*

Under current law, physicians, physician assistants, and hospitals must file a petition with DPH within 30 days of receiving information that a physician or physician assistant is or may be unable to practice with reasonable skill or safety due to a variety of reasons, including physical or mental impairment and chemical dependency. Similarly, current law requires "health care professionals" to file a petition with DPH within 30 days of receiving any information



that another health care professional is unable to practice with reasonable skill or safety. The term “health care professional” is currently defined to include podiatrists, dentists, psychologists, physical and occupational therapists, and other health care professionals but does not include physicians or physician assistants.

This legislation (P.A. 16-66) revises the definition of “health care professional” to include physicians and physician assistants, as well as nursing home administrators, perfusionists, electrologists, and audiologists.

#### **OTHER RELEVANT PROVISIONS OF PUBLIC ACT 16-66**

- Under this new legislation, the Department of Social Services (DSS), in consultation with the Office of Policy and Management, may waive a Medicaid overpayment recoupment from a hospital if the hospital was under prior ownership during a portion of the relevant audit period. *Effective upon passage.*
- P.A. 16-66 removes rest homes from the list of DPH-licensed institutions and revises the definitions of residential care home and nursing home for DPH licensure purposes. Under this legislation, a residential care home is defined as a community residence that furnishes, in one or more facilities, food and shelter to two or more persons not related to the proprietor of the residence and provides services that meet a need beyond the basic provisions of food, shelter, and laundry. Residential care homes may qualify as a setting that permits residents to receive state- and federal-funded home and community-based services. A nursing home or nursing home facility is now defined as (1) any chronic and convalescent nursing home or rest home with nursing supervision that provides 24-hour nursing supervision under a medical director or (2) any chronic and convalescent nursing home that provides skilled nursing care, under medical supervision and direction, to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases, or injuries. *Effective October 1, 2016*
- For purposes of the DPH licensure statutes, this legislation renames mental health facilities as behavioral health facilities and revises the definition of behavioral health facilities to state that behavioral health facilities are facilities that provide (1) mental health services to individuals aged 18 years or older or (2) substance use disorder services to individuals of any age in an outpatient or residential setting. *Effective October 1, 2016*
- Existing law permits certified homemaker-home health aides to administer certain medications, except those administered by injection, as long as a registered nurse delegates such task to the homemaker-home health aide. This legislation requires homemaker-home health aides to obtain recertification every three years to continue administering medications. *Effective October 1, 2016*

#### **Public Act 16-23: An Act Concerning The Palliative Use Of Marijuana.**

*Effective October 1, 2016*

This legislation (P.A. 16-23) makes a number of revisions to Connecticut statutes governing the palliative use of marijuana by patients to treat certain medical conditions.

## **CURRENT LAW ON THE PALLIATIVE USE OF MARIJUANA**

Under current law, only a “qualifying patient” is permitted to engage in the palliative use of marijuana in Connecticut. Current law defines qualifying patient as a Connecticut resident 18 years of age or older who has been diagnosed as having a “debilitating medical condition.” A debilitating medical condition is currently defined to include (1) cancer, (2) glaucoma, (3) Parkinson’s disease, (4) multiple sclerosis, (5) epilepsy, (6) Crohn’s disease, (7) positive status for human immunodeficiency virus or acquired immune deficiency syndrome, (8) damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, (9) cachexia, (10) wasting syndrome, (11) posttraumatic stress disorder or any other condition, medical treatment, or disease approved in regulations adopted by DCP. A physician must issue a written certification to a qualifying patient authorizing the palliative use of marijuana. Current law also requires certain qualifying patients to have a “primary caregiver,” which is currently defined as a person 18 years of age or older (other than the qualifying patient and the qualifying patient’s physician) that “has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the palliative use of marijuana.” If the qualifying patient lacks legal capacity, the primary caregiver must be a parent, guardian, or legal custodian of the patient. A qualifying patient’s physician must evaluate whether the patient needs a primary caregiver and document such determination in the physician’s written certification for the qualifying patient’s palliative use of marijuana.

## **PALLIATIVE USE OF MARIJUANA BY MINORS**

P.A. 16-23 revises the definition of “qualifying patient” to enable minors (persons under 18 years of age) to also engage in the palliative use of marijuana in Connecticut. As revised, a qualifying patient is a resident of Connecticut, diagnosed by a physician as having a debilitating medical condition, and “(1) is eighteen years of age or older; (2) is an emancipated minor; or (3) has written consent from a custodial parent, guardian or other person having legal custody of such person” to engage in the palliative use of marijuana. In situations where a parent, guardian, or other legal custodian must provide written consent, the person providing consent must also agree to serve as a primary caregiver for the patient and control the acquisition and possession of marijuana and any related paraphernalia on the patient’s behalf. This legislation also revises the current definition of “primary caregiver” to provide that, where the qualifying patient is an unemancipated minor or otherwise lacks legal capacity, the primary caregiver must be a parent, guardian, or other person having legal custody of the patient.

For minor patients (whether emancipated or not), P.A. 16-23 restricts the definition of “debilitating medical condition” to refer only to (1) terminal illness requiring end-of-life care, (2) cystic fibrosis, (3) cerebral palsy, (4) irreversible spinal cord injury with objective neurological indication of intractable spasticity, or (5) severe epilepsy or uncontrolled intractable seizure disorder.

Currently, qualifying patients issued a written certification for the palliative use of marijuana and their primary caregivers are required to register with DCP and provide certain identifying information. This legislation mandates that, where the qualifying patient is under 18 years of age and not an emancipated minor, the custodial parent or other person having legal custody must, as part of the DCP registration process, provide a letter from both the qualifying patient’s primary care provider and a physician board certified in an area of medicine relating to the treatment of the patient’s debilitating medical condition that confirms the palliative use of marijuana is in the best interest of the patient.

This legislation prohibits physicians from issuing certifications to minor patients for marijuana in a smokable, inhalable, or vaporizable dosage form. This legislation similarly prohibits DCP-licensed dispensaries from dispensing any marijuana product in a smokable, inhalable, or vaporizable form to a minor patient or a minor patient's primary caregiver.

## **EXPANSION OF LIST OF DEBILITATING MEDICAL CONDITIONS FOR ADULTS**

P.A. 16-23 expands the definition of a "debilitating medical condition" that enables a qualifying patient 18 years of age or older to engage in the palliative use of marijuana to also include (1) terminal illness requiring end-of-life care, (2) cystic fibrosis, (3) cerebral palsy, (4) irreversible spinal cord injury with objective neurological indication of intractable spasticity, and (5) uncontrolled intractable seizure disorder.

## **DISTRIBUTION OF MEDICAL MARIJUANA TO HOSPICES AND INPATIENT HEALTH CARE FACILITIES**

Current law permits only licensed dispensaries to distribute or dispense marijuana to a registered qualifying patient or such patient's primary caregiver. P.A. 16-23 also permits dispensaries to distribute or dispense marijuana to hospices and inpatient health care facilities licensed by DPH that possess a DCP-approved protocol for handling and distributing marijuana, as well as laboratories and organizations engaged in DCP-approved research programs. This legislation exempts nurses who administer marijuana to a qualifying patient in a hospital or health care facility licensed by DPH from criminal, civil, or professional penalties.

Current law also prohibits licensed producers of marijuana from selling or otherwise providing marijuana to anyone other than licensed dispensaries. P.A. 16-23 permits licensed marijuana producers to sell, transport, deliver, or distribute marijuana directly to laboratories and organizations engaged in DCP-approved research programs.

## **MEDICAL MARIJUANA RESEARCH PROGRAMS**

P.A. 16-23 establishes protections on the acquisition and use of marijuana in connection with a "research program," which is defined as a DCP-approved study "undertaken to increase information or knowledge regarding the growth, processing, medical attributes, dosage forms, administration or use of marijuana to treat or alleviate symptoms of any medical conditions or the effects of such symptoms." This legislation also establishes criteria that research programs must meet to be approved by DCP. In pertinent part, a research program must be overseen by a DPH-licensed hospital or health care facility, an institution of higher education, a licensed marijuana producer, or a licensed marijuana dispensary. The research program must also be overseen by an institutional review board. If the research program involves the use of animals, it must have an institutional animal care and use committee. Research program employees must be licensed by DCP but can receive a temporary certification from DCP prior to DCP's implementation of licensure regulations for such employees. This legislation establishes immunity for research program employees acting within the scope of their employment from criminal, civil, and professional sanctions related to the acquisition, possession, delivery, transportation, or distribution of marijuana to a licensed dispensary, a licensed producer, or a research program subject or distributing or administering marijuana to an animal research subject.

Current law prohibits ingestion of marijuana in public or private schools, including dormitories and college or university property. This legislation revises that prohibition to allow ingestion of marijuana on the grounds of colleges or universities pursuant to a DCP-approved research program. Additionally, this legislation exempts from criminal,

civil, or professional penalties nurses who administer marijuana to a research program subject who is registered with DCP.

#### **ACQUISITION AND USE OF MEDICAL MARIJUANA BY LABORATORIES**

P.A. 16-23 directs DCP to adopt regulations on the licensure of controlled substances analysis laboratories and laboratory employees. As with research employees, laboratory employees must be licensed by DCP. Because DCP has not yet issued licensure regulations, this legislation permits laboratory employees to receive a temporary DCP certification until those regulations become effective. P.A. 16-23 relatedly establishes immunity for licensed laboratories and laboratory employees acting within the scope of their employment from criminal, civil, and professional sanctions related to the acquisition, possession, delivery, transportation, or distribution of marijuana to a licensed dispensary or a licensed producer, or participating in an approved research program.

#### **APRN AUTHORITY TO CERTIFY PALLIATIVE USE OF MARIJUANA**

As described above, effective January 1, 2017, P.A. 16-39 expands the authorized scope of practice of APRNs in Connecticut to allow APRNs to diagnose qualifying patients with debilitating medical conditions and certify such patients for palliative use of marijuana.

### **Public Act 16-59: An Act Expanding Utilization Of Patient-Designated Caregivers.**

*Effective October 1, 2016*

Under this new legislation, when a nursing home plans to discharge a resident to the resident's home, the nursing home must permit the resident to designate a caregiver prior to, or upon the resident's receipt of, a copy of the resident's written discharge plan. If the resident designates a caregiver prior to receipt of written discharge instructions, the nursing home must (1) record the relationship, name, and contact information of the caregiver; (2) make at least two attempts to notify the caregiver of the resident's discharge; (3) provide the caregiver with instructions for all postdischarge tasks in the discharge plan; and (4) record in the resident's medical record any training for initial implementation of the discharge plan and any instructions provided to the caregiver.

The postdischarge instructions to the caregiver must include written, live, or recorded demonstrations of the tasks. Caregivers must be allowed to ask questions about such tasks, and the nursing home must provide answers to the caregiver's questions. The nursing home is required to provide the instructions and answers, in nontechnical language to the extent possible, in a culturally competent manner and in accordance with applicable laws mandating the provision of language access services.

### **Public Act 16-6: An Act Concerning Notification Of Penalties For Abuse And Neglect Of Nursing Home Residents.**

*Effective October 1, 2016*

Current law requires DPH to approve a change of ownership of a nursing home. The potential licensee or owner must submit a change in ownership application that includes information regarding whether the applicant has had (1) three or more civil penalties imposed by DPH for certain violations related to a nursing home facility or residential care home, or civil penalties imposed pursuant to the statutes or regulations of another state, during the previous two

years; (2) any state sanctions, other than civil penalties of less than \$20,000, imposed under the Medicare or Medicaid programs; or (3) a Medicare or Medicaid provider agreement terminated or not renewed. If the potential nursing home licensee or owner meets any of the above categories, DPH is prohibited from approving such individual's or entity's application to acquire another nursing home in Connecticut for a period of five years from the date of final order on such penalties, final adjudication of such sanctions, or termination/non-renewal unless the potential nursing home licensee or owner can demonstrate good cause.

This legislation retains the requirements for nursing home change-in-ownership applications and approvals set forth above but also implements a new requirement under which DPH must incorporate the following notice on the first page of all nursing home change-in-ownership applications:

NOTICE: The State of Connecticut values the quality of care provided to all nursing home residents. Please know that any nursing home licensee, owner or officer, including, but not limited to, a director, trustee, limited partner, managing partner, general partner or any person having at least a ten per cent ownership interest in the nursing home or the entity that owns the nursing home, and any administrator, assistant administrator, medical director, director of nursing or assistant director of nursing may be subject to civil and criminal liability, as well as administrative sanctions under applicable federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

This legislation further provides that inclusion of the above notice shall not be construed as expanding or otherwise affecting the liability of any person or entity referenced in the notice.

## **Public Act 16-87: An Act Concerning The Department Of Public Health's Recommendations For Revisions To The Statutes Regarding Human Immunodeficiency Virus.**

*Effective October 1, 2016*

This legislation (P.A. 16-87) makes a number of changes to Connecticut statutes related to persons with human immunodeficiency virus (HIV), hepatitis C, and related medical conditions. Currently, DPH is required to establish needle and syringe exchange programs in the three cities having the highest total number of HIV infections among injection drug users. These programs are required to be incorporated into existing HIV prevention programs and include free and confidential needle and syringe exchanges as well as education on the transmission of HIV, prevention measures, and drug treatment services. Current law requires that first-time applicants be provided with needles and syringes as well as educational materials and a list of drug counseling services. Current law also requires DPH to establish requirements for monitoring return rates of needles and syringes, program participation rates, and the number of participants who then seek treatment and the status of their treatment.

P.A. 16-87 revises the current program requirements by providing that such programs are to be established within available appropriations and by removing the requirement that the programs be limited to the three cities having the highest total number of HIV infections. Instead, the programs are to be available in any community affected by HIV or hepatitis and be incorporated into existing HIV and hepatitis C prevention programs. This legislation requires that the programs offer education on HIV, hepatitis C, and drug overdose prevention measures and, further, that they provide

referrals for substance abuse counseling or treatment, as well as medical or mental health care. Finally, DPH is required to include an evaluation component that monitors the amount of syringes distributed and collected, program participation rates, the number of participants referred for treatment, and the incidence of HIV from injection drug use.

Under current law, health care providers that furnish prenatal care to pregnant women in Connecticut are required to provide certain information regarding HIV testing to such women, including that HIV testing is a routine part of prenatal care and that all HIV-related information is confidential. If the patient provides informed consent, the health care provider responsible for HIV counseling must perform, or arrange for the performance of, an HIV-related test and must document the test result in the patient's medical record. If the patient does not have an HIV-related test documented in her record at the time the baby is delivered, the responsible health care provider must provide the patient with the information described above and, absent a specific written objection from the patient, cause the test to be administered.

This legislation implements a new reporting requirement for health care providers that administer HIV-related testing of a newborn in connection with a newborn infant health screening or an HIV-related test of the birth mother. Such health care providers are required to report the test results to the mother of the newborn upon the earlier of her departure from the hospital or within 48 hours of the birth. If the newborn tests positive for HIV infection, the health care provider must provide the mother with a list of support services for persons with HIV infection and AIDS and refer her to an HIV case manager and an appropriate health care provider.

Finally, this legislation also repeals a law allowing DPH to create a registry of data on infants exposed to HIV or AIDS medication, DPH's HIV and AIDS education and counseling grant program, a needle exchange van donation program, and DPH's training program for health care providers related to HIV counseling and testing of pregnant women or newborns.

## **Public Act 16-47: An Act Concerning Nursing Home Beds For Aids Patients.**

*Effective July 1, 2016*

Currently, there is a moratorium on the addition of new nursing home beds, meaning that DSS is prohibited from approving requests for additional nursing home beds, subject to certain exceptions. These exceptions include beds for patients requiring neurological rehabilitation, beds associated with a continuing care facility that guarantees life care for residents, Medicaid-certified beds relocated from one licensed nursing facility to another to meet certain identified priority needs, and certain Medicaid-certified beds relocated to a new licensed facility upon closure of another licensed facility. This legislation adds an additional exception that permits DSS to approve requests for additional nursing home beds that are restricted to use by patients with AIDS.