SEPTEMBER 2009

2009 Legislative Update

The following is a general summary of significant Connecticut health care legislation enacted during the 2009 regular and special legislative sessions.

Effective October 1, 2009 or Later

Unless noted otherwise, all changes are effective October 1, 2009.

Patient Safety - Public Act 09-16

Under the current law, a person may not operate an ambulance service, rescue service or management service for emergency medicine without a license or certificate issued by the Commissioner of the Department of Public Health ("DPH"). This Public Act extends the restriction to provide that a person may not transport a patient on a stretcher in a motor vehicle without such license or certificate. In addition, effective immediately, any ambulance used for interfacility critical care transport (which is defined as the transport of a patient between licensed hospitals) must meet the requirements for a basic level ambulance. This includes the requirements concerning medically necessary supplies and services. A licensed registered nurse, advanced practice registered nurse, physician assistant, or respiratory care practitioner may supplement ambulance personnel if appropriately trained and certified in advanced life support.

Release of Biological Material for Genetic Testing - Public Act 09-37

This new law allows a deceased person's spouse, adult child, parent, adult sibling, or grandparent ("next of kin") to provide written consent to release the deceased person's blood or other tissue that is suitable for DNA analysis and testing ("biologic material") to determine paternity or diagnose a life-threatening illness in a living individual. If the next of kin does not provide consent, an interested person may seek a court order for the release of the deceased person's biological material for such purposes. An "interested person" is not defined by the Public Act. If such a court order is granted, the interested person must pay all reasonable testing costs and may receive the results from the laboratory performing the test.

Required Communication of Mammographic Breast Density Information to Patients - Public Act 09-41

This Public Act establishes a new requirement that any mammography report provided to a patient must include breast density information based on the Breast Imaging Reporting and Data System established by the American College of Radiology. The mammography report must also include the following notice, where applicable:

"If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk

factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report."

Exposure to Infectious Diseases and Emergency Responders - Public Act 09-76

Hospitals' Duty to Notify

This new law requires any hospital that diagnoses a patient, including a deceased patient, with pulmonary tuberculosis to provide notification of such diagnosis to any emergency services organization ("ESO"), which includes a police department, fire department or ambulance company, that attended, treated, assisted, handled, or transported the patient. Specifically, the hospital must verbally notify the ESO within forty-eight hours of such diagnosis and provide written notification within seventy-two hours of such diagnosis. The notification may not reveal the patient's identity but must include at least the diagnosis and the date on which the ESO transported the patient.

Hospitals' Duty to Respond

An ESO may request that a hospital notify the ESO of the infectious disease test results for any patient that the ESO transported and reasonably believes may have exposed ESO members to an "infectious disease." The statute defines "infectious disease" as the following:

1. Pulmonary TB;
2. Hepatitis A;
3. Hepatitis B;
4. Hepatitis C;
5. HIV and AIDS;
6. Diphtheria;
7. Novel influenza A virus infections with pandemic potential;
8. Methicillin Resistant Staphylococcus Aureus (MRSA);
9. Hemorrhagic Fevers;
10. Meningococcal Disease;
11. Plague; and
12. Rabies.

After receiving a request, the hospital must notify the ESO of any infectious disease or confirmed positive test result, if known, verbally within forty-eight hours of receiving such request and in writing within three days of receiving such request. Both the verbal and written notification must include the name of the infectious disease and the date on which the ESO transported the patient, but not the patient's identity.

If, ten days after receiving the request, the hospital has not performed any infectious disease tests, the hospital has not made a diagnosis, or the test results are negative, the hospital shall inform the ESO of such information. If an ESO has made a request but the patient died at or before reaching the hospital, the hospital must forward the request to the medical facility in charge of determining the cause of death. No civil penalty or cause of action for damages shall be imposed for a hospital's failure to comply with the requirements of this Public Act.

Nursing Home Bill of Rights - Public Act 09-168

Under the current law, nursing home facilities and chronic disease hospitals may not charge, solicit, accept, or receive any gift, money, donation, or other consideration as a precondition for

admitting, expediting the admission of, or as a requirement for the continued stay of an individual who is entitled to medical assistance.

This Public Act extends the protection offered by the current law to all individuals, not just those entitled to medical assistance. In addition, nursing home facilities and chronic disease hospitals cannot require a third-party payment guarantee as a condition for admitting, expediting admission, or as a requirement for continued stay. It also provides that the rights specified under the Patients' Bill of Rights (Conn. Gen. Stat. § 19a-550 (b) to (d)) may not be reduced, rescinded, or abrogated by contract.

Contracts Between Health Care Providers and Contracting Health Organizations - Public Act 09-204

This Public Act addresses the new requirements for contracts between health care providers ("Providers") and contracting health organizations ("CHOs"). For purposes of this Public Act, those terms have the following meanings:

1. CHO - a managed care organization or a preferred provider network.

2. Provider - a licensed physician, surgeon, chiropractor, podiatrist, psychologist, optometrist, natureopath, or advance practice registered nurse, or group of such individuals, who has entered into or renews a participating provider contract with a CHO to render services to such organization's enrollees and enrollee's dependants.

Increased Provider Access

Current law requires CHOs to develop reasonable procedures that permit physicians, physician groups, or physician organizations under contract with the CHO ("contracted physicians") to do the following:

1. Access, in either a digital format or by electronic means, the fee-for-service amount for the fifty current procedural terminology ("CPT") codes most commonly performed by such contracted physician and reimbursed by the CHO, and

2. Request and view the fee-for-service amount the CHO reimburses for other terminology codes, but only if such terminology codes are within the contract physician's specialty or subspecialty.

Effective January 1, 2010, each CHO must now establish procedures that permit Providers to access, via the Internet or other electronic or digital format, the following:

1. The CHO's fees for CPT codes applicable to the Provider's specialty, Health Care Procedure Coding System ("HCPCS") codes applicable to the Provider, and other CPT and HCPCS codes requested by the Provider that the Provider intends to bill the CHO, provided such codes are within the Provider's specialty or subspecialty; and

2. The CHO's policies and procedures regarding payments to Providers, Providers' duties and requirements under the participating provider contract, and inquiries and appeals from Providers.

The CHO may also impose penalties for the unauthorized distribution of the CHO's information, including termination of the participating provider contract.

Material Changes to Fee Schedule

Effective July 1, 2010, a CHO may only make material changes to a Provider's fee schedule in two situations. First, material changes may be made once a year and only if the CHO provides the Provider with ninety days' advance notice of the change. After receiving notice of such a change, a Provider may terminate the participating provider contact after providing the CHO with at least sixty days' advance written notice. Second, changes may be made if the CHO provides at least thirty days' advance notice of the change, and the change meets one of the following conditions:

1. Is made to comply with requirements of federal or state law, regulation or policy; is made to the medical data code sets (set forth in 45 C.F.R. § 162.1002); or is made to the

national best practice protocols made by the National Quality Forum or other nationally accredited organizations;

2. Is consistent with Medicare's change in billing or medical management practices, provided such changes apply to relevant participating provider contracts where such changes pertain to the same specialty or payment methodology;

3. Is made after a drug, treatment, procedure, or device is identified as no longer safe and effective by the FDA or relevant medical literature;

4. Is made to address payment or reimbursement for a new drug, treatment, procedure, or device approved by the FDA or relevant medical literature; or

5. Is mutually agreed to by the CHO and the Provider.

Return of Payment for an Authorized Covered Service

Effective July 1, 2010, a CHO may not cancel, deny, or demand the return of an authorized covered service's payment because of an administrative or eligibility error more than eighteen months after the receipt of a clean claim, except in one of the following conditions:

1. The CHO has a documented basis for believing that the Provider fraudulently submitted the claim;

2. The Provider inappropriately billed for a claim based on the documentation or evidence submitted by the Provider;

3. The CHO has paid the Provider more than once for the claim;

4. The CHO paid a claim that should have been or was paid by a federal or state program;

5. The Provider received payment for the claim from a different insurer, payor, or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy.

A CHO must give a Provider at least thirty days' advance written notice of the CHO's cancelation, denial, or demand for the return of any authorized covered service's payment. The notice given to the Provider must disclose the amount to be returned, the claim that is the subject of the demand, and the basis on which the CHO seeks the return. A Provider has thirty days after receiving the CHO's written notice to appeal the cancellation, denial, or demand in accordance with the CHO's procedures. If the Provider does not appeal or the CHO denies the appeal, the Provider may resubmit an adjusted claim within thirty days of receiving the written notice, except when the CHO has paid the Provider more than once. Within one year of the date of the written notice, the Provider may identify any other appropriate insurance coverage applicable on the date of service and file a claim with such insurer, health care center, or other issuing entity, regardless of such entity's timely filing requirements.

Health Care Cost Control Initiatives - Public Act 09-206

Effective January 1, 2010, hospitals and outpatient surgical facilities may not seek payment for additional costs they incur from treating a patient with a hospital-acquired condition (those identified as nonpayable by Medicare). This restriction applies regardless of the patient's insurance status or source of payment, including self-pay status.

Beginning October 1, 2009, a practitioner may not seek payment for the technical component of computerized axial tomography ("CAT"), positron emission tomography ("PET"), or magnetic resonance imaging ("MRI") diagnostic imaging services unless such services are actually performed by or under the supervision of such practitioner. Furthermore, the radiological facility or imaging center performing the technical component of CAT, PET or MRI scans may bill the patient or third party payor for such scans, but may not bill the ordering practitioner.

Solicitations of Clients, Patients, or Customers - Public Act 09-222

This new law prohibits a person ("runner") from procuring or attempting to procure, for money, a patient or customer at the direction of a health care professional or owner, or operator of a health care practice or facility ("provider") when the provider's purpose is to obtain benefits under an insurance contract, assert a claim against an insurance carrier, or obtain benefits under or assert a claim against a health care benefits program or prescription drug program. A runner does not include an individual who meets the following criteria:

1. Procures or attempts to procure a patient or customer through public media;

2. Makes a referral authorized by law;

3. Facilitates, presents, or speaks at a public meeting, seminar, or program about the provider's services; or

4. Is a provider's employee and responds to an inquiry by a prospective patient or customer.

An individual who knowingly acts as, or employs, solicits, or uses, a runner may be fined not more than $5,000 or imprisoned not more than one year, or both. Referrals between health care professionals and between attorneys and health care professionals are exempt from the prohibition.

Revisions to the Department of Public Health Licensing Statutes - Public Act 09-232

This Public Act makes a number of substantive and technical changes to the DPH statutes. A summary of the provisions which are effective October 1, 2009 or later follows:

Unacceptable Conduct by Nursing Home Administrators

Under the current law, the DPH may take disciplinary action against a licensed nursing home administrator if such administrator has met or meets the following criteria:

1. Employs or knowingly cooperates in fraud or material deception in order to obtain his or her license;

2. Engages in fraud or material deception in the course of professional services or activities;

3. Suffers from physical or mental illness, emotional disorder, or loss of motor skill;

4. Engages in illegal, incompetent, or negligent conduct in his or her practice; or

5. Violates any provision or regulation of the Public Health statutes.

This Public Act now also authorizes the DPH to take disciplinary action against a licensed nursing home administrator for violation of any provision of state or federal law governing such administrator's practices within a nursing home.

Intern or Resident Physician Permit

Under the current law, a person must have a permit issued by the DPH to participate in an intern or resident physician program. This Public Act provides that, upon termination of such program, the person's privileges cease and the permit is automatically revoked. Such a person who acts in violation of the licensure statutes will be subject to disciplinary action.

Continuing Medical Education Requirement for Physicians

Current law requires any physician applying for a license renewal to have earned a minimum of fifty contact hours of continuing medical education ("CME") within the preceding twenty-four months. For all physicians applying for license renewal on October 1, 2010 and thereafter, at least one of the fifty CME hours must involve training or education in cultural competency.

Radiographer License

Under current law, a person may not operate an X-ray system unless such person has obtained a radiographer's license from the DPH. Effective immediately, operation of an X-ray system also includes energizing the beam, positioning the patient, and positioning or moving any equipment

in relation to the patient. This Public Act also specifies that this restriction does not apply to a licensed, supervised physician's assistant using fluoroscopy for diagnostic and therapeutic procedures, or positioning and utilizing a mini C-arm in conjunction with fluoroscopic procedures (collectively, "Fluoroscopy D-T-C procedures"), as further discussed below.

Use of Fluoroscopy by a Physician's Assistant

Beginning October 1, 2011, a physician's assistant ("PA") may use fluoroscopy for diagnostic and therapeutic procedures only after satisfying both of the following requirements:

1. Completing a course that includes forty hours of training on topics that include, but are not limited to, radiation physics, radiation biology, radiation safety, and radiation management applicable to fluoroscopy. The training course must include not less than ten hours of radiation safety and not less than fifteen hours of radiation physics and radiation biology; and

2. Passing an examination prescribed by the DPH Commissioner.

The employment site of the PA must maintain documentation that proves the PA has satisfied these requirements and, if requested, provide the DPH such documentation. Prior to October 1, 2011, a PA is not prohibited from performing Fluoroscopy D-T-C procedures. Furthermore, a PA who passes the DPH examination on or before October 1, 2011 need not complete a training course; however, a PA who fails to pass the examination before such time may not engage in Fluoroscopy D-T-C procedures until satisfying requirements (1) and (2) above.

Radiologist Assistant

This Public Act deals with radiologist assistants in two separate phases, both with different effective dates.

First Phase

Initially, effective October 1, 2009, a licensed radiologic technologist may perform radiologic procedures as a radiologic assistant under the direct supervision and direction of a licensed physician who is board certified in radiology ("supervising radiologist"). In addition to the licensure requirements of a radiologic technologist, the radiologic assistant must meet the following criteria:

1. Have graduated from a radiologist assistant program recognized by the American Registry of Radiologic Technologists ("ARRT");

2. Have passed the ARRT radiologist assistant examination;

3. Maintain a current Connecticut license in good standing as a radiologic technologist;

4. Maintain current certification in advanced cardiac life support and as a radiographer and radiologist assistant by the ARRT; and

5. Maintain professional liability insurance of at least $500,000 per occurrence and $1.5 million in the aggregate.

A radiologist assistant must have a clearly identifiable supervising radiologist. A licensed radiologist may supervise no more than two full-time radiologist assistants, or the part-time equivalent, at one time. Radiologist assistants must perform their work at the supervising radiologist's primary medical practice or within a health care facility where the supervising radiologist holds staff privileges. A radiologist assistant may perform radiologic procedures delegated by the supervising radiologist, provided that the following criteria are met:

1. The supervising radiologist is satisfied with the radiologist assistant's ability and competence and assumes full control and responsibility for such procedures;

2. Such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and

3. Such procedures are performed under the supervising radiologist's oversight, control, and direction.

A radiologist assistant may perform the following procedures only under the supervising radiologist's personal supervision (i.e., the supervising radiologist is in the same room):

1. Lumbar puncture under fluoroscopic guidance;

2. Lumbar myelogram;

3. Thoracic or cervical myelogram;

4. Nontunneled venous central line placement, venous catheter placement for dialysis, breast needle localization;

5. Ductogram;

6. Contrast media administration and needle or catheter placement; and

7. Procedures the supervising radiologist deems appropriate to be performed under personal supervision.

A radiologist assistant may not interpret images, make diagnoses, prescribe medications or therapies, or administer anesthesia. These requirements do not apply to the activities and services of a student enrolled in a radiologist assistant program recognized by the ARRT if such activities and services are incidental to the student's course of study.

Second Phase

Effective July 1, 2011, the Public Act creates a new license category for radiologist assistants, but only if DPH has appropriations available to implement it. To obtain a radiologist assistant license, a person must complete an application, pay a $150 application fee, and provide the DPH with proof that such person meets the requirements of a radiologic assistant specified above. A license may not be issued to those who have professional disciplinary action pending against them or who are the subject of an unresolved complaint in Connecticut or any other state or territory.

Effective July 1, 2009

In addition to the above provisions, the following important statutes became effective as of July 1, 2009:

Revisions to the Department of Public Health Licensing Statutes - Public Act 09-232

Billing for Anatomic Pathology Services

Physicians, clinical laboratories, and referring clinical laboratories may now charge, bill, or solicit payment for providing anatomic pathology services (defined as the gross and microscopic examination and histologic or cytologic processing of human specimens) only if such services were performed by or under the direct supervision of such providers. A clinical laboratory or referring clinical laboratory may only solicit payment for such services from the patient, hospital, insurer of a third party payor, or a governmental agency or its responsible agent. However, a clinical laboratory is not prohibited from billing a referring clinical laboratory for specimens transferred between such laboratories for histologic or cytologic processing or consolation. Patients and third-party payors are not responsible for reimbursing charges or claims submitted in violation of the Public Act.

Certificates of Need

Health Care Facility or Institution Transfer of Ownership

Under the current law, a health care facility or institution that intends to transfer all or part of its ownership or control must submit to the Office of Health Care Access ("OHCA") a request for permission to undertake such a transfer or change. Effective July 1, 2009, a transfer of ownership or control is defined as a transfer that impacts or changes the governance or

controlling body of a health care facility or institution, including all affiliations, mergers, or any sale or transfer of net assets of such facility or institution.

Cineangiography Equipment

Current law requires OHCA approval prior to the acquisition of certain imaging equipment by any person or entity. Effective July 1, 2009, an applicant need not request approval from OHCA for cineangiography equipment. Further, under the current law, any person or health care facility or institution that owns, operates, or is seeking to acquire certain imaging equipment, including cineangiography equipment, that fails to file the required information is subject to a civil penalty of up to $1,000 per day for each day such information is missing, incomplete, or inaccurate. Effective July 1, 2009, this Public Act eliminates that penalty relative to cineangiography equipment.

Exemptions

Effective July 1, 2009, the certificate of need requirements for health care facilities and institutions do not apply to programs licensed or funded by the Department of Children and Families, other than psychiatric residential treatment facilities. In addition, a short-term acute care general or children's hospital, chronic disease hospital, or hospital for the mentally ill shall be exempt from the certificate of need requirement, as it relates to a proposal to provide outpatient services at an alternative location (Conn. Gen. Stat. 19a-638(a)), if the hospital meets the following criteria:

1. Is providing outpatient services on July 1, 2009;

2. Proposes to provide such outpatient services at an alternative location within the primary service area of the health care facility or institution; and

3. Provides the OHCA with information on the type of outpatient services the hospital plans to provide at the alternative location, the alternative location where such services will be provided and the reason(s) for providing such services at an alternative location.

Exemption for Nonprofit Institutions

Under current law, provided certain requirements are satisfied, the OHCA Commissioner may grant an exemption to the certificate of need requirements for any nonprofit institution under contract with the state seeking to engage in any activity, other than termination of a service or facility, that otherwise requires a certificate of need. This Public Act provides that psychiatric residential facilities are not eligible for such exemption.

Waiver of Requirements

The current law provides that OHCA may waive the certificate of need requirements and grant a certificate of need to any heath care facility, institution, or provider for replacement of major medical equipment, a CT scanner, PET scanner, PET/CT scanner or MRI scanner, cineangiography equipment, or a linear accelerator if both of the following apply:

1. The facility, institution, or provider has previously obtained a certificate of need for such equipment; and

2. The replacement value or expenditure is less than $3,000,000.

Effective July 1, 2009, the OHCA may also waive the certificate of need requirements for such equipment, excluding cineangiography (which no longer requires a certificate of need), if both of the following apply:

1. The facility, institution, or provider had previously obtained a determination that a certificate of need was not required for the equipment's original acquisition; and

2. The replacement value or expenditure is less than $3,000,000.

State-Wide Health Care Facility Planning - Public Act 09-77

This Public Act, effective July 1, 2009, revises the statute concerning the authority of OHCA to

engage in utilization studies and facility planning.

Utilization Studies

Current law requires OHCA, in consultation with DPH, to conduct a statewide health care facility utilization study that includes the following:

1. Reviewing existing health care delivery systems,
2. Making recommendation for improving health care procedures,
3. Recommending health care programs to the Commissioner of OHCA, and
4. Reporting annually OHCA's recommendations, findings, and proposals for improving efficiency, lowering health care costs, coordinating use facilities and services, and expanding the availability of health care throughout Connecticut ("study requirements") to the Governor and General Assembly.

This Public Act modifies the way OHCA conducts the utilization study by removing the requirements one through four above and the DPH consultation requirement. The study must now include, at a minimum, an annual assessment of all of the following:

1. Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care, and clinic care;
2. Areas and subpopulations underserved or having reduced access to specific types of heath care services; and
3. Other factors the Commissioner of OHCA deems pertinent.

The Commissioner of OHCA must annually report the study's findings to the Governor and the General Assembly's joint standing committees that have awareness of public health and human services matters. Such report may include the Commissioner of OHCA's recommendations for addressing the health care services' gaps and the lack of access to health care services.

Facilities Plan

Under current law, OHCA must create and maintain a statewide health care facilities plan, which includes a continued evaluation of the utilization study to determine the following:

1. The availability of acute, long-term, and home health care services in private, public, and community-based facilities providing diagnostic or therapeutic services for Connecticut residents;
2. The scope of such services; and
3. The anticipated future need for such services and facilities.

This Public Act modifies the abovementioned requirements to require a facilities plan that includes, at a minimum, the following:

1. Availability assessments of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care, and clinic care;
2. Evaluations of the unmet needs of persons at risk and vulnerable populations;
3. Projections of future demand for health care services and the impact that technology may have on the demand, capacity, or need for such services; and
4. Recommendations for the expansion, reduction, or modification of heath care facilities or services.

In developing the facilities plan, OHCA may consult with other state agencies, consider recommendations from advisory boards created by the OHCA Commissioner, and incorporate authoritative organizations' recommendations. OHCA must update the current facilities plan no

later than July 1, 2012 and every five years thereafter.

Training in Pain Management - Public Act 09-108

Under this Public Act, nursing home facilities must provide at least two hours of annual training in pain recognition and administration of pain management techniques to all licensed direct care staff, registered direct care staff, and nurse's aides who provide direct patient care. The Public Act exempts nursing home facilities that are residential care homes or Alzheimer's special care units or programs from this new requirement.

Ultrasound Procedures for Medical and Diagnostic Purposes - Public Act 09-125

This Public Act prohibits a person from performing an obstetrical ultrasound unless the procedure is ordered by a licensed health care provider, acting within the scope of such provider's authority and for a medical or diagnostic purpose.

Revisions to the HIV Testing Consent Law - **Public Act 09-133**

Obtaining Consent for HIV-Related Tests

Under current law, HIV-related tests may not be administered on a person unless such person, or an individual authorized to consent to health care for such person, gives written or documented oral informed consent. In addition, prior to obtaining informed consent, the person ordering the test(s) (the "ordering physician") must provide an explanation of HIV and AIDS-related illness, and information on behaviors that may increase the risks for transmission ("pre-test counseling").

This Public Act eliminates the requirements for separate informed consent and pre-test counseling. Specifically, effective July 1, 2009, a person need not provide separate, specific informed consent for HIV-related tests if such person has given general consent for medical procedures and tests. General consent includes the following instructions to the patient:

1. As part of the medical procedures or tests, the patient may be tested for HIV; and

2. Such testing is voluntary and the patient may withhold consent to HIV testing (the "General Consent Instructions").

A patient may decline an HIV-related test but such a decision must be documented in the patient's medical record. A person shall not be liable for ordering such a test without specific informed consent if he or she made a good faith effort to provide the patient with the General Consent Instructions.

Communicating the Test Results to the Patient

Current law requires that the ordering physician, when communicating HIV test results to the patient, must provide the patient, or the individual authorized to consent to heath care for such person, with counseling or referrals for counseling to help with the following:

1. Coping with the emotional consequences of learning the result,

2. Coping with discrimination that may result from disclosure of the patient's illness,

3. Making behavior changes to prevent transmission or contraction of HIV,

4. Learning about available medical treatments,

5. Involving a minor's parent or legal guardians in medical treatment decisions, and

6. Notifying a partner of the illness or getting assistance in notifying the partner.

This Public Act, in addition to the above requirements, adds a new requirement that the ordering physician must also provide counseling or referrals for counseling to inform the patient of the following:

1. Available medical services, and

2. Local or community-based HIV/AIDS support services agencies.

Establishment of the SustiNet Plan - Public Act 09-148

This Public Act establishes the SustiNet Health Partnership's board of directors (the "board of directors"), which consists of nine members from various areas of government and industry. The board of directors will develop procedures and guidelines for the SustiNet Plan as well as design and establish procedures to implement the SustiNet Plan. The SustiNet Plan will be designed to do the following:

1. Improve the health of Connecticut residents, the quality of health care, and access to health care,

2. Provide health insurance to Connecticut residents who would otherwise be uninsured,

3. Increase the range of health care insurance coverage options,

4. Slow the growth of long-term and short-term per capita health care spending, and

5. Implement reforms to the health care delivery system that will apply to all SustiNet Plan members.

The board of directors will establish the following advisory committees for the following purposes:

1. Information Technology - to formulate a plan for developing, acquiring, financing, leasing, or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers;

2. Medical Home - to develop recommended internal procedures and proposed regulations governing the administration of patient-centered medical homes that provide health care services to SustiNet Plan members;

3. Health Care Provider - to develop recommended clinical care and safety guidelines for use by participating health care providers; and

4. Preventive Health Care - to draft recommendations to improve health outcomes for members in areas involving nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances.

Effective immediately, the Public Act also establishes task forces to study the following: childhood and adult obesity, tobacco use by children and adults, and Connecticut's health care workforce. No later than July 1, 2010, each task force shall submit a report on its finding and recommendations. Each task force shall terminate on the date it reports its findings or January 1, 2011, whichever is later.

Licensing of Adolescent Substance Abuse Treatment Facilities and Maternity Homes - Public Act 09-197

Current law provides that a person may not establish, conduct, operate, or maintain a health care institution, including a substance abuse facility or a maternity home, in Connecticut unless such person has a license issued by the DPH. Effective July 1, 2009, DPH licensure is not required to establish, conduct, operate, or maintain either a substance abuse treatment facility or a facility operated for the purpose of caring for women during pregnancies and for women and their infants following such pregnancy if such person has a license issued by the Commissioner of the Department of Children and Families ("DCF").

Medical Foundations and Medical Group Clinic Corporations - Public Act 09-212

Establishing a Medical Foundation

Under this Public Act, any hospital or health system may organize and become a member of a medical foundation. Any medical foundation organized on or after July 1, 2009 must file its certificate of incorporation, including amendments, with OHCA within ten business days after it files them with the Secretary of the State. Any corporation, including a medical group clinic

corporation, organized for the purposes of practicing medicine and providing health care services to the public under another state law may also become a medical foundation. To do so, such corporation must amend its certificate of incorporation to be consistent with the Public Act's requirements and affirmatively state in the amended articles of incorporation that members have elected to bring the corporation within the Public Act's requirements. A medical group clinic corporation, in existence on September 30, 1995 and continuing in existence through July 1, 2009, has until July 1, 2010 to comply with the Public Act's requirements and become a medical foundation.

A medical foundation's corporate name must include the word "Corporation" or the abbreviation "Inc." or "Corp." and a word or words describing the professional services rendered by the medical foundation or a reference to the name of the member hospital or health system. A medical foundation may not operate for profit, operate at locations other than those locations designated by its members or engage in any business other than rendering health care services for which it was specifically incorporated. This Public Act does not prohibit a medical foundation from investing its funds in real estate, mortgages, stocks, bonds, or any other type of investment, or owning real or personal property incident to rendering professional services.

Medical foundations are specifically exempted from the definition of an "affiliate" in the OHCA statutes by this Public Act. Therefore, entities that previously would have been considered "affiliates" of a health care facility or institution are not required to seek OHCA approval for actions such as a change to the medical foundation's board of directors if they become medical foundations.

If you have any questions about this new legislation, please feel free to contact any member of Robinson & Cole's Health Law Group.

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