Department of Public Health

Technical Legislative Proposals

October 15, 2015

Legislative Liaison Contact Information:

DeVaughn Ward/Jill Kennedy
(860) 509-7246/(860) 509-7280
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Health Care Quality and Safety Branch

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kennedy Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov
Lead agency division requesting this proposal: Facility Licensing and Investigations Section, HCQSB
Agency Analyst/Drafter of Proposal: Suzanne Blancaflor, Environmental Health Section, RSB

Title of Proposal **An Act Extending the Medical Order For Life Sustaining Treatment Pilot Program**
Statutory Reference **Public Act 14-231 Sec 67**
Proposal Summary *To extend the current MOLST Pilot Program to October 1, 2017*
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

On October 1, 2016 the MOLST Pilot Program will end and the MOLST document will no longer be valid for extant individuals who have a MOLST. It will not be feasible to propose final legislation during the next session because it is a short session; and, the data that is currently being collected will be insufficient to draw any conclusions related to the feasibility of the use of the MOLST in CT. Extending the program will 1.) Assist individuals with a MOLST document to have their wishes honored 2.) Provide the opportunity to develop a robust data set, and 3.) Develop legislation for the 2017 session that is based on the pilot's findings.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

TECHNICAL CHANGE

(a) Any pilot program established in accordance with this section shall terminate not later than [October1, 2016] October1, 2017

PROPOSAL IMPACT

- **Agencies Affected** – No agencies impacted

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) 0
State 0
Federal 0
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Positive, for reasons enumerated in proposal background section.

Section 67 of Public Act No. 14-231 is repealed and the following is substituted in lieu thereof:

Sec. 67. Section 1 of special act 14-5 as amended by section 67 of Public Act 14-231 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Public Health may, within available appropriations, establish a pilot program in one or more geographic areas in the state to implement the use of medical orders for life-sustaining treatment by health care providers. For purposes of this section: (1) "Medical order for life-sustaining treatment" means a written medical order by a physician, advanced practice registered nurse or physician assistant to effectuate a patient's request for life-sustaining treatment when the patient has been determined by a physician to be approaching the end stage of a serious, life-limiting illness or is in a condition of advanced, chronic progressive frailty; (2) "health care provider" means any person, corporation, limited liability company, facility or institution operated, owned or licensed by this state to provide health care or professional medical services, or an officer, employee or agent thereof acting in the course and scope of his or her employment; and (3) "legally authorized representative" means a patient's parent, guardian or health care representative appointed in accordance with sections 19a-576 and 19a-577 of the general statutes.

(b) The Commissioner of Public Health may establish an advisory group of health care providers and consumer advocates to make recommendations concerning the pilot program described in this section. The members of such advisory group may include one or more: (1) Physicians; (2) advanced practice registered nurses; (3) physician assistants; (4) emergency medical service providers; (5) patient advocates, including, but not limited to, advocates for persons with disabilities; (6) hospital representatives; or (7) long-term care facility representatives.

(c) Prior to commencement of the pilot program pursuant to this section, said commissioner may contact a representative of each health care institution, as defined in section 19a-490 of the general statutes, a representative of each emergency medical service organization, as defined in section 19a-175 of the general statutes, any physician licensed under chapter 370 of the general statutes, any advanced practice registered nurse licensed under chapter 378 of the general statutes and any physician assistant licensed under chapter 370 of the general statutes in the geographic area in which the commissioner intends to establish the pilot program to request such institution's, organization's, physician's, advanced practice registered nurse's or physician assistant's participation in the pilot program. Participation by each institution, organization, physician, advanced practice registered nurse or physician assistant shall be voluntary.

(d) Patient participation in the pilot program shall be voluntary. Any agreement to participate in the pilot program shall be made in writing, signed by the patient or the patient's legally authorized representative. Such agreement shall be maintained by the health care institution, emergency medical services organization, physician, advanced practice registered nurse or physician assistant that presented such agreement to the patient and shall be made available to the commissioner upon request.

(e) Notwithstanding the provisions of sections 19a-495 and 19a-580d of the general statutes, and regulations adopted thereunder, the Commissioner of Public Health shall

implement policies and procedures for any pilot program established in accordance with this section to ensure that: (1) Medical orders for life-sustaining treatment are transferrable among, and recognized by, various types of health care institutions; (2) any procedures and forms developed for recording medical orders for life-sustaining treatment are developed after considering the physician orders for life-sustaining treatment paradigm and require the signature of the patient or the patient's legally authorized representative and a witness on the medical order for life-sustaining treatment and the patient or the patient's legally authorized representative is given a copy of any such order immediately after signing such order; (3) prior to requesting the signature of the patient or the patient's legally authorized representative on such order, the physician, advanced practice registered nurse or physician assistant writing the medical order discusses with the patient or the patient's legally authorized representative the patient's goals for care and treatment and the benefits and risks of various methods for documenting the patient's wishes for end-of-life treatment, including medical orders for life-sustaining treatment; and (4) each physician, advanced practice registered nurse or physician assistant that intends to write a medical order for life-sustaining treatment receives training concerning: (A) The importance of talking with patients about their personal treatment goals; (B) methods for presenting choices for end-of-life care that elicit information concerning patients' preferences and respects those preferences without directing patients toward a particular option for end-of-life care; (C) the importance of fully informing patients about the benefits and risks of an immediately effective medical order for life-sustaining treatment; (D) awareness of factors that may affect the use of medical orders for life-sustaining treatment, including but not limited to: Race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence; and (E) procedures for properly completing and effectuating medical orders for life-sustaining treatment.

(f) After the termination of any pilot program established pursuant to this section, said commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the pilot program.

(g) Said commissioner may implement policies and procedures necessary to implement the pilot program while in the process of adopting such policies and procedures in regulation form, in accordance with chapter 54 of the general statutes, provided the commissioner holds a public hearing prior to implementing such policies and procedures and prints notice of the intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation of such policies and procedures. Policies implemented pursuant to this section shall be valid until the time final regulations are adopted or until the pilot program terminates, whichever occurs earlier.

(h) Any pilot program established in accordance with this section shall terminate not later than [October 1, 2016] October 1, 2017.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:

Agency Analyst/Drafter of Proposal:

Title of Proposal
An Act to Repeal Section 19a-57 of the Connecticut General Statutes

Statutory Reference
19a-57. Loans for Purchase of hemodialysis treatment machines

Proposal Summary
The law was put in place in 1973, with technical changes in 1977, 1993 and 1995 to correct the Department name. Currently, the Department of Public Health is not collaborating with The Kidney Foundation of Connecticut, Inc. to secure loans for residents of the state to purchase hemodialysis machines for treatment in their homes. No funding has been provided to the Department to implement the provisions of this law.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

- **Origin of Proposal ___ New Proposal ___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 19a-57 of the General statutes is repealed

Agency Legislative Proposal - 2016 Session

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Lead agency division requesting this proposal: Practitioner Licensing and Investigations Section

Agency Analyst/Drafter of Proposal: Chris Andresen/Steve Carragher

Title of Proposal
An Act Concerning the Hairdresser Application Fee

Statutory Reference 20-254

Proposal Summary
This proposal will update the application fee for hairdresser licensing without examination to make it consistent with the required fee for licensing by examination.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
The department is currently charging out of state applicants the same application fee as applicants for examination, even though the statutes differ. This proposal will make the fees the same, regardless of basis for licensure. We believe this statute was missed when public act 09-3 (section 231, section 20-253) was passed to increase the fees for hairdresser licensure from $50.00 to $100.00

- **Origin of Proposal** **X New Proposal** **___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) 0
State $0 as we are currently collecting this fee as part of routine operations.
Federal $0
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

Sec. 20-254. License without examination. Any person who holds a license at the time of application as a registered hairdresser and cosmetician, or as a person entitled to perform similar services under different designations in any other state, in the District of Columbia, or in a commonwealth or territory of the United States, and who was issued such license on the basis of successful completion of a program of education and training in hairdressing and cosmetology and an examination shall be eligible for licensing in this state and entitled to a license without examination

upon payment of a fee of **[fifty]** **one hundred** dollars**.** No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

If the issuance of such license in any other state, in the District of Columbia, or in a commonwealth or territory of the United States did not include an examination, an applicant who has legally practiced cosmetology for at least five years in a state outside of Connecticut shall be eligible for licensure if the applicant submits satisfactory evidence of education and experience and upon payment of a fee of **[fifty]** **one hundred dollars**. Evidence of experience shall include 1) an original certification from the out of state licensing agency demonstrating at least 5 years of licensure, 2) Letters from former employers, co-workers, or clients that satisfactorily describe the applicant's experience in the state for at least five years, and 3) Copy of tax returns which indicate cosmetology as occupation. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Agency Legislative Proposal - 2016 Session

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Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
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Lead agency division requesting this proposal:
HCQS

Agency Analyst/Drafter of Proposal:
Chris Andresen

Title of Proposal
Updates to midwifery statute

Statutory Reference 20-86

Proposal Summary
This proposal proposal updates the certifying bodies for midwives and midwifery education

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The Department realized that the midwifery certifying bodies in statute need to be updated by adding the term "or any successor" to the statute. So we don't have the same issue as we did with the Massage Therapist last year.

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact NO FISCAL IMPACT

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This will update the statutes to align with current midwifery certifying bodies.

20-86a. Definitions

(2) "Nurse-midwife" means a person who has demonstrated competence to practice nurse-midwifery through successful completion of an educational program accredited by the [American College of Nurse-Midwives] Accreditation Commission for

Midwifery Education and who is certified by the ~~American College of Nurse-Midwives~~ [American Midwifery Certification Board], and is licensed under the provisions of this chapter.

Sec. 20-86c. Requirements for licensure. Fee. The Department of Public Health may issue a license to practice nurse-midwifery upon receipt of a fee of one hundred dollars, to an applicant who (1) is eligible for registered nurse licensure in this state, under sections 20-93 or 20-94; (2) holds and maintains current certification from the [American College of Nurse-Midwives] American Midwifery Certification Board; and (3) has completed thirty hours of education in pharmacology for nurse-midwifery. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Sec. 20-86i. Temporary practice of graduates of nurse-midwifery programs. Nothing in this chapter shall be construed to prohibit graduates of nurse-midwifery programs approved by the [American College of Nurse-Midwives] Accreditation Commission for Midwifery Education from practicing midwifery for a period not to exceed (1) ninety calendar days after the date of graduation, or (2) the date upon which the graduate is notified that he or she has failed the licensure examination, whichever is shorter, provided (A) such graduate nurses are working in a hospital or organization where adequate supervision, as determined by the Commissioner of Public Health, is provided, and (B) such hospital or other organization has verified that the graduate nurse has successfully completed a midwifery program approved by the [American College of Nurse-Midwives] Accreditation Commission for Midwifery Education.

Agency Legislative Proposal - 2016 Session

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E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
HCQS

Agency Analyst/Drafter of Proposal:
Chris Andresen

Title of Proposal
Updating social work statute

Statutory Reference 20-195q(c)

Proposal Summary
This proposal would remove the non-prohibited activity in this section that allows an unlicensed person with a masters or doctoral degree in social work to gain social work experience under supervision related to becoming an LCSW. The newly implemented LMSW requires someone holding a doctoral or masters degree to be licensed as an LMSW to work under professional supervision to gain this experience.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The state law for licensed masters level social workers was implemented in 2015. The language proposal will remove language that provides an exception for someone to work in the role of an LMSW without a license to gain the experience needed to become an LCSW.

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This proposal will eliminate a loophole for an unlicensed person with a social work degree from working in the role of an LMSW without a license

Sec. 20-195q. Use of title. Certain activities not prohibited. (a) No person shall (1) use the title "licensed master social worker" or any initials associated with such title, or (2) advertise services under the description of a licensed master social worker, as defined in section 20-195m, unless such person is licensed as a master social worker pursuant to this chapter.

(b) No person shall (1) use the title “licensed clinical social worker” or any initials associated with such title, or (2) advertise services under the description of a licensed clinical social worker, as defined in section 20-195m, unless such person is licensed as a clinical social worker pursuant to this chapter.

(c) Nothing in this section shall prohibit: (1) A student enrolled in a doctoral or master’s degree program accredited by the Council on Social Work Education from performing such work as is incidental to his course of study, provided such person is designated by a title which clearly indicates his status as a student; [(2) a person holding a doctoral or master’s degree from a program accredited by the Council on Social Work Education from gaining social work experience under professional supervision, provided such activities are necessary to satisfy the work experience required by section 20-195n and such person is designated as “social work intern”, “social work trainee” or other title clearly indicating the status appropriate to his level of training;] [(3)] (2) a person licensed or certified in this state in a field other than clinical social work from practicing within the scope of such license or certification; [(4)] (3) a person enrolled in an educational program or fulfilling other state requirements leading to licensure or certification in a field other than social work from engaging in work in such other field; [(5)] (4) a person who is employed or retained as a social work designee, social worker, or social work consultant by a nursing home or rest home licensed under section 19a-490 and who meets the qualifications prescribed by the department in its regulations from performing the duties required of them in accordance with state and federal laws governing those duties; [(6)] (5) for the period from October 1, 2010, to October 1, 2013, inclusive, a master social worker from engaging in independent practice; [(7)] (6) a social worker from practicing community organization, policy and planning, research or administration that does not include engaging in clinical social work or supervising a social worker engaged in clinical treatment with clients; and [(8)] (7) individuals with a baccalaureate degree in social work from a Council on Social Work Education accredited program from performing nonclinical social work functions.

Infectious Diseases

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
TB, HIV, STD, & Viral Hepatitis Program – HIV Prevention

Agency Analyst/Drafter of Proposal:
Gina D'Angelo

Title of Proposal
HIV Statutes and Regulations Proposed Changes 2016

Statutory Reference

Section 1: 19a-32a. AIDS research education account.
Section 2: 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care.
Section 3: 19a-124. Needle and syringe exchange programs.
Section 4: 19a-581. Definitions.
Section 5: 19a-582. General consent required for HIV-related testing. Counseling requirements. Exceptions.
Section 6: 19a-583. Limitations on disclosure of HIV-related information.
Section 7: 19a-584. Informing and warning of known partners of possible exposure to HIV. Disclosure of HIV-related information to public health officers.
Section 8: 19a-593. Testing of pregnant women and newborns. Notification and documentation requirements.
Section 9 repealers:
Sec. 19a-54a. Registry of data on infants exposed to AIDS medication.
Sec. 19a-124a. Donation of vans to entities operating needle exchange programs
Sec. 19a-121a. AIDS: Funding to local health departments.
Sec. 19a-594. Pregnant women and newborn testing public awareness programs and health care provider training.

Proposal Summary

Section 1: Removes "AIDS-related community service" programs language from section 19a-32a because it is a very broad and undefined term that does not align with the types of AIDS related programs funded by DPH through this account.
Section 2: Removes the term "female" from subsection 4 of Sec. 19a-112e, definition of "Victim of Sexual Assault" because males may also be victims of sexual assault.
Section 3: Makes changes to the language in section 19a-124 to to reflect current program terminology used at the state and national level. Language changes include: "syringe exchange" to "syringe access"; adds the term Hepatitis C in addition to HIV because people who inject drugs are at risk for both; adds the terms harm reduction and overdose prevention services (Harm reduction as a strategy focuses on reducing harm if it cannot be eliminated completely and overdose prevention is a tool to save lives of those injecting or using opioids and is a critical component of any program for people who inject drugs); Changes language to not limit services to the three cities with highest HIV incidence but also allow for programs in areas with high rates of injection drug use and overdose (Data reflects pockets of rural injection drug use in Connecticut and pockets of overdoses occurring in rural/suburban areas as well. Data can be provided upon request). By changing this statute DPH has more latitude to ensure services are funded where there is the greatest need. The language also makes changes

to the evaluation components to match current program criteria outlined in RFPs and contracts.

<u>Section 4:</u> Removes language from Sec. 19a-581 regarding counseling because with the onset of rapid testing and routine testing CDC no longer requires the same level of counseling when testing for HIV. The language also adds a definition of Community-based HIV Testing Provider as a tester who conducts HIV testing in a non-clinical setting. DPH currently funds over 20 agencies to provide Outreach, HIV Testing and Linkage Services.
<u>Section 5:</u> Remove counseling requirements from Sec. 19a-582. based on CDC recommendations; Revises the steps to match current practice as indicated by CDC in the Fundamentals of Rapid Test Training, DPH HIV Testing programs have moved from traditional counseling to brief counseling; and Changes the law to align with the general consent law and allow outreach workers who conduct testing in community settings (vans, parks, bars, etc.) to obtain verbal rather than written consent and document such consent in a local use field on the HIV Test Form. The tester would still inform the person being tested about the test, testing procedure and testing method before obtaining verbal consent. However, the specific HIV consent form would be eliminated as it has been a barrier to testing in the field. Also, the forms are signed and collected and kept at organizations seemingly unnecessarily. The law requiring informed written consent was passed in a time when there was more stigma, discrimination and lawsuits over HIV testing and information. In addition, the HIV rapid test is a screening tool. Informed or general consent could be obtained for any preliminary positive result before drawing blood for a confirmatory lab test.
<u>Section 6.</u> Replaces "HIV" for "AIDS Virus" Sec. 19a-583.
<u>Section 7.</u> Removes words "the" and "virus" from title of Sec. 19a-584.
<u>Section 8.</u> Adds section (c) in Sec. 19a-593 regarding reporting requirements for testing of newborns, previously found in Sec. 19a-594 because it is a better fit.

<u>Repealers:</u>
Sec. 19a-54a. This statute was passed in 1999 and there is no evidence that such a registry exists or ever existed. Currently, infants born to mothers who may have been taking AIDS medications are not followed or studied. In addition, there haven't been any children born with HIV in Connecticut in a number of years since the passing of 19a-593 requires women to be tested for HIV twice during pregnancy.
Sec. 19a-124a. Repeal. There are no vans or funds to provide vans to programs.
Sec. 19a-121a. Repeal. This statute is unnecessary because there is not a separate account for money to fund local health departments. They are eligible for funding along with other organizations through an RFP process under 19a-121.
Sec. 19a-594. Suggest repeal of statute. Funding and other resources for pregnant women and newborn testing public awareness programs and health care provider trainings no longer exist because there is no longer a need. Since the passing of 19a-593, all pregnant women are screened for HIV twice during pregnancy and there have not been any infants born with HIV in a number of years.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

See above

- **Origin of Proposal** **_x__ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

These statutes/regulations will have programmatic or policy impact. The rest only involve technical or language changes.

Section 2. Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care. The impact will be that all victims of sexual assault regardless of gender will be entitled to the same standards of care outlined in the statute.

Section 3. Sec. 19a-124. Needle and syringe exchange programs. The impact will be on the clients seeking syringe access services with the expansion of services and the addition of other areas of the state where services can be accessed. It will also allow for more comprehensive and ancillary services rather than just needle exchange. It will also give DPH more latitude over where services are funded.

Section 5. Sec. 19a-582. ***General consent required for HIV-related testing. Counseling requirements. Exceptions.***

The impact for the clients will be eliminating barriers to testing. One barrier to be eliminated is the in depth counseling which has been replaced in practice with a brief five step counseling process integrated into the testing procedure while the test is being processed. The other barrier to eliminate is the requirement of written consent to HIV Testing (rapid screening) in the field. The impact on HIV outreach testers will be the elimination of extra paperwork in the field and in the office. Another impact is the de-stigmatization of HIV.

Section 1. Section 19a-32a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) There is established an AIDS research education account which shall be a separate, nonlapsing account within the General Fund. Any moneys collected under the contribution system established under section 12-743 shall be deposited by the Commissioner of Revenue Services into the account. This account may also receive moneys from public and private sources or from the federal government. All moneys deposited in the account shall be used by the Department of Public Health or persons acting under a contract with the department, (1) to assist AIDS research or[,] education [and AIDS-related community service] programs or (2) the promotion of the income tax contribution system and the AIDS research education account. Expenditures from the account in any fiscal year for the promotion of the contribution system or the account shall not exceed ten per cent of the amount of moneys raised during the previous fiscal year provided such limitation shall not apply to an expenditure of not more than fifteen thousand dollars from the account on or before July 1, 1994, to reimburse expenditures made on or before said date, with prior written authorization of the Commissioner of Public Health, by private organizations to promote the contribution system and the AIDS research education account.

(b) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to provide for the distribution of funds available pursuant to this section and section 12-743.

Section 2. Section 19a-112e of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Emergency contraception" means one or more prescription drugs used separately or in combination administered to or self-administered by a patient to prevent pregnancy, within a medically recommended amount of time after sexual intercourse and provided for that purpose, in accordance with professional standards of practice, and determined to be safe by the United States Food and Drug Administration.

(2) "Emergency treatment" means any medical examination or treatment provided in a licensed health care facility to a victim of sexual assault following an alleged sexual assault.

(3) "Medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable.

(4) "Victim of sexual assault" means any [female] person who alleges or is alleged to have suffered an injury as a result of a sexual offense.

(5) "Sexual offense" means a violation of subsection (a) of section 53a-70, section 53a-70a or 53a-70b, subsection (a) of section 53a-71, section 53a-72a or 53a-72b, subdivision (2) of subsection (a) of section 53a-86, subdivision (2) of subsection (a) of section 53a-87 or section 53a-90a, 53a-196a or 53a-196b.

(6) "Independent provider" means a physician licensed under chapter 370, a physician assistant licensed under chapter 370, an advanced practice registered nurse or registered nurse licensed under chapter 378, or a nurse-midwife licensed under chapter 377, all of whom are trained to conduct a forensic exam in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a.

(b) The standard of care for each licensed health care facility that provides emergency treatment to a victim of sexual assault shall include promptly:

(1) Providing each victim of sexual assault with medically and factually accurate and objective information relating to emergency contraception;

(2) Informing such victim of sexual assault of the availability of emergency contraception, its use and efficacy; and

(3) Providing emergency contraception to such victim of sexual assault at the facility upon the request of such victim, except that a licensed health care facility shall not be required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test approved by the United States Food and Drug Administration.

(c) In order to comply with the standard of care requirements prescribed in subsection (b) of this section, a licensed health care facility may contract with one or more independent providers

to: (1) Ensure compliance at the facility with the standard of care requirements prescribed in said subsection (b), and (2) conduct at the facility a forensic exam of the sexual assault victim in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a.

(d) No licensed health care facility that provides emergency treatment to a victim of sexual assault shall determine such facility's protocol for complying with the standard of care requirements prescribed in subsection (b) of this section on any basis other than a pregnancy test approved by the United States Food and Drug Administration.

Section 3. Section 19a-124 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) On or after July 1, 2016, and with availability of funding, The Department of Public Health shall establish syringe access programs [needle and syringe exchange programs] in order to enhance health outcomes of people who inject drugs in any community impacted by Human Immuno-deficiency Virus ("HIV") or Hepatitis C ("HCV"). [in the three cities having the highest total number of human immunodeficiency virus infections among injection drug users.] The department shall establish protocols in accordance with the provisions of subsection (b) of this section. [The department may authorize similar programs in other areas of the state, as determined by the commissioner, through local health departments or other local organizations.]

(b) The programs shall: (1) [Be]be incorporated into existing HIV and HCV outreach and prevention programs in the selected communities [cities]; (2) provide syringe access, [disposal] and/or exchange to persons who inject drugs; (3) provide access to free syringes; (4) provide for safe disposal and/or exchange of syringes; (5) ensure first time applicants to the program receive an initial intake and starter pack of syringes; (6) provide education and or educational materials on the transmission and prevention of HIV and HCV, harm reduction information, and overdose prevention; (7) provide referral for substance abuse counseling and/or treatment; and (8) provide referral for medical and/or mental health care. [for free and confidential exchanges of needles and syringes and (A) provide that program participants receive an equal number of needles and syringes for those returned; and (B) provide that first-time applicants to the program receive an initial packet of thirty needles and syringes, educational material and a list of drug counseling services; and (3) offer education on the transmission of the human immunodeficiency virus and prevention measures and assist program participants in obtaining drug treatment services.]

(c) The department shall require programs to include an annual evaluation component to [establish requirements to] monitor (1) number of syringes distributed and collected, [return rates of needles and syringes distributed,] (2) behavioral change of program participants, [program participation rates, and] (3) program participation rates and the number of participants who are referred to treatment and, (4) the incidence of HIV from injection drug use to determine if there is a reduction as a result of the syringe access program. [number of participants who are motivated to enter treatment as a result of the program and the status of their treatment.]

(d) The local health department or community-based organization of each community conducting a [the] syringe access program shall submit a report evaluating the effectiveness of

this program to the Department of Public Health. [Any organization conducting a needle and syringe exchange program shall submit a report evaluating the effectiveness of the program to the Department of Public Health.]

Section 4. Section 19a-581 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in this chapter except where the context otherwise requires:

(1) "Department" means the Department of Public Health;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "AIDS" means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;

(4) "HIV infection" means infection with the human immunodeficiency virus [or any other related virus identified as a probable causative agent of AIDS;] as defined by the Centers for Disease Control of the United States Public Health Service;

(5) "HIV-related illness" means any illness that may result from or may be associated with HIV infection;

(6) "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection;

(7) "Protected individual" means a person who [has been counseled regarding HIV infection,] is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or HIV-related illness;

(8) "Confidential HIV-related information" means any information pertaining to the protected individual or obtained pursuant to a release of confidential HIV-related information, concerning whether a person [has been counseled regarding HIV infection,] has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify a person as having one or more of such conditions, including information pertaining to such individual's partners;

(9) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual or a person authorized to consent to health care for the individual and which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV-related information and complies with the requirements of this subdivision;

(10) "Partner" means an identified spouse or sex partner of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual;

(11) "Health facility" means an institution, as defined in section 19a-490, blood bank, blood center, sperm bank, organ or tissue bank, clinical laboratory or facility providing care or treatment to persons with psychiatric disabilities or persons with intellectual disability or a facility for the treatment of substance abuse;

(12) "Health care provider" means any physician, dentist, nurse, provider of services for persons with psychiatric disabilities or persons with intellectual disability or other person involved in providing medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan;

(13) "Community-based HIV Testing Provider" means any individual or organization that provides HIV testing services for persons at risk of HIV infection who are identified and tested in non-clinical settings.

[(13)] (14) "Significant risk of transmission" means sexual activity that involves the transfer of one person's blood, semen, vaginal or cervical secretions [to another person] or the transfer of blood through the sharing of needles during [intravenous] injection drug use to another person. The department may further define significant risk of transmission in regulations adopted pursuant to section 19a-589;

[(14)] (15) "Significant exposure" means a parenteral exposure such as a needle stick or cut, or mucous membrane exposure such as a splash to the eye or mouth, to blood or a cutaneous exposure involving large amounts of blood or prolonged contact with blood, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis. The department may further define significant exposure in regulations adopted pursuant to section 19a-589;

[(15)] (16) "Exposure evaluation group" means at least three impartial health care providers, at least one of whom shall be a physician, designated by the chief administrator of a health facility, correctional facility or other institution to determine if a health care or other worker has been involved in a significant exposure. No member of the group shall be directly involved in the exposure. The department may further define exposure evaluation group in regulations adopted pursuant to section 19a-589.

Section 5. Section 19a-582 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as required pursuant to section 19a-586, a person who has provided general consent as described in this section for the performance of medical procedures and tests is not required to also sign or be presented with a specific informed consent form relating to medical procedures or tests to determine human immunodeficiency virus infection or antibodies to human immunodeficiency virus. General consent shall include instruction to the patient that: (1) As part of the medical procedures or tests, the patient may be tested for human immunodeficiency virus, and (2) such testing is voluntary and that the patient can choose not to be tested for human immunodeficiency virus or antibodies to human immunodeficiency virus. General consent that

includes HIV-related testing shall be obtained without undue inducement or any element of compulsion, fraud, deceit, duress or other form of constraint or coercion. If a patient declines an HIV-related test, such decision by the patient shall be documented in the medical record. The consent of a parent or guardian shall not be a prerequisite to testing of a minor. The laboratory shall report the test result to the person who orders the performance of the test.

(b) A person ordering the performance of an HIV-related test shall not be held liable for ordering a test without specific informed consent if a good faith effort is made to convey the instruction required pursuant to subsection (a) of this section.

(c) At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV-related test shall provide the subject of the test or the person authorized to consent to health care for the subject with counseling or referrals for counseling, as needed: [(1) For coping with the emotional consequences of learning the result; (2) regarding the discrimination problems that disclosure of the result could cause; (3) for behavior change to prevent transmission or contraction of HIV infection;][(4)] (1) to inform such person of available medical treatments and medical services; [(5)] (2) regarding local or community-based HIV/AIDS support services agencies; [(6)] (3) to work towards the goal of involving a minor's parents or legal guardian in the decision to seek and in the ongoing provision of medical treatment; and [(7)] (4) regarding the need of the test subject to notify his partners and, as appropriate, provide assistance or referrals for assistance in notifying partners; except that if the subject of the test is a minor who was tested without the consent of his parents or guardian, such counseling shall be provided to such minor at the time of communicating such test result to such minor. A health care provider or health facility shall not withhold test results from the protected individual. [The protected individual may refuse to receive his test result but the person ordering the performance of the test shall encourage him to receive the result and to adopt behavior changes that will allow him to protect himself and others from infection.]

(d) The provisions of this section shall not apply to the performance of an HIV-related test:

(1) By licensed medical personnel when the subject is unable to grant or withhold consent and no other person is available who is authorized to consent to health care for the individual and the test results are needed for diagnostic purposes to provide appropriate urgent care, except that in such cases the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided as soon as practical;

(2) By a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals, provided if the test results are communicated to the subject, the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided;

(3) For the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and is unable to be retrieved by the researcher;

(4) On a deceased person when such test is conducted to determine the cause or circumstances of death or for epidemiological purposes;

(5) In cases where a health care provider or other person, including volunteer emergency medical services, fire and public safety personnel, in the course of his occupational duties has had a significant exposure, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his occupation, (B) the worker completes an incident report within forty-eight hours of exposure identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline HIV test within seventy-two hours of the exposure and is negative on that test, (D) the patient's or person's physician or, if the patient or person does not have a personal physician or if the patient's or person's physician is unavailable, another physician or health care provider has approached the patient or person and sought voluntary consent and the patient or person has refused to consent to testing, except in an exposure where the patient or person is deceased, (E) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that the worker has a significant exposure to the blood of a patient or person and the patient or person, or the patient's or person's legal guardian, refuses to grant informed consent for an HIV test. If the patient or person is under the care or custody of the health facility, correctional facility or other institution and a sample of the patient's blood is available, said blood shall be tested. If no sample of blood is available, and the patient is under the care or custody of a health facility, correctional facility or other institution, the patient shall have a blood sample drawn at the health facility, correctional facility or other institution and tested. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorized the HIV testing of a patient or other person, nor the health facility, correctional facility or other institution, nor any person in a health facility or other institution who relies in good faith on the group's determination and performs that test shall have any liability as a result of his action carried out pursuant to this section, unless such person acted in bad faith. If the patient or person is not under the care or custody of a health facility, correctional facility or other institution and a physician not directly involved in the exposure certifies in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that a significant exposure has occurred, the worker may seek a court order for testing pursuant to subdivision (8) of this subsection, (F) the worker would be able to take meaningful immediate action, if results are known, which could not otherwise be taken, as defined in regulations adopted pursuant to section 19a-589, (G) the fact that an HIV test was given as a result of an accidental exposure and the results of that test shall not appear in a patient's or person's medical record unless such test result is relevant to the medical care the person is receiving at that time in a health facility or correctional facility or other institution, (H) the counseling described in subsection (c) of this section shall be provided but the patient or person may choose not to be informed about the result of the test, and (I) the cost of the HIV test shall be borne by the employer of the potentially exposed worker;

(6) In facilities operated by the Department of Correction if the facility physician determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, provided no reasonable alternative exists that will achieve the same goal;

(7) In facilities operated by the Department of Correction if the facility physician and chief administrator of the facility determine that the behavior of the inmate poses a significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility and no reasonable alternative exists that will achieve the same goal. No involuntary testing shall take place pursuant to subdivisions (6) and (7) of this subsection until reasonable effort has been made to secure informed consent. When testing without consent takes place pursuant to subdivisions (6) and (7) of this subsection, the counseling referrals and notification of test results described in subsection (c) of this section shall, nonetheless be provided;

(8) Under a court order which is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the HIV-related test result which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for a test result against the privacy interests of the test subject and the public interest which may be disserved by involuntary testing, (B) pleadings pertaining to the request for an involuntary test shall substitute a pseudonym for the true name of the subject to be tested. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court, (C) before granting any such order, the court shall provide the individual on whom a test result is being sought with notice and a reasonable opportunity to participate in the proceeding if he is not already a party, (D) court proceedings as to involuntary testing shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice;

(9) When the test is conducted by any life or health insurer or health care center for purposes of assessing a person's fitness for insurance coverage offered by such insurer or health care center; or

(10) By community-based HIV testing providers conducting HIV testing in non-clinical and/or outreach settings when they have received and documented verbal consent.[When the test is subsequent to a prior confirmed test and the subsequent test is part of a series of repeated testing for the purposes of medical monitoring and treatment, provided (A) the patient has previously given general consent that includes HIV-related tests, (B) the patient, after consultation with the health care provider, has declined reiteration of the general consent, counseling and education requirements of this section, and (C) a notation to that effect has been entered into the patient's medical record.]

Section 6. Section 19a-583 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person who obtains confidential HIV-related information may disclose or be compelled to disclose such information, except to the following:

(1) The protected individual, his legal guardian or a person authorized to consent to health care for such individual;

(2) Any person who secures a release of confidential HIV-related information;

(3) A federal, state or local health officer when such disclosure is mandated or authorized by federal or state law;

(4) A health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual or when confidential HIV-related information is already recorded in a medical chart or record and a health care provider has access to such record for the purpose of providing medical care to the protected individual;

(5) A medical examiner to assist in determining the cause or circumstances of death;

(6) Health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews;

(7) A health care provider or other person in cases where such provider or person in the course of his occupational duties has had a significant exposure to HIV infection, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his occupation, (B) the worker completes an incident report within forty-eight hours of exposure, identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline HIV test within seventy-two hours of the exposure and is negative on that test for the presence of [the AIDS virus] HIV, (D) the patient's or person's physician or, if the patient or person does not have a personal physician or if the patient's or person's physician is unavailable, another physician or health care provider has approached the patient or person and sought voluntary consent to disclosure and the patient or person refuses to consent to disclosure, except in an exposure where the patient or person is deceased, (E) the worker would be able to take meaningful immediate action as defined in regulations adopted pursuant to section 19a-589 which could not otherwise be taken, (F) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (E) of this subdivision are met and that a worker has a significant exposure to the blood of a patient or person and the patient or person or the patient's or person's legal guardian refuses to consent to release of the information. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorizes the disclosure of confidential HIV-related information nor the health facility, correctional facility or other institution nor any person in a health facility, correctional facility or other institution who relies in good faith on the group's determination and discloses the result shall have any liability as a result of his action carried out under this section, unless such persons acted in bad faith. If the information is not held by a health facility, correctional facility or other institution, a physician not directly involved in the exposure has certified in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (E) of this subdivision are met and that a significant exposure has occurred;

(8) Employees of hospitals for mental illness operated by the Department of Mental Health and Addiction Services if the infection control committee of the hospital determines that the behavior of the patient poses a significant risk of transmission to another patient of the hospital. Disclosure shall only be allowed if it is likely to prevent or reduce the risk of transmission and no reasonable alternatives exist that will achieve the same goal and also preserve the confidentiality of the information. Such "reasonable alternatives" include counseling the patient concerning

behaviors that pose a risk of transmission and other efforts to prevent or address the behaviors that pose a significant risk of transmission without disclosing the patient's HIV status or other confidential HIV-related information. Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information to achieve the purpose authorized by this subdivision;

(9) Employees of facilities operated by the Department of Correction to provide services related to HIV infection or if the medical director and chief administrator of the facility determine that the behavior of an inmate poses significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility. Such a disclosure shall only be made if it is specifically required to enable the inmate to receive such services or is likely to prevent or reduce the risk of transmission and no reasonable alternatives exist that will achieve the same goal and also preserve the confidentiality of the information. Such "reasonable alternatives" include counseling the inmate concerning behaviors that pose a risk of transmission or other efforts to prevent or address the behaviors that pose a significant risk of transmission without disclosing the patient's HIV status or other confidential HIV-related information. Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information to achieve a purpose authorized by this subdivision;

(10) Any person allowed access to such information by a court order which is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the test results which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy interest of the test subject and the public interest which may be disserved by disclosure which deters future testing or which may lead to discrimination. (B) Pleadings pertaining to disclosure of confidential HIV-related information shall substitute a pseudonym for the true name of the subject of the test. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court. (C) Before granting any such order, the court shall provide the individual whose test result is in question with notice and a reasonable opportunity to participate in the proceedings if he is not already a party. (D) Court proceedings as to disclosure of confidential HIV-related information shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice. (E) Upon the issuance of an order to disclose test results, the court shall impose appropriate safeguards against unauthorized disclosure, which shall specify the persons who may have access to the information, the purposes for which the information shall be used, and appropriate prohibitions on future disclosure;

(11) Life and health insurers, government payers and health care centers and their affiliates, reinsurers, and contractors, except agents and brokers, in connection with underwriting and claim activity for life, health, and disability benefits;

(12) Any health care provider specifically designated by the protected individual to receive such information received by a life or health insurer or health care center pursuant to an application for life, health or disability insurance; and

(13) A procurement organization, for the purposes of assessing donor suitability pursuant to subsection (c) of section 19a-289m.

(b) No person, except the protected individual, his legal guardian or a person authorized to consent to health care for such individual, to whom confidential HIV-related information is disclosed may further disclose such information, except as provided in this section and sections 19a-584 and 19a-585.

Section 7. Section 19a-584 of the general statutes is repealed and the following is substituted in lieu thereof:

Informing and warning of known partners of possible exposure to [the] HIV [virus]. Disclosure of HIV-related information to public health officers. (a) A public health officer may inform or warn partners of an individual that they may have been exposed to HIV under the following conditions: (1) The public health officer reasonably believes there is a significant risk of transmission to the partner; (2) the public health officer has counseled the protected individual regarding the need to notify the partner and the public health officer reasonably believes the protected individual will not inform the partner; (3) the public health officer has informed the protected individual of such officer's intent to make such disclosure. The public health officer may also warn or inform a partner at the request of a protected individual. When making such disclosure to the partner the public health officer shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of learning the information and for changing behavior to prevent transmission or contraction of HIV infection. The public health officer shall not disclose the identity of the protected individual or the identity of any other partner. The public health officer, making a notification, shall make such disclosure in person, except where circumstances reasonably prevent doing so. The public health officer shall make a good faith effort to notify the partner of the risk of HIV infection. The public health officer shall have no obligation to warn or inform, identify or locate any partner.

Section 8. Section 19a-593 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each health care provider giving prenatal care to pregnant women in this state shall inform her, or ascertain from the woman's medical record that such information has already been provided to her, that HIV testing is a part of routine prenatal care and shall inform her of the health benefits to herself and her newborn of being tested for HIV infection. Such information shall be conveyed along with the counseling required by section 19a-582. The health care provider shall inform the patient that HIV-related information is confidential pursuant to section 19a-583. If the patient provides informed consent to an HIV-related test consistent with section 19a-582, the health care provider responsible for HIV counseling under this section shall perform or arrange to have performed an HIV-related test and document the test result in the medical record.

(b) If, during the current pregnancy, an HIV-related test has not been documented in the patient's medical record at admission for delivery of the baby, then the health care provider responsible for the patient's care shall inform the pregnant woman as required under subsection (a) of this

section and shall also inform her of the health benefits to herself and her newborn of being tested for HIV infection either before delivery or within twenty-four hours after delivery and, in the absence of specific written objection, shall cause such test to be administered.

(c) Any health care provider who performs an HIV test on a newborn under the provisions of sections 19a-90, 19a-555 and 19a-593 shall report the results of such test to the mother of such newborn before the mother leaves the hospital or within forty-eight hours of the birth of such newborn whichever is sooner. Such provider shall refer any women whose newborn tests positive for HIV to an HIV case manager and an appropriate health care provider. Such provider shall also give the woman a list of support services for people with HIV and AIDS

Section 9. Sections 19a-54a, 19a-124a, 19a-121a, and 19a-594 of the general statutes are repealed.

Population Health Statistics and Surveillance/ Vital Records

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Population Health Statistics and Surveillance

Agency Analyst/Drafter of Proposal:
Lisa Kessler

Title of Proposal
An Act Concerning Who is Eligible to Marry

Statutory Reference 46b-20a Eligibility to marry

Proposal Summary

Fix the language so that a married couple cannot re-marry each other.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? ***Yes***
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? ***N/A***
(3) Have certain constituencies called for this action? ***No***
(4) What would happen if this was not enacted in law this session? ***Marriage record keeping in Connecticut will continue to be faulty.***

- **Origin of Proposal ___ New Proposal ___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None
State None
Federal None
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The laws regarding marriage were substantially changed in 2009 in order to accommodate same sex marriage. At that time, a new section was added to the marriage laws, C.G.S. section 46b-20a, regarding who was eligible to marry. Subdivision (1) of the law allows someone to marry if they are not already married or in a similar legally recognized relationship, unless the parties to the marriage will be the same as the parties to such other marriage or relationship. This means that the same couple may marry multiple times.

The law was likely written this way in order to overcome barriers that same sex couples encountered, and the varying rights that were granted to same sex couples from state to state. Though the law granted protections, it also created a system that fostered disorganized record keeping, and legal complications for marrying couples.

Following the recent Supreme Court decision that allows same sex couples to marry nationwide giving equal rights to all marrying couples, this provision is no longer as necessary, and the Department is proposing its repeal in order to improve marriage record keeping practices, and eliminate the potential legal complications that couples may encounter when determining the date of their marriage.

Subdivision (1) of Section 46b-20a of the general statutes is repealed and the following is substituted in lieu thereof:

A person is eligible to marry if such person is:

(1) Not a party to another marriage, or a relationship that provides substantially the same rights, benefits and responsibilities as a marriage, entered into in this state or another state or jurisdiction[, unless the parties to the marriage will be the same as the parties to such other marriage or relationship];

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:

Agency Analyst/Drafter of Proposal:

Title of Proposal
An Act to Repeal Section 19a-57 of the Connecticut General Statutes

Statutory Reference
19a-57. Loans for Purchase of hemodialysis treatment machines

Proposal Summary
The law was put in place in 1973, with technical changes in 1977, 1993 and 1995 to correct the Department name. Currently, the Department of Public Health is not collaborating with The Kidney Foundation of Connecticut, Inc. to secure loans for residents of the state to purchase hemodialysis machines for treatment in their homes. No funding has been provided to the Department to implement the provisions of this law.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

- **Origin of Proposal ___ New Proposal ___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 19a-57 of the General statutes is repealed

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Pop. Health Statistics and Surveillance/ Vital Records

Agency Analyst/Drafter of Proposal:
Lisa Kessler

Title of Proposal
An Act Concerning A Search Fee for Vital Records

Statutory Reference
7-74 Fees for certification of birth registration, certified copy of vital statistics certificate and uncertified copy of original certificate of birth. Waiver of fee for certificate of death for a veteran.

Proposal Summary
This proposal will allow the State Office of Vital Records and local vital records offices to charge a search fee for a vital record. The search fee will cover the cost of a certified copy of the vital record if found, or a letter of 'No Record Found' if the record is not on file. For birth records, the search fee of $30 applies regardless of whether the persons is requesting a Birth Certificate (long form) or Certification of Birth (short form).

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? ***No***
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? ***Yes. Search fees are in place, and actual operating costs are better compensated.***
(3) Have certain constituencies called for this action? ***No***
(4) What would happen if this was not enacted in law this session? ***Uncompenstated operational costs will remain high***

- **Origin of Proposal ___ New Proposal __X_ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package? ***Not included in Administrative proposals, reason unknown.***
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? ***No***
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? ***N/A***
(4) What was the last action taken during the past legislative session? ***Was not included in the Adminstration's legislative proposals.***

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) Positive fiscal impact for municipalities. Will vary from town to town depending on the volume of vital records requested.
State Positive fiscal impact for the state estimated at $50,000 per year.
Federal None
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Currently, the State Vital Records Office receives approximately 13,500 requests per year for certified copies of birth, death and marriage certificates. Of these requests, about 15% are unfilled because no record is on file. Local vital records offices have similar scenarios, with the number of overall requests varying depending upon the size of the town.

The State Vital Records Office is permitted by statute to charge a fee for the issuance of a certified copy of a vital record -- $30 for a birth certificate and $20 for a marriage or death certificate. Local vital records offices charge $20 for all vital records. The fees only apply when a record is found and a certified copy of the record can be issued. When a record cannot be found the Department and local registrars must return the fee, meaning that the vital records offices receive no compensation for the search of the record or the time spent to prepare correspondence informing the requester of the negative search result. Based upon the diligent searches that Vital Records staff perform to fill all vital records requests, there is much time and cost involved in searching for a record. Those records that are ultimately not found are those that staff expend the most time – multiple databases and index books must be searched before it is determined that the record is not on file, and communication between the different vital records offices takes place to confirm that the record is not recorded in another vital records office. Yet, the Department and local registrars receive no compensation for this considerable expenditure of time and resources.

Given the substantial time and costs involved in processing unfilled requests, the Department is proposing a fee that will apply to the *search* of the vital record. Since the fee applies to the search, it is applicable whether or not the record is found. Note that ***at least 46*** of the 50 states charge a non-refundable search fee for vital records requests.

Also included in this proposal is an increase in the fee for Certification of Birth Registrations. The proposed increase makes the cost of a Certification of Birth Registration equal to that of a certified copy of the birth record. This will not only make birth certificate fees uniform, but will also compensate vital records offices for the extra work involved in preparing the Certification of Birth Registration. To prepare the Certification of Birth Registration a search of the birth certificate takes place, and if found, the birth information is abstracted from the record and manually typed onto the short form birth certificate.

Sec. 7-74 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) [The fee for a certification of birth registration, short form, shall be fifteen dollars. The fee for a certified copy of a certificate of birth, long form, shall be twenty dollars, except that the fee for such certifications and copies when issued by the department shall be thirty dollars.] A fee of twenty dollars shall be charged to search for a vital record, except that the department shall charge a fee of thirty dollars to search for a birth record. Such fee shall cover the cost of the search and either one certified copy of the vital record or a certification of birth registration, or a certified letter indicating that no record is on file.

(b) [The fee for a certified copy of a certificate of marriage or death shall be twenty dollars. Such fees shall not be required of the department.]

[(c)] The fee for one certified copy of a certificate of death for any deceased person who was a veteran, as defined in subsection (a) of 27-103, shall be waived when such copy is requested by a spouse, child or parent of such deceased veteran.

(d) The fee for an uncertified copy of an original certificate of birth issued pursuant to section 7-53, as amended by this act, shall be sixty-five dollars.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Regulatory Services Branch, Environmental Health Section

Agency Analyst/Drafter of Proposal: Christine Applewhite- Food Protection Program

Title of Proposal
An Act Concerning Adoption of the Federal Food and Drug Administration's 2013 Model Food Code by Reference

Statutory Reference
Sec. 19a-36(a) (1),(4) AND (5), 19a-36 (a) through (c)

Proposal Summary
Enabling statutory language that gives the Department the authority to repeal sections 19-13-B40, 19-13-B42, 19-13-B48 and 19-13-B49 of the current Regulations of CT State Agencies and adopt the 2013 FDA Model Food Code by reference.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Enabling statutory language that allows the Department to adopt the Federal Food and Drug Administration's 2013 Model Food Code by reference. This change would align Connecticut with the majority of other states that have moved towards a national, uniform regulatory system that provides a scientific foundation and legal framework for regulating the foodservice industry. Adoption of the Code will provide consistency with federal performance standards currently established and implemented in Connecticut, as well as consistency with foodservice industry practices. Mandating these federal standards alleviates the burden of local and state agencies of having to develop and update the Connecticut food regulations and instead provides the opportunity to focus resources on the implementation and enforcement of the Code

- **Origin of Proposal** **New Proposal** **X Resubmission**

If this is a resubmission, please share:

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Consumer Protection
Agency Contact (name, title, phone): Frank Greene, Supervisor, 860-713-6168
Date Contacted: TBD

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO
Agency Name: Department of Agriculture Agency Contact (name, title, phone): Wayne Kasacek, Supervisor, 860-713-2587 Date Contacted: TBD Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) 0
State 0
Federal 0
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Mandating these federal standards alleviates the burden to local and state agencies of having to develop and update the Connecticut food regulations and training and provides the opportunity to focus resources on the implementation and enforcement of the Code.

(NEW) (*Effective from passage*) Notwithstanding the provisions of chapter 54 of the general statutes, sections 19-13-B40, 19-13-B42, 19-13-B48 and 19-13-B49 of the regulations of Connecticut state agencies are repealed and the following is substituted in lieu thereof:

Section 19a-36a(1)[Said code may include regulations pertaining to retail food establishments, including, but not limited to, food service establishments, catering food service establishments and itinerant food vending establishments and the required permitting from local health departments or districts to operate such establishments]<u>No person, firm or corporation shall operate or maintain within the State of Connecticut any place where food or beverages are served to the public except in compliance with the requirements of the Federal Food and Drug Administration's 2013 Model Food Code, as adopted by reference, and from time to time, amend the same.</u>

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc)**:** **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kennedy Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov
Lead agency division requesting this proposal: Drinking Water Section
Agency Analyst/Drafter of Proposal: Lori Mathieu, Public Health Section Chief, Drinking Water Section

Title of Proposal An Act Concerning Aging Water Company Infrastructure
Statutory Reference **NEW**
Proposal Summary
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

(New)

(a) Each water company shall prepare a fiscal and asset management plan for all of the capital assets that comprise each of the water company's small water systems. The fiscal and asset management plan shall include, but not be limited to, a list of all capital assets of the small water system, the useful life of such capital assets based on an examination of its condition and

the manufacturer's recommendation, and the water company's plan for the reconditioning, refurbishment, or replacement of such capital assets. Each water company shall commence the creation of the fiscal and asset management plan with the consideration of its hydropneumatic pressure tanks as its initial priority. Each water company shall complete the fiscal and asset management plan for all of the capitol assets of each of its small water systems not later than January 1, 2019, except that each water company shall complete consideration of its hydropneumatic pressure tanks not later than July 1, 2017. The water company shall update each of its fiscal and asset management plans annually and make such fiscal and asset management plans available to the Department of Public Health upon demand.

(b) For purposes of this section, (1) "water company" has the same meaning as provided in section 25-32a and (2) "small water system" means a water system that serves not more than 10,000 persons.

(c) This section shall be deemed to relate to the purity and adequacy of water supplies for the purposes of section 25-32e of the Connecticut General Statutes with respect to the imposition of civil penalties.

(d) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Food Protection Program

Agency Analyst/Drafter of Proposal:
Christine Applewhite

Title of Proposal
Repeal of Herd-Sharing Public Act

Statutory Reference
PA 15-101

Proposal Summary
Section 1. Subsection (c) of section 22-129 of the general statutes is repealed and the following is substituted in lieu thereof: (effective from passage)
(c) The provisions of this section shall not apply to the production of milk, milk products, raw milk or raw milk products and the manufacture of cheese for personal consumption or for consumption by immediate family members.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

This proposal has been implemented in other states. Data from those states indicate that they have seen an increase in foodborne illness related to consumption of raw milk from herd sharing programs. In Tennessee, "since the state legalized cow share programs, reports have increased of disease and outbreaks linked to raw milk consumption. In 2013, nine Tennessee children became extremely sick with E. coli after drinking raw milk. Five of those required hospitalization and three developed severe, life-threatening kidney problems."

In addition, the testimony the FPP wrote in opposition to this bill was not submitted. Therefore, the implications to public health, as those being seen in Tennessee, were not fully understood at the time.

- **Origin of Proposal __X_ New Proposal ___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Agriculture Agency Contact (name, title, phone): Wayne Kasacek, 860-713-2587, Supervisor Date Contacted: Approve of Proposal ___ YES ___NO _x__Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO
Agency Name: Department of Consumer Protection Agency Contact (name, title, phone): Frank Greene, Program Supervisor, 860-713-6160 Date Contacted: Approve of Proposal ___ YES ___NO __x_Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? __ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None
State None
Federal
Additional notes on fiscal impact None

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

To be determined

Section 1. Subsection (c) of section 22-129 of the general statutes is repealed and the following is substituted in lieu thereof: (effective from passage)

(c) The provisions of this section shall not apply to the production of milk, milk products, raw milk or raw milk products and the manufacture of cheese for personal consumption or for consumption by immediate family members.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Drinking Water Section

Agency Analyst/Drafter of Proposal:
Lori Mathieu, Public Health Section Chief, Drinking Water Section

Title of Proposal
An Act Concerning Civil Penalties

Statutory Reference
Section 25-32e Imposition of civil penalties for violations of certain drinking water laws and regulations.

Proposal Summary
This legislative proposal will update the existing Statute that gives the Commissioner authority to issue civil penalties against public water systems and eliminate the need for separate civil penalty regulations

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

- **Origin of Proposal** **__X__ New Proposal** **____ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Energy and Environmental Protection Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Section 25-32e of the general statutes is repealed and the following is substituted in lieu thereof:

(a) If, upon review, investigation or inspection, the Commissioner of Public Health determines that a water company has violated any provision of section 25-32, section 25-32d or any regulation adopted under section 25-32d, or any [regulation in the Public Health Code] Regulation of Connecticut State

Agencies relating to the regulation of the purity and adequacy of water supplies or to the testing of water supplies or any report of such testing, the commissioner may impose a civil penalty not to exceed five thousand dollars per violation per day upon such water company. Governmental immunity shall not be a defense against the imposition of any civil penalty imposed pursuant to this section. [The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a schedule or schedules of the amounts, or the ranges of amounts, of civil penalties which may be imposed under this section. In adopting such regulations, the commissioner shall consider the size of or the number of persons served by the water company, the level of assessment necessary to insure immediate and continued compliance with such provision, and the character and degree of injury or impairment to or interference with or threat thereof to: (1) The purity of drinking water supplies; (2) the adequacy of drinking water supplies; and (3) the public health, safety or welfare. No such civil penalty may be imposed until the regulations required by this subsection have been adopted.]

(b) In setting a civil penalty in a particular case, the commissioner shall consider all factors which the commissioner deems relevant, including, but not limited to, the following: (1) The amount of assessment necessary to insure immediate and continued compliance with such provision; (2) the character and degree of impact of the violation on the purity and adequacy of drinking water supplies; (3) whether the water company incurring the civil penalty is taking all feasible steps or procedures necessary or appropriate to comply with such provisions or to correct the violation; (4) any prior violations by such water company of statutes, regulations, orders or permits administered, adopted or issued by the commissioner; and (5) the character and degree of injury to, or interference with, public health, safety or welfare which has been or may be caused by such violation; and (6) [after the adoption of the federal Safe Drinking Water Act Public Notification Rule pursuant to section 5 of public act 01-185*,] whether the consumers of the water company have been notified of such violation pursuant to [such rule] section 19-13-B102 of the Regulations of Connecticut State Agencies.

(c) If the commissioner has reason to believe that a violation has occurred, the commissioner may impose a penalty [if compliance is not achieved by a specified date] and send to the violator[, by certified mail, return receipt requested, or personal service] at the address provided to the Department of Public Health by the water company as required by section 25-33(a) or, if the water company did not provide an address as required by section 25-33(a), to the last known address of the water company on file at the department, a notice which shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the [matters asserted or charged] violation; (3) a statement of the amount of the civil penalty or penalties [to be] imposed; (4) the initial date of the imposition of the penalty, when the penalty imposed is for a continuing violation, or the dates for which the penalty is imposed; and (5) a statement of the [party's] water company's right to a hearing. The commissioner shall send a copy of such notice to the local director of health in the municipality or municipalities in which such violation occurred or that utilize such water.

(d) The civil penalty shall be payable for noncompliance on the date specified in subsection (c) of this section and for each day thereafter until the water company against which the penalty was issued [notifies] demonstrates to the commissioner that the violation has [been corrected] ceased to occur or for the period in which the violation occurred. [Upon receipt of such notification, the commissioner shall determine whether or not the violation has been corrected and shall notify the water company, in writing, of such determination. The water company may, within twenty days after such notice is sent by the commissioner, request a hearing to contest an adverse determination. If, after such hearing, the commissioner finds that the violation still exists, or if the water company fails to request a hearing, the penalty shall continue in force from the original date of imposition.]

(e) The water company to which the notice is addressed shall have [twenty] ten days from the date of mailing of the notice to make written application to the commissioner for a hearing to contest the

imposition of the penalty, which shall set forth the reason or reasons for the appeal. The water company shall send a copy of such application to the local director of health in the municipality or municipalities in which such violation occurred or that utilize such water. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive, except that the presiding officer shall automatically grant each local director of health in the municipality or municipalities in which such violation occurred or that utilize such water the right to be heard in the proceeding. [Any civil penalty may be mitigated by the commissioner upon such terms and conditions as the commissioner, in the commissioner's discretion, deems proper or necessary upon consideration of the factors set forth in subsection (b) of this section.]

(f) A final order of the commissioner assessing a civil penalty shall be subject to appeal as set forth in section 4-183 after a hearing before the commissioner pursuant to subsection (e) of this section, except that any such appeal shall be taken to the superior court for the judicial district of New Britain and shall have precedence in the order of trial as provided in section 52-191. Such final order shall not be subject to appeal under any other provision of the general statutes. No challenge to any such final order shall be allowed as to any issue which could have been raised by an appeal of an earlier order, notice, permit, denial or other final decision by the commissioner. The local director of health in the municipality or municipalities in which such violation occurred or that utilize such water for which the order was assessed shall have the right to be heard on such appeal.

(g) If any water company fails to pay any civil penalty, the Attorney General, upon request of the commissioner, may bring an action in the superior court for the judicial district of Hartford to obtain enforcement of the penalty by the court. All actions brought by the Attorney General pursuant to the provisions of this section shall have precedence in the order of trial as provided in section 52-191.

(h) The provisions of this section are in addition to and not in derogation of any other enforcement provisions of any statute administered by the commissioner. The powers, duties and remedies provided in such other statutes, and the existence of or exercise of any powers, duties or remedies under this section or under such other statute shall not prevent the commissioner from exercising any other powers, duties or remedies available to the commissioner at law or in equity.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Drinking Water Section

Agency Analyst/Drafter of Proposal:
Lori Mathieu, Public Health Section Chief, Drinking Water Section

Title of Proposal
An Act Concerning Certificates of Public Convenience and Necessity for the Expansion and Construction of Public Water Systems

Statutory Reference
Section 16-262m Construction specifications for water companies.

Proposal Summary
This legislative proposal will streamline the Certificate of Public Convenience and Necessity (CPCN) process by removing the PURA from the review and issuance of CPCNs for community water systems, except that the PURA will determine if the person that will own the water system has the requisite financial resources. Under the legislative proposal, the DPH will review and issue CPCNs for community water systems. In addition, the legislative proposal increases the application fee for a CPCN from $100 to $500.
The Department has worked with PURA to assure this section

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

- This new section is the same as *Conn. Gen. Stat*. § 16-262m except that PURA is removed from the CPCN process with respect to systems that will serve twenty-five or more residents, except that PURA is required to make the determination regarding financial capacity of the person who will own the water supply system.
- Increases the application fee from $100 to $500.

- **Origin of Proposal ___ New Proposal _X_ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Energy and Environmental Protection
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Section 16-262m of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section and section 8-25a, "water company" means a corporation, company, association, joint stock association, partnership, municipality, state agency, other entity or person, or lessee thereof, owning, leasing, maintaining, operating, managing or controlling any pond, lake, reservoir, stream, well or distributing plant or system employed for the purpose of supplying water to fifteen or more service connections or twenty-five or more persons for at least sixty days in any one year.

(b) No person, including, but not limited to, a water company may begin the construction of a water supply system for the purpose of supplying water to fifteen or more service connections or twenty-five or more persons for at least sixty days in any one year, and no person **[**or entity**]** including, but not limited to, a water company, except a water company supplying more than two hundred fifty service connections or one thousand persons, may begin expansion of **[**such**]** a water supply system, without having first obtained a certificate of public convenience and necessity from the Department of Public Health.

(c) For systems serving twenty-five or more residents that are not the subject of proceedings under **[**subsection (c) of**]** section 16-262n, as amended by this act, **[**or**]** section 16-262o, as amended by this act, or section 15 of this act, an application for a certificate of public convenience and necessity shall be on a form prescribed by the **[**Public Utilities Regulatory Authority, in consultation with the**]** Department of Public Health, and accompanied by a copy of the applicant's construction or expansion plans, a fee of **[**one**]** five hundred dollars and, when an exclusive service area provider has been determined pursuant to section 25-33g, a copy of a signed ownership agreement between the applicant and provider for the exclusive service area, as determined pursuant to section 25-33g, detailing those terms and conditions under which the system will be constructed or expanded and for which the provider will assume service and ownership responsibilities. When an exclusive service area provider has been determined pursuant to section 25-33g, the application shall also be accompanied by a written confirmation from the exclusive service area provider, as the person that will own the water supply system, that such exclusive service area provider has received the application and is prepared to assume responsibility for the water supply system subject to the terms and conditions of the ownership agreement. Written confirmation from the exclusive service area provider shall be on a form prescribed by **[**said authority and**]** the department. **[**Said authority and**]** The department shall issue a certificate to an applicant upon determining, to **[**their**]** its satisfaction, that (1) no interconnection is feasible with a water system owned by, or made available through arrangement with, the provider for the exclusive service area, as determined pursuant to section 25-33g, or with another existing water system where no exclusive service area has been assigned, (2) the applicant will complete the construction or expansion in accordance with engineering standards established by regulation by the**[**Public Utilities Regulatory Authority**]** department for water supply systems, (3) ownership of the system will be assigned to the provider for the exclusive service area, when an exclusive service area provider has been determined pursuant to section 25-33g, (4) the proposed construction or expansion will not result in a duplication of

water service in the applicable service area, (5) the applicant meets all federal and state standards for water supply systems, (6) the person that will own the water supply system has the financial, managerial and technical resources to (A) operate the proposed water supply system in a reliable and efficient manner, and (B) provide continuous adequate service to consumers served by the water supply system, (7) the proposed water supply system will not adversely affect the adequacy of nearby water supply systems, and (8) any existing or potential threat of pollution that the **[**Department of Public Health**]** department deems to be adverse to public health will not affect any new source of water supply. When the person that will own the water supply system is a water company, as defined in section 16-1, the concurrence of the Public Utilities Regulatory Authority shall be required regarding whether such person has the financial resources required under subdivision (6) of this subsection. Any construction or expansion with respect to which a certificate is required shall thereafter be built, maintained and operated in conformity with the certificate and any terms, limitations or conditions contained therein.

[(d) The Public Utilities Regulatory Authority and the Department of Public Health shall each adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of subsections (a) to (c), inclusive, of this section.**]**

[(e) (1)**]** (d) For systems serving twenty-five or more persons, but not twenty-five or more residents, at least sixty days in any one year, an application for a certificate of public convenience and necessity shall be on a form prescribed by the Department of Public Health and accompanied by a copy of the construction or expansion plans and a fee of five hundred dollars. The**[**Department of Public Health**]** department shall issue a certificate to an applicant upon determining, to its satisfaction, that: **[**(A) no**]** (1) No interconnection is feasible with a water system owned by, or made available through arrangement with, the provider for the exclusive service area, as determined pursuant to section 25-33g or with another existing water system where no existing exclusive service area has been assigned, **[**(B)**]** (2) the applicant will complete the construction or expansion in accordance with engineering standards established by regulation by the department for water supply systems, **[**(C)**]** (3) ownership of the system will be assigned to the provider for the exclusive service area, as determined pursuant to section 25-33g, if agreeable to the exclusive service area provider and the **[**Department of Public Health**]** department, or may remain with the applicant, if agreeable to the **[**Department of Public Health**]** department, until such time as the water system for the exclusive service area, as determined by section 25-33g, has made an extension of the water main, after which the applicant shall obtain service from the provider for the exclusive service area, **[**(D)**]** (4) the proposed construction or expansion will not result in a duplication of water service in the applicable service area, **[**(E)**]** (5) the applicant meets all federal and state standards for water supply systems, **[**(F)**]** (6) the person that will own the water supply system has the financial, managerial and technical resources to **[**(i)**]** (A) operate the proposed water supply system in a reliable and efficient manner, and **[**(ii)**]** (B) provide continuous adequate service to consumers served by the water supply system, **[**(G)**]** (7) the proposed water supply system will not adversely affect the adequacy of nearby water supply systems, and **[**(H)**]** (8) any existing or potential threat of pollution that the **[**Department of Public Health**]** department deems to be adverse to public health will not affect any new source of water supply. Any construction or expansion with respect to which a certificate is required shall thereafter be built, maintained and operated in conformity with the certificate and any terms, limitation or conditions contained therein.

(e) Properties held by the Department of Energy and Environmental Protection and used for, or in support of, fish culture, natural resource conservation or outdoor recreational purposes shall be exempt from the requirements of subdivisions (1), (3) and (4) of **[**subsection (c) of this section and subparagraphs (A), (C) and (D) of subdivision (1) of subsection (e)**]** subsections (c) and (d) of this section. All state agencies are exempt from the fee requirements provided in subsections (c) and (d) of this section.

[(2)**]** (f) The Department of Public Health **[**shall**]** may adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of this **[**subsection**]** section. Such regulations may include measures that encourage water conservation and proper maintenance.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc)**: GRE will fill in**
State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kennedy Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov
Lead agency division requesting this proposal: Office of Local Health Administration
Agency Analyst/Drafter of Proposal: Juanita Estrada/Sue Walden
Title of Proposal THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING FUNDING FOR MUNICIPAL HEALTH DEPARTMENTS AND HEALTH DISTRICTS
Statutory Reference **Section 1. 19a-202 Payments to Municipalities** **Section 2. 19a-245 Reimbursement by State**
Proposal Summary *Local health departments and districts would be required to submit their per capita applications by September 30th of the current fiscal year. Local health departments and districts would no longer be allowed to carryover per-capita funds as currently permitted in Sections 19a-202 and 19a-245. In addition, per-capita funds would be pro-rated as to when a town or towns join and/or form a health district effective from the date of forming and/or joining the health district during the state fiscal year. The proration would also apply to the towns' contribution of at least a one dollar per capita to a newly formed district. The revised language also aligns the municipal and district criteria for per capita funding.*

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Local health departments and districts currently can submit their per capita applications between July 1, the start of the fiscal year through June 30th, the last day of the current fiscal year. Local health departments and districts are also able to carryover unexpended per capita funds from year to year. Over the last five years, approximately one million dollars (20%) of per capita funds have been carried over each year. By deleting the language to carryover funding and adding an application deadline, this will require local health departments and districts to better plan and utilize the state funds or return the unspent funds to the Department of Public Health. The Department of Public Health will establish a separate, non-lapsing account within the General Fund. These funds will be used to establish a competitive supplemental grant program to support the delivery of local public health services.

When a town joins a health district or a health district forms at any time during the fiscal year, the district receives 100% of the per-capita funding regardless of the date of joining and/or forming. To decrease the burden of the State and to increase better planning at the local level in regards to districting, DPH is proposing to disperse the per-capita funds on a pro-rated basis effective the date of the joining and/or forming the health district.

- **Origin of Proposal** **___ New Proposal** **_X__ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

Two local health agencies (one municipality and one district) submitted testimony against SB 995. Further discussion is needed with local health departments to help them understand why the language is being proposed. The last action on SB 995 was the Senate recommitted the bill to the Public Health Committee.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Local Health Departments and Districts
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO _X__Talks Ongoing

Summary of Affected Agency's Comments

- Not in agreement with returning unexpended funds and pro-rating funds if a new district forms or a town joins a district.

Will there need to be further negotiation? ___ YES _X__NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Section 19a-202 of the General Statutes is repealed and the following is substituted in lieu thereof:

Upon application by September 30th to the Department of Public Health any municipal health department shall annually receive from the state an amount equal to one dollar and eighteen cents per capita, provided such municipality (1) employs a full-time director of health, except [that] if a vacancy exists in the [office of] municipality's director of health position or the [office] position is filled by an acting director for more than [three months] ninety days, such municipality shall not be eligible for funding unless the Commissioner of Public Health [waives this requirement] grants the municipal health department a waiver of the requirement for a full-time director of health; (2) submits a public health program and budget [which] that is approved by the Commissioner of Public Health; (3) appropriates not less than one dollar per capita, from the annual tax receipts, for health department services; (4) has a population of fifty thousand or more; and (5) meets the requirements of section 19a-207a, within available appropriations. Such municipal department of health may use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such municipal department of health. The money so received shall be disbursed upon warrants approved by the chief executive officer of such municipality. The Comptroller shall annually in July and upon a voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such municipal department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. [Any] For the fiscal years ending June 30, 2016, and June 30, 2017, any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of such municipal department of health for the ensuing year. For the fiscal year ending June 30, 2018, and each fiscal year thereafter, any such moneys shall be refunded to the Department of Public Health. The Department of Public Health will establish an account to be known as the "Local Health Department and District Program Fund" which shall be a separate, non-lapsing account within the General Fund. These funds will be used to support a competitive supplemental grant program to support the delivery of local public health services. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Language from SB 995 (2015) Sec. 2. Section 19a-202 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Upon application to the Department of Public Health any municipal health department shall annually receive from the state an amount equal to one dollar and eighteen cents per capita, provided such municipality (1) employs a full-time director of health, except [that] if a vacancy exists in the [office of] municipality's director of health position or the [office] position is filled by an acting director for more than [three months] ninety days, such municipality shall not be eligible for funding unless the Commissioner of Public Health [waives this requirement] grants the municipal health department a waiver of the requirement for a full-time director of health; (2) submits a public health program and budget [which] that is approved by the Commissioner of Public Health; (3) appropriates not less than one dollar per capita, from the annual tax receipts, for health

department services; (4) has a population of fifty thousand or more; and (5) meets the requirements of section 19a-207a, within available appropriations. Such municipal department of health may use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such municipal department of health. The money so received shall be disbursed upon warrants approved by the chief executive officer of such municipality. The Comptroller shall annually in July and upon a voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such municipal department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. **[**Any**]** For the fiscal years ending June 30, 2015, and June 30, 2016, any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of such municipal department of health for the ensuing year. For the fiscal year ending June 30, 2017, and each fiscal year thereafter, any such moneys shall revert to the General Fund of the state. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Section 2. Section 19a-245 of the General Statutes is repealed and the following is substituted in lieu thereof:

Upon application by September 30th to the Department of Public Health, each health district [that has a total population of fifty thousand or more, or serves three or more municipalities irrespective of the combined total population of such municipalities,] shall annually receive from the state an amount equal to one dollar and eighty-five cents per capita for each town, city and borough of such district, provided the district (1) employs a full-time director of health, except if a vacancy exists in the director of health position or the position is filled by an acting director for more than ninety days, such district shall not be eligible for funding unless the Commissioner of Public Health grants the health district a waiver of the requirement for a full-time director of health, [1] (2) the Commissioner of Public Health approves the public health program and budget of such health district, **[**(2)**]** (3) the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one dollar per capita from the annual tax receipts, [and (3)**]** (4) has a total population of fifty thousand or more, or serves three or more municipalities irrespective of the combined total population of such municipalities, and (5) the health district meets the requirements of section 19a-207a, within available appropriations. Notwithstanding the provisions of this section, any health district formed during a fiscal year shall, for that fiscal year, receive an amount prorated from the date of formation. Such district departments of health are authorized to use additional funds, **[**which**]** that the Department of Public Health may secure from federal agencies or any other source and **[**which**]** that it may allot to such district departments of health. The district treasurer shall disburse the money so received upon warrants approved by a majority of the board and signed by its chairman and secretary. The Comptroller shall quarterly, in July, October, January and April, upon such application and upon the voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such district department of health for the amount due in accordance with

the provisions of this section and under rules prescribed by the commissioner. [Any] For the fiscal years ending June 30, 2016, and June 30, 2017, any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of the district for the ensuing year. For the fiscal year ending June 30, 2018, and each fiscal year thereafter, any such moneys shall be refunded to the Department of Public Health. The Department of Public Health will establish an account to be known as the "Local Health Department and District Program Fund" which shall be a separate, non-lapsing account within the General Fund. These funds will be used to support a competitive supplemental grant program to support the delivery of local public health services. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

From SB 995 2015 - Section 1. Section 19a-245 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Upon application to the Department of Public Health, each health district that has a total population of fifty thousand or more, or serves three or more municipalities irrespective of the combined total population of such municipalities, shall annually receive from the state an amount equal to one dollar and eighty-five cents per capita for each town, city and borough of such district, provided (1) (A) the district employs a full-time director of health, or (B) a vacancy exists in the director of health position for more than ninety days and the Commissioner of Public Health grants the health district a waiver from the requirement for a full-time director of health, (2) the Commissioner of Public Health approves the public health program and budget of such health district, [(2)] (3) the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one dollar per capita from the annual tax receipts, and [(3)] (4) the health district meets the requirements of section 19a-207a, within available appropriations. Notwithstanding the provisions of this section, any health district formed during a fiscal year shall, for that fiscal year, receive an amount prorated from the date of formation. Such district departments of health are authorized to use additional funds, [which] that the Department of Public Health may secure from federal agencies or any other source and [which] that it may allot to such district departments of health. The district treasurer shall disburse the money so received upon warrants approved by a majority of the board and signed by its chairman and secretary. The Comptroller shall quarterly, in July, October, January and April, upon such application and upon the voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such district department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. [Any] For the fiscal years ending June 30, 2015, and June 30, 2016, any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of the district for the ensuing year. For the fiscal year ending June 30, 2017, and each fiscal year thereafter, any such moneys shall revert to the General Fund of the state. This aid shall be rendered from appropriations made from

time to time by the General Assembly to the Department of Public Health for this purpose.

Commented [KJ1]: Language Different from 2015 SB 995

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal: Drinking Water Section

Agency Analyst/Drafter of Proposal: Lori Mathieu, Public Health Section Chief, Drinking Water Section

Title of Proposal
An Act Concerning Drinking Water and Drinking Water State Revolving Fund Service Charges

Statutory Reference
Section 1: § 22a-477 Clean Water Fund: Accounts and subaccounts.
Section 2: § 22a-477 Clean Water Fund: Accounts and subaccounts.
Section 3: § 22a-478 Eligible water quality projects. Eligible drinking water projects. Project grants. Grant account loans.
Section 4: § 22a-478 Eligible water quality projects. Eligible drinking water projects. Project grants. Grant account loans.
Section 5: §22a-478 Eligible water quality projects. Eligible drinking water projects. Project grants. Grant account loans.
Section 6: § 22a-478 Eligible water quality projects. Eligible drinking water projects. Project grants. Grant account loans.
Section 7: § 22a-478 Eligible water quality projects. Eligible drinking water projects. Project grants. Grant account loans.
Section 8: NEW
Section 9: NEW
Section 10: NEW
Section 11: NEW

Proposal Summary
To create a service charge structure to sustain state drinking water program staff salaries to support their current and growing work effort to assure primacy under the Safe Drinking Water Act, as well as support the various responsibilities under state statute.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? No.
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Yes. Many other states have authorization to collect fees or service charges for sanitary surveys, project reviews, and drinking water loan projects to provide support to their public drinking water programs.
(3) Have certain constituencies called for this action? No, however, this action is needed to sustain current and growing costs to operate the DPH Drinking Water Section.
(4) What would happen if this was not enacted in law this session? The ability of the State of Connecticut, through the DPH, to maintain primary enforcement responsibility of the Federal Safe Drinking Water Act and Connecticut General Statutes may be severely compromised.

- **Origin of Proposal** **__X__ New Proposal** **____ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
Throughout the legislative proposal, language is added to allow DPH to collect a small to be set nominal service charge that municipalities that own or control a public water supply system will have to pay to DPH after they receive the DWSRF cash needed to fund drinking water improvement project, and when they apply to DPH to receive a permit or approval to modify, construct or repair a drinking water infrastructure. The service charge is needed to offset the cost to DPH associated with the review, analyses and determination of the application inclusive of all engineering & planning reports, studies, plans & construction specifications.

State
Throughout the legislative proposal language is added to allow DPH to collect a small to be set nominal service charge that State Agencies (such as DEEP, DOT, DOC) that own or control a public water supply system will have to pay to DPH when they apply to DPH to receive a permit or approval to construct or repair a drinking water infrastructure. The service charge is needed to offset the cost to DPH associated with the review, analyses and determination of the application inclusive of all engineering & planning reports, studies, plans & construction specifications.

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The DPH will have to hire a consultant to assist DPH in determining the appropriate service charges to offset the cost, and then develop regulations that will set the service charges and the protocol for collection, implementation and transparency.

Section 1. Subsection (q) of Section 22a-477 of the general statutes is repealed and the following is substituted in lieu thereof:

(q) There shall be deposited in the drinking water state account of the Clean Water Fund: (1) The proceeds of notes, bonds or other obligations issued by the state for the purpose of deposit therein and use in accordance with the permissible uses thereof; (2) funds appropriated by the General Assembly for the purpose of deposit therein and use in accordance with the permissible uses thereof; (3) interest or other income earned on the investment of moneys in the drinking water state account; (4) payments received from any recipient as repayment for a project loan, including any service charge paid as part of the project loan for the expenses of the Department of Public Health in administering the program, made with moneys on deposit in the drinking water state account; and (5) any additional moneys made available from any sources, public or private, for the purposes for which the drinking water state account has been established other than moneys on deposit in the federal receipts subaccount of the drinking water federal revolving loan account.

Sec. 2. Subsection (r) of Section 22a-477 of the general statutes is repealed and the following is substituted in lieu thereof:

(r) Within the drinking water state account there are established the following subaccounts: (1) A state bond receipts subaccount, into which shall be deposited the proceeds of notes, bonds or other obligations issued by the state for the purpose of deposit therein; (2) a General Fund receipts subaccount into which shall be deposited funds appropriated by the General Assembly for the purpose of deposit therein; and (3) a state loan repayment subaccount into which shall be deposited payments received from any recipient in repayment of a project loan, including any service charges paid as part of the project loan for the expenses of the Department of Public Health in administering the program, made from any moneys deposited in the drinking water state account.

Sec. 3. Subsection (i) of Section 22a-478 of the general statutes is repealed and the following is substituted in lieu thereof:

(i) In each fiscal year the Commissioner of Public Health may make project loans to recipients in the order of the priority list of eligible drinking water projects to the extent of moneys available therefor in the appropriate accounts of the Clean Water Fund. Each recipient undertaking an eligible drinking water project may apply for and receive a project loan or loans in an amount equal to one hundred per cent of the eligible project costs, which shall include a service charge for the expenses of the Department of Public Health in administering the program.

Sec. 4. Subsection (j) of Section 22a-478 of the general statutes is repealed and the following is substituted in lieu thereof:

(j) The funding of an eligible drinking water project shall be pursuant to a project funding agreement between the state, acting by and through the Commissioner of Public Health, and the recipient undertaking such project and shall be evidenced by a project fund obligation or an interim funding obligation of such recipient issued in accordance with section 22a-479. A project funding agreement shall be in a form prescribed by the Commissioner of Public Health. Any eligible drinking water project shall receive a project loan for the costs of the project, which shall include a service charge for the expenses of the Department of Public Health in administering the program. All loans made in accordance with the provisions of this section for an eligible drinking water project shall bear an interest rate not exceeding one-half the rate of the average net interest cost as determined by the last previous similar bond issue by the state of Connecticut as determined by the State Bond Commission in accordance with subsection (t) of section 3-20. The Commissioner of Public Health may allow any project fund obligation or interim funding obligation for an eligible drinking water project to be repaid by a borrowing recipient prior to maturity without penalty.

Sec. 5. Subsection (k) of Section 22a-478 of the general statutes is repealed and the following is substituted in lieu thereof:

(k) Each project loan for an eligible drinking water project shall be made pursuant to a project funding agreement between the state, acting by and through the Commissioner of Public Health, and such recipient, and each project loan for an eligible drinking water project shall be evidenced by a project loan obligation or by an interim funding obligation of such recipient issued in accordance with sections 22a-475 to 22a-483, inclusive. Except as otherwise provided in said sections 22a-475 to 22a-483, inclusive, each project funding agreement shall contain such terms and conditions, including provisions for default which shall be enforceable against a recipient and provisions requiring a service charge for the expenses of the Department of Public Health in administering the program, as shall be approved by the Commissioner of Public Health. Each project loan obligation or interim funding obligation issued pursuant to a project funding agreement for an eligible drinking water project shall bear an interest rate not exceeding one-half the rate of the average net interest cost as determined by the last previous similar bond issue by the state of Connecticut as determined by the State Bond Commission in accordance with subsection (t) of section 3-20. Except as otherwise provided in said sections 22a-475 to 22a-483, inclusive, each project loan obligation and interim funding obligation shall be issued in accordance with the terms and conditions set forth in the project funding agreement. Notwithstanding any other provision of the general statutes, public act or special act to the contrary, each project loan obligation for an eligible drinking water project shall mature no later than twenty years from the date of completion of the construction of the project and shall be paid in monthly installments of principal and interest or in monthly installments of principal unless a finding is otherwise made by the State Treasurer requiring a different payment schedule. Interest on each project loan obligation for an eligible drinking water project shall be payable monthly unless a finding is otherwise made by the State Treasurer requiring a different payment schedule. Principal and interest on interim funding obligations issued under a project funding agreement

for an eligible drinking water project shall be payable at such time or times as provided in the project funding agreement, not exceeding six months after the date of completion of the planning and design phase or the construction phase, as applicable, of the eligible drinking water project, as determined by the Commissioner of Public Health, and may be paid from the proceeds of a renewal note or notes or from the proceeds of a project loan obligation. The Commissioner of Public Health may allow any project loan obligation or interim funding obligation for an eligible drinking water project to be repaid by the borrowing recipient prior to maturity without penalty.

Sec. 6. Subsection (*l*) of Section 22a-478 of the general statutes is repealed and the following is substituted in lieu thereof:

(*l*) The Commissioner of Public Health may make a project loan, which shall include a service charge for the expenses of the Department of Public Health in administering the program, to a recipient pursuant to a project funding agreement for an eligible drinking water project for the planning and design phase of an eligible project, to the extent provided by the federal Safe Drinking Water Act, as amended. Principal and interest on a project loan, which shall include a service charge for the expenses of the Department of Public Health in administering the program, for the planning and design phases of an eligible drinking water project may be paid from and included in the principal amount of a loan for the construction phase of an eligible drinking water project.

Sec. 7. Subsection (n) of Section 22a-478 of the general statutes is repealed and the following is substituted in lieu thereof:

(n) Notwithstanding any provision of sections 22a-475 to 22a-483, inclusive, to the contrary, the Commissioner of Public Health may make a project loan or loans, which shall include a service charge for the expenses of the Department of Public Health in administering the program, in accordance with the provisions of subsection (j) of this section with respect to an eligible drinking water project without regard to the priority list of eligible drinking water projects if a public drinking water supply emergency exists, pursuant to section 25-32b, which requires that the eligible drinking water project be undertaken to protect the public health and safety.

Sec. 8. (NEW)

The General Assembly finds that it is a paramount policy of the State to protect the purity and adequacy of the water we drink, that the maintenance of high quality potable water is essential to safeguard the public health, welfare, and economic wellbeing of the people of the State of Connecticut and that the Department of Public Health has been is authorized to carry out this public purpose; that the DPH mission is to protect and improve the health and safety of the people of Connecticut; that the Federal Safe Drinking Water Act provides a comprehensive framework , at a minimum , for establishing standards, providing technical assistance and for regulating the collection, treatment, monitoring, storage, and distribution of portable water, and that it is in the best interest of the people of the State of Connecticut for the State through the Department of Public Health to maintain primary enforcement responsibility.

Sec. 9. (NEW)

(a) The Department of Public Health is authorized to charge such service charge as the Commissioner of Public Health deems appropriate for the purpose of funding the public drinking water program under the provisions of the Connecticut General Statutes and the Federal Safe Drinking Water Act, as amended from time to time. The service charge shall include a charge for the consideration of any application for an approval or permit or other request for service submitted to the department, a service charge from each person, collected through that person's water company, for the connection to and ongoing supply of public drinking water to that person, and a service charge for the consideration of any application for licensure.

(b)The commissioner shall adopt regulations in accordance with the provisions of Chapter 54 to implement subsection (a) of this section with respect to the method and manner of payment. The commissioner shall promulgate annually a list containing the charge for each type application submitted and the charge for each connection to a water company, which list shall be amended from time to time as the commissioner recalculates what is appropriate and reasonable in the opinion of the commissioner for the service and to ensure the appropriate level of financial support for the public drinking water program.

(c)The commissioner may contract for professional services to aid in the determination of the appropriate service charge for the various services provided by the department and the appropriate connection service charge for persons connected to a public water system.

Sec. 10. (NEW)

All funds collected under the provisions of section 2 of this Act shall be deposited in a non-lapsing fund to be drawn upon by the Department of Public Health to defer the cost of administering the public drinking water program.

Sec. 4. (NEW)

(a) If any public water system fails to pay any service charge as determined appropriate by the Department of Public Health, the department shall not consider the application submitted to the department until such time as the service charge is paid and if a violation of a regulation occurs as a result the application not being considered, the public water system shall be subject to the appropriate civil penalty.

(b) If any person fails to pay a connection service charge which has been assessed by the department to the public water system to which it is connected, the department may order the suspension of service. The water company shall file an application for the order for the failure of the person to pay. The department shall provide notice and an opportunity for a hearing to the person.

(c) Any water company that fails to collect the connection service charge owed by each person in accordance with the regulations adopted under section 2 of the Act shall be assessed a

civil penalty under the provisions of section 25-32e, which will accrue daily until the appropriate amount plus interest is tendered to the department. The water company may be subject to such other orders as the department deems appropriate. The department shall provide an opportunity for a hearing upon the assessment and shall not penalize a water company when it has been properly notified of any person's failure to pay the connection service charge.

Sec. 11. (NEW)

The Commissioner of Public Health may request the Attorney General to initiate an action in the Superior Court for the Hartford Judicial District to obtain an order from the court to aid in enforcement of any provision of this act or order issued thereunder.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Community, Family, and Health Equity Section

Agency Analyst/Drafter of Proposal:

Title of Proposal
An Act Concerning Enhancements in Tobacco Prevention

Statutory Reference:
Section 1. 19a-342. Smoking prohibited. Exemptions. Signs required. Penalties
Section 2. 31-40q. Smoking in the workplace. Designation of smoking rooms.
Section 3. 53-344. Sale or delivery of tobacco to minors. Purchase or misrepresentation of age to purchase tobacco or possession of tobacco in public place by persons under eighteen. Transaction scans. Affirmative defense
Section 4. 53-344b. Sale or delivery of electronic nicotine delivery system or vapor product to minors. Purchase or misrepresentation of age by persons under eighteen years of age. Transaction scans. Affirmative defense.

Proposal Summary

Three changes are suggested:
1)A fully comprehensive Clean Indoor Air Act that includes:

- *a) Eliminating the exemption for small businesses*
- *b) Disallows smoking rooms at all employers*
- *c) Incorporates language to within 25 feet of entryways or air intake vents and windows*
- *d) Outside food service locations*
- *e) All school properties 24/7*

(This is a repeat of a previous request, changes to 19a-342 and 31-40q)
2) Increase the age for the sale of tobacco products to those 21 and older
(Changes to 53-344 and 53-344b)
3) Incorporate clearer language to allow for research studies to be conducted in both the Clean Indoor Air Act and within the statute for possession of minors.
(These changes are also to Sections 19a-34, 53-344 and 53-344 b)

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

The first two changes are suggested policy changes by the Centers for Disease Control and Prevention and have been recommended and carried forward in other states.

The research language clarification is to assure that necessary research can be performed to inform tobacco use prevention activities and to help guide decisions made by the Food and Drug Administration.

- **Origin of Proposal ___ New Proposal ___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

The Comprehensive Clean Indoor Air Act is a resubmission.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:

The workforce provisions also affect the Labor Department – Wage and Workplace Standards Unit and they have supported this in the past two legislative sessions.

Increasing the age for sales to minors also affects the Department of Mental Health and Addiction Services who currently performs compliance checks and oversees training of tobacco merchants.

Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Sec. 19a-342 of the General Statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section, "smoke" or "smoking" means the lighting or carrying of a lighted cigarette, cigar, pipe or similar device, including all electronic nicotine delivery systems.

(b) Nothing in this section shall be construed to require any smoking inside or outside any building or entryway.

[(b)] (c) (1) Notwithstanding the provisions of section 31-40q, no person shall smoke: (A) In any area of a building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail food store; (D) in any restaurant; (E) in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22c, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of an establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, and, on and after April 1, 2004, in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c; (F) [within] in any area of a school building or on school property [while school is in session or student activities are being conducted]; (G) in any passenger elevator, provided no person shall be arrested for violating this subsection unless there is posted in such elevator a sign which indicates that smoking is prohibited by state law; (H) in any dormitory in any public or private institution of higher education; or (I) on and after April 1, 2004, in any area of a dog race track or a facility equipped with screens for the simulcasting of off-track betting race programs or jai alai games. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building, kept, used, maintained, advertised and held out to the public to be a place where meals are regularly served to the public.

(2) **Subsection (1) of this [**This] section shall not apply to the following establishments: (A) [correctional facilities; (B) designated smoking areas in psychiatric facilities;] [(C)] (B) public housing projects, as defined in subsection (b) of section 21a-278a; [(D)] (C) classrooms where demonstration smoking is taking place as part of a medical or scientific experiment or lesson or medical research site if smoking or vaping is integral to the research being conducted; [€] (D) smoking rooms provided by employers for employees, pursuant to section 31-40q; [(F)] (E) notwithstanding the provisions of subparagraph (E) of subdivision (1) of this subsection, the outdoor portion of the premises of any permittee listed in subparagraph (E) of subdivision (1) of this subsection, provided, in the case of any seating area maintained for the service of food, at least seventy-five per cent of the outdoor seating capacity is an area in which smoking is prohibited and which is clearly designated with written signage as a nonsmoking area, except that any temporary seating area established for special events and not used on a regular basis shall not be subject to the smoking prohibition or signage requirements of this subparagraph;] or [(G)] (F) any tobacco bar, provided no tobacco bar shall expand in size or change its location from its size or location as of December 31, 2002. [For purposes of this subdivision, "outdoor" means an area which has no roof or other ceiling enclosure,] "tobacco bar" means an establishment with a permit for the sale of alcoholic liquor to consumers issued pursuant to chapter 545 that, in the calendar year ending December 31, 2002, generated ten per cent or more of its total annual gross income from the on-site sale of tobacco products and the rental of on-site humidors, and "tobacco product" means any substance that contains nicotine or tobacco,

including, but not limited to, cigarettes, cigars, pipe tobacco, [or] chewing tobacco, and all forms of electronic nicotine delivery systems, inclusive of devices that may or may not have or is labeled to indicate there is no nicotine content.

(c) The operator of a hotel, motel or similar lodging may allow guests to smoke in not more than twenty-five per cent of the rooms offered as accommodations to guests.

(d) In each room, elevator, area or building in which smoking is prohibited by this section, the person in control of the premises shall post or cause to be posted in a conspicuous place signs stating that smoking is prohibited by state law. Such signs, except in elevators, restaurants, establishments with permits to sell alcoholic liquor to consumers issued pursuant to chapter 545, hotels, motels or similar lodgings, and health care institutions, shall have letters at least four inches high with the principal strokes of letters not less than one-half inch wide.

(e) Any person found guilty of smoking in violation of this section, failure to post signs as required by this section or the unauthorized removal of such signs shall have committed an infraction.

(f) Nothing in this section shall be construed to require any smoking area in any building.

[(g) The provisions of this section shall supersede and preempt the provisions of any municipal law or ordinance relative to smoking effective prior to, on or after October 1, 1993.]

Section 2. Section 31-40q of the General Statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Person" means one or more individuals, partnerships, associations, corporations, limited liability companies, business trusts, legal representatives or any organized group of persons.

(2) "Employer" means a person engaged in business who has employees, including the state and any political subdivision thereof.

(3) "Employee" means any person engaged in service to an employer in the business of his employer.

(4) "Business facility" means a structurally enclosed location or portion thereof at which employees perform services for their employer. The term "business facility" does not include: (A) Facilities listed in subparagraph (A), (C) or (G) of subdivision (2) of subsection (b) of section 19a-342; (B) any establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued on or before May 1, 2003; (C) for any business that is engaged in the testing or development of tobacco or tobacco products, the areas of such business designated for such testing or development; or (D) during the period from October 1, 2003, to April 1, 2004, establishments with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c.

(5) "Smoking" means the burning of a lighted cigar, cigarette, pipe or any other matter or substance which contains tobacco, including all electronic nicotine delivery systems.

(b) Each employer with fewer than five employees in a business facility shall establish one or more work areas, sufficient to accommodate nonsmokers who request to utilize such an area, within each business facility under his control, where smoking is prohibited. The employer shall clearly designate the existence and boundaries of each nonsmoking area by posting signs which can be readily seen by employees and visitors. In the areas within the business facility where

smoking is permitted, existing physical barriers and ventilation systems shall be used to the extent practicable to minimize the effect of smoking in adjacent nonsmoking areas.

(c) (1) Each employer with five or more employees shall prohibit smoking in any business facility under said employer's control, except that an employer may designate one or more smoking rooms.

(2) Each employer that provides a smoking room pursuant to this subsection shall provide sufficient nonsmoking break rooms for nonsmoking employees.

(3) Each smoking room designated by an employer pursuant to this subsection shall meet the following requirements: (A) Air from the smoking room shall be exhausted directly to the outside by an exhaust fan, and no air from such room shall be recirculated to other parts of the building; (B) the employer shall comply with any ventilation standard adopted by (i) the Commissioner of Labor pursuant to chapter 571, (ii) the United States Secretary of Labor under the authority of the Occupational Safety and Health Act of 1970, as from time to time amended, or (iii) the federal Environmental Protection Agency; (C) such room shall be located in a nonwork area, where no employee, as part of his or her work responsibilities, is required to enter, except such work responsibilities shall not include any custodial or maintenance work carried out in the smoking room when it is unoccupied; and (D) such room shall be for the use of employees only.

(d) Nothing in this section may be construed to prohibit an employer from designating an entire business facility and property as a nonsmoking area.

Section 3. Section 53-344 of the General Statutes is repealed and the following is substituted in lieu thereof:

Sec. 53-344. Sale or delivery of tobacco to minors. Purchase or misrepresentation of age to purchase tobacco or possession of tobacco in public place by persons under [eighteen] twenty-one. Transaction scans. Affirmative defense. (a) As used in this section:

(1) "Cardholder" means any person who presents a driver's license or an identity card to a seller or seller's agent or employee, to purchase or receive tobacco from such seller or seller's agent or employee;

(2) "Identity card" means an identification card issued in accordance with the provisions of section 1-1h;

(3) "Transaction scan" means the process by which a seller or seller's agent or employee checks, by means of a transaction scan device, the validity of a driver's license or an identity card; and

(4) "Transaction scan device" means any commercial device or combination of devices used at a point of sale that is capable of deciphering in an electronically readable format the information encoded on the magnetic strip or bar code of a driver's license or an identity card.

(b) Any person who sells, gives or delivers to any [minor] person under [eighteen]twenty-one years of age tobacco, unless th[e minor] that person is delivering or accepting delivery in such person's capacity as an employee, or as part of a scientific study being conducted for the purpose of medical research to further efforts in tobacco use prevention in any form shall be fined not more than two hundred dollars for the first offense, not more than three hundred fifty dollars for a second offense within an eighteen-month period and not more than five hundred dollars for each subsequent offense within an eighteen-month period.

(c) Any person under [eighteen] twenty-one years of age who purchases or misrepresents such person's age to purchase tobacco in any form or possesses tobacco in any form in any public place shall be fined not more than fifty dollars for the first offense and not less than fifty dollars or more than one hundred dollars for each subsequent offense. For purposes of this subsection, "public place" means any area that is used or held out for use by the public whether owned or operated by public or private interests.

(d) (1) A seller or seller's agent or employee may perform a transaction scan to check the validity of a driver's license or identity card presented by a cardholder as a condition for selling, giving away or otherwise distributing tobacco to the cardholder.

(2) If the information deciphered by the transaction scan performed under subdivision (1) of this subsection fails to match the information printed on the driver's license or identity card presented by the cardholder, or if the transaction scan indicates that the information so printed is false or fraudulent, neither the seller nor any seller's agent or employee shall sell, give away or otherwise distribute any tobacco to the cardholder.

(3) Subdivision (1) of this subsection does not preclude a seller or seller's agent or employee from using a transaction scan device to check the validity of a document other than a driver's license or an identity card, if the document includes a bar code or magnetic strip that may be scanned by the device, as a condition for selling, giving away or otherwise distributing tobacco to the person presenting the document.

(e) (1) No seller or seller's agent or employee shall electronically or mechanically record or maintain any information derived from a transaction scan, except the following: (A) The name and date of birth of the person listed on the driver's license or identity card presented by a cardholder; (B) the expiration date and identification number of the driver's license or identity card presented by a cardholder.

(2) No seller or seller's agent or employee shall use a transaction scan device for a purpose other than the purposes specified in subsection (e) of section 53-344b, subsection (d) of this section or subsection (c) of section 30-86.

(3) No seller or seller's agent or employee shall sell or otherwise disseminate the information derived from a transaction scan to any third party, including, but not limited to, selling or otherwise disseminating that information for any marketing, advertising or promotional activities, but a seller or seller's agent or employee may release that information pursuant to a court order.

(4) Nothing in subsection (d) of this section or this subsection relieves a seller or seller's agent or employee of any responsibility to comply with any other applicable state or federal laws or rules governing the sale, giving away or other distribution of tobacco.

(5) Any person who violates this subsection shall be subject to a civil penalty of not more than one thousand dollars.

(f) (1) In any prosecution of a seller or seller's agent or employee for a violation of subsection (b) of this section, it shall be an affirmative defense that all of the following occurred:

(A) A cardholder attempting to purchase or receive tobacco presented a driver's license or an identity card; (B) a transaction scan of the driver's license or identity card that the cardholder presented indicated that the license or card was valid; and (C) the tobacco was sold, given away or otherwise distributed to the cardholder in reasonable reliance upon the identification presented and the completed transaction scan.

(2) In determining whether a seller or seller's agent or employee has proven the affirmative defense provided by subdivision (1) of this section, the trier of fact in such prosecution shall consider that reasonable reliance upon the identification presented and the completed transaction scan may require a seller or seller's agent or employee to exercise reasonable diligence and that the use of a transaction scan device does not excuse a seller or seller's agent or employee from exercising such reasonable diligence to determine the following: (A) Whether a person to whom the seller or seller's agent or employee sells, gives away or otherwise distributes tobacco is [eighteen] twenty-one years of age or older; and (B) whether the description and picture appearing on the driver's license or identity card presented by a cardholder is that of the cardholder.

Section 4. Section 53-344b of the General Statutes is repealed and the following is substituted in lieu thereof:

Sec. 53-344b. Sale or delivery of electronic nicotine delivery system or vapor product to minors. Purchase or misrepresentation of age by persons under [eighteen] twenty-one years of age. Transaction scans. Affirmative defense. (a) As used in this section:

(1) "Electronic nicotine delivery system" means an electronic device that may be used to simulate smoking in the delivery of nicotine or other substance to a person inhaling from the device, and includes, but is not limited to, an electronic cigarette, electronic cigar, electronic cigarillo, electronic pipe or electronic hookah and any related device and any cartridge or other component of such device;

(2) "Cardholder" means any person who presents a driver's license or an identity card to a seller or seller's agent or employee, to purchase or receive an electronic nicotine delivery system or vapor product from such seller or seller's agent or employee;

(3) "Identity card" means an identification card issued in accordance with the provisions of section 1-1h;

(4) "Transaction scan" means the process by which a seller or seller's agent or employee checks, by means of a transaction scan device, the validity of a driver's license or an identity card;

(5) "Transaction scan device" means any commercial device or combination of devices used at a point of sale that is capable of deciphering in an electronically readable format the information encoded on the magnetic strip or bar code of a driver's license or an identity card;

(6) "Sale" or "sell" means an act done intentionally by any person, whether done as principal, proprietor, agent, servant or employee, of transferring, or offering or attempting to transfer, for consideration, an electronic nicotine delivery system or vapor product, including

bartering or exchanging, or offering to barter or exchange, an electronic nicotine delivery system or vapor product;

(7) "Give" or "giving" means an act done intentionally by any person, whether done as principal, proprietor, agent, servant or employee, of transferring, or offering or attempting to transfer, without consideration, an electronic nicotine delivery system or vapor product;

(8) "Deliver" or "delivering" means an act done intentionally by any person, whether as principal, proprietor, agent, servant or employee, of transferring, or offering or attempting to transfer, physical possession or control of an electronic nicotine delivery system or vapor product; and

(9) "Vapor product" means any product that employs a heating element, power source, electronic circuit or other electronic, chemical or mechanical means, regardless of shape or size, to produce a vapor that may or may not include nicotine, that is inhaled by the user of such product.

(b) Any person who sells, gives or delivers to any minor under [eighteen] twenty-one years of age an electronic nicotine delivery system or vapor product, unless the minor is delivering or accepting delivery in such person's capacity as an employee or as part of a scientific study being conducted for the purpose of medical research to further efforts in tobacco use prevention, in any form shall be fined not more than two hundred dollars for the first offense, not more than three hundred fifty dollars for a second offense within an eighteen-month period and not more than five hundred dollars for each subsequent offense within an eighteen-month period.

(c) Any person under [eighteen] twenty-one years of age who purchases or misrepresents such person's age to purchase an electronic nicotine delivery system or vapor product in any form or possesses an electronic nicotine delivery system or vapor product in any form in any public place shall be fined not more than fifty dollars for the first offense and not less than fifty dollars or more than one hundred dollars for each subsequent offense. For purposes of this subsection "public place" means any area that is used or held out for use by the public whether owned or operated by public or private interests.

(d) (1) A seller or seller's agent or employee may perform a transaction scan to check the validity of a driver's license or identity card presented by a cardholder as a condition for selling, giving or otherwise delivering an electronic nicotine delivery system or vapor product to the cardholder.

(2) If the information deciphered by the transaction scan performed under subdivision (1) of this subsection fails to match the information printed on the driver's license or identity card presented by the cardholder, or if the transaction scan indicates that the information so printed is false or fraudulent, neither the seller nor any seller's agent or employee shall sell, give or otherwise deliver any electronic nicotine delivery system or vapor product to the cardholder.

(3) Subdivision (1) of this subsection does not preclude a seller or seller's agent or employee from using a transaction scan device to check the validity of a document other than a

driver's license or an identity card, if the document includes a bar code or magnetic strip that may be scanned by the device, as a condition for selling, giving or otherwise delivering an electronic nicotine delivery system or vapor product to the person presenting the document.

(e) (1) No seller or seller's agent or employee shall electronically or mechanically record or maintain any information derived from a transaction scan, except the following: (A) The name and date of birth of the person listed on the driver's license or identity card presented by a cardholder; and (B) the expiration date and identification number of the driver's license or identity card presented by a cardholder.

(2) No seller or seller's agent or employee shall use a transaction scan device for a purpose other than the purposes specified in subsection (d) of this section, subsection (d) of section 53-344 or subsection (c) of section 30-86.

(3) No seller or seller's agent or employee shall sell or otherwise disseminate the information derived from a transaction scan to any third party, including, but not limited to, selling or otherwise disseminating that information for any marketing, advertising or promotional activities, but a seller or seller's agent or employee may release that information pursuant to a court order.

(4) Nothing in subsection (d) of this section or this subsection relieves a seller or seller's agent or employee of any responsibility to comply with any other applicable state or federal laws or rules governing selling, giving or otherwise delivering electronic nicotine delivery systems or vapor products.

(5) Any person who violates this subsection shall be subject to a civil penalty of not more than one thousand dollars.

(f) (1) In any prosecution of a seller or seller's agent or employee for a violation of subsection (b) of this section, it shall be an affirmative defense that all of the following occurred: (A) A cardholder attempting to purchase or receive an electronic nicotine delivery system or vapor product presented a driver's license or an identity card; (B) a transaction scan of the driver's license or identity card that the cardholder presented indicated that the license or card was valid; and (C) the electronic nicotine delivery system or vapor product was sold, given or otherwise delivered to the cardholder in reasonable reliance upon the identification presented and the completed transaction scan.

(2) In determining whether a seller or seller's agent or employee has proven the affirmative defense provided by subdivision (1) of this section, the trier of fact in such prosecution shall consider that reasonable reliance upon the identification presented and the completed transaction scan may require a seller or seller's agent or employee to exercise reasonable diligence and that the use of a transaction scan device does not excuse a seller or seller's agent or employee from exercising such reasonable diligence to determine the following: (A) Whether a person to whom the seller or seller's agent or employee sells, gives or otherwise delivers an electronic nicotine delivery system or vapor product is [eighteen] <u>twenty-one</u> years of age or older; and (B) whether the description and picture appearing on the driver's license or identity card presented by a cardholder is that of the cardholder.

(g) Each seller of electronic nicotine delivery systems or vapor products or such seller's agent or employee shall require a person who is purchasing or attempting to purchase an electronic nicotine delivery system or vapor product, whose age is in question, to exhibit proper proof of age. If a person fails to provide such proof of age, such seller or seller's agent or employee shall not sell an electronic nicotine delivery system or vapor product to the person. As used in this subsection, "proper proof" means a motor vehicle operator's license, a valid passport or an identity card issued in accordance with the provisions of section 1-1h.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: HCQS
Agency Analyst/Drafter of Proposal: Chris Andresen

Title of Proposal **Establishing grounds for denying or revoking a dental anesthesia permit**
Statutory Reference 20-123b
Proposal Summary The Department is proposing to add language to the dental anesthesia permit language in 20-123b to provide a basis to deny or revoke a dental anesthesia permit based on disciplinary action taken against a dentist pursuant to 20-114.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The Department recently prosecuted a dentist case and realized we have the authority to issue the anesthesia permit, but no authority to revoke the permit based on disciplinary action taken against the dentist.

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact NO FISCAL IMPACT on any area

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

If passed, this proposal will allow the Department to deny or revoke a dental anesthesia permit if a dentist that has one and is disciplined pursuant to 20-114

Insert fully drafted bill here

(NEW) Sec. 20-123b(e) The commissioner may deny or revoke a permit based on disciplinary action taken against a dental license pursuant to section 20-114.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Facility Licensing and Investigations Section, HCQSB
Agency Analyst/Drafter of Proposal: Suzanne Blancaflor, Environmental Health Section, RSB

Title of Proposal **An Act Extending the Medical Order For Life Sustaining Treatment Pilot Program**
Statutory Reference **Public Act 14-231 Sec 67**
Proposal Summary *To extend the current MOLST Pilot Program to October 1, 2017*
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

On October 1, 2016 the MOLST Pilot Program will end and the MOLST document will no longer be valid for extant individuals who have a MOLST. It will not be feasible to propose final legislation during the next session because it is a short session; and, the data that is currently being collected will be insufficient to draw any conclusions related to the feasibility of the use of the MOLST in CT. Extending the program will 1.) Assist individuals with a MOLST document to have their wishes honored 2.) Provide the opportunity to develop a robust data set, and 3.) Develop legislation for the 2017 session that is based on the pilot's findings.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

TECHNICAL CHANGE

(a) Any pilot program established in accordance with this section shall terminate not later than [October1, 2016] October1, 2017

PROPOSAL IMPACT

- **Agencies Affected** – No agencies impacted

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) 0
State 0
Federal 0
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Positive, for reasons enumerated in proposal background section.

Section 67 of Public Act No. 14-231 is repealed and the following is substituted in lieu thereof:

Sec. 67. Section 1 of special act 14-5 as amended by section 67 of Public Act 14-231 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Public Health may, within available appropriations, establish a pilot program in one or more geographic areas in the state to implement the use of medical orders for life-sustaining treatment by health care providers. For purposes of this section: (1) "Medical order for life-sustaining treatment" means a written medical order by a physician, advanced practice registered nurse or physician assistant to effectuate a patient's request for life-sustaining treatment when the patient has been determined by a physician to be approaching the end stage of a serious, life-limiting illness or is in a condition of advanced, chronic progressive frailty; (2) "health care provider" means any person, corporation, limited liability company, facility or institution operated, owned or licensed by this state to provide health care or professional medical services, or an officer, employee or agent thereof acting in the course and scope of his or her employment; and (3) "legally authorized representative" means a patient's parent, guardian or health care representative appointed in accordance with sections 19a-576 and 19a-577 of the general statutes.

(b) The Commissioner of Public Health may establish an advisory group of health care providers and consumer advocates to make recommendations concerning the pilot program described in this section. The members of such advisory group may include one or more: (1) Physicians; (2) advanced practice registered nurses; (3) physician assistants; (4) emergency medical service providers; (5) patient advocates, including, but not limited to, advocates for persons with disabilities; (6) hospital representatives; or (7) long-term care facility representatives.

(c) Prior to commencement of the pilot program pursuant to this section, said commissioner may contact a representative of each health care institution, as defined in section 19a-490 of the general statutes, a representative of each emergency medical service organization, as defined in section 19a-175 of the general statutes, any physician licensed under chapter 370 of the general statutes, any advanced practice registered nurse licensed under chapter 378 of the general statutes and any physician assistant licensed under chapter 370 of the general statutes in the geographic area in which the commissioner intends to establish the pilot program to request such institution's, organization's, physician's, advanced practice registered nurse's or physician assistant's participation in the pilot program. Participation by each institution, organization, physician, advanced practice registered nurse or physician assistant shall be voluntary.

(d) Patient participation in the pilot program shall be voluntary. Any agreement to participate in the pilot program shall be made in writing, signed by the patient or the patient's legally authorized representative. Such agreement shall be maintained by the health care institution, emergency medical services organization, physician, advanced practice registered nurse or physician assistant that presented such agreement to the patient and shall be made available to the commissioner upon request.

(e) Notwithstanding the provisions of sections 19a-495 and 19a-580d of the general statutes, and regulations adopted thereunder, the Commissioner of Public Health shall

implement policies and procedures for any pilot program established in accordance with this section to ensure that: (1) Medical orders for life-sustaining treatment are transferrable among, and recognized by, various types of health care institutions; (2) any procedures and forms developed for recording medical orders for life-sustaining treatment are developed after considering the physician orders for life-sustaining treatment paradigm and require the signature of the patient or the patient's legally authorized representative and a witness on the medical order for life-sustaining treatment and the patient or the patient's legally authorized representative is given a copy of any such order immediately after signing such order; (3) prior to requesting the signature of the patient or the patient's legally authorized representative on such order, the physician, advanced practice registered nurse or physician assistant writing the medical order discusses with the patient or the patient's legally authorized representative the patient's goals for care and treatment and the benefits and risks of various methods for documenting the patient's wishes for end-of-life treatment, including medical orders for life-sustaining treatment; and (4) each physician, advanced practice registered nurse or physician assistant that intends to write a medical order for life-sustaining treatment receives training concerning: (A) The importance of talking with patients about their personal treatment goals; (B) methods for presenting choices for end-of-life care that elicit information concerning patients' preferences and respects those preferences without directing patients toward a particular option for end-of-life care; (C) the importance of fully informing patients about the benefits and risks of an immediately effective medical order for life-sustaining treatment; (D) awareness of factors that may affect the use of medical orders for life-sustaining treatment, including but not limited to: Race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence; and (E) procedures for properly completing and effectuating medical orders for life-sustaining treatment.

(f) After the termination of any pilot program established pursuant to this section, said commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the pilot program.

(g) Said commissioner may implement policies and procedures necessary to implement the pilot program while in the process of adopting such policies and procedures in regulation form, in accordance with chapter 54 of the general statutes, provided the commissioner holds a public hearing prior to implementing such policies and procedures and prints notice of the intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation of such policies and procedures. Policies implemented pursuant to this section shall be valid until the time final regulations are adopted or until the pilot program terminates, whichever occurs earlier.

(h) Any pilot program established in accordance with this section shall terminate not later than [October 1, 2016] October 1, 2017.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Drinking Water Section & Community, Family and Health Equity Section/Office of Oral Health

Agency Analyst/Drafter of Proposal:
Lori Mathieu, Public Health Section Chief, Drinking Water Section
Linda Ferraro, Public Health Services Manager, Director, Office of Oral Health

Title of Proposal
An Act Concerning Fluoridation of Public Water Supplies

Statutory Reference
Section 19a-38

Proposal Summary
To revise the current statute to reflect the new recommendation for the optimal concentration of fluoride to be added to public water supplies at a level to prevent tooth decay.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Seventy years ago, nearly everyone in the United States had tooth decay. No one knew how to prevent it. As recently as the late 1950's, about half of Americans older than 65 years of age had lost all of their natural teeth.

Dental caries, the disease that causes tooth decay (cavities), is a chronic, progressive, transmissible, bacterial, infectious disease that is almost always preventable. Tooth decay is the most common chronic disease in children, almost 5 times more common than asthma. Dental caries can begin as soon as a baby tooth has erupted and can lead to a lifetime of cavities and its ensuing pain, infections, suffering, and tooth loss. If left untreated, tooth decay can impact an individual's ability to eat nutritious meals and the ability to speak clearly; concentrate in school and work; affect employment opportunities; limit self-esteem and social interactions; and have a negative impact on overall health and quality of life.

Approximately 51 million school hours are lost due to oral disease. Employed adults lose more than 164 million hours of work each year due to oral diseases and conditions.

Fluoridation began in Grand Rapids, Michigan in 1945 and became the foundation of making tooth decay, for the

first time in history, a preventable disease for most people. "Fluoridation" is the process of adding small amounts of fluoride to public water supplies to reach the optimal level to prevent tooth decay. It is one of several examples of how everyday products are fortified to enhance the health of Americans — iodine is added to salt, folic acid is added to breads and cereals, and Vitamin D is added to milk.

Fluoride protects teeth from decay and cavities in two ways: 1) when bacteria in the mouth combine with sugars from foods and beverages, acid is produced that can erode tooth enamel and damage teeth. Fluoride makes the tooth structure stronger, so teeth are more resistant to acid attacks - demineralization that is caused by the acid; and 2) if teeth have already been damaged by acid, fluoride accumulates in the demineralized areas and begins strengthening the enamel - a process called re-mineralization. Fluoride is a mineral that exists naturally in water, but usually not at the level to prevent tooth decay.

Because fluoridation of public drinking water systems had been demonstrated as effective in reducing dental caries, the US Department of Health and Human Services (HHS) issued Public Health Service (PHS) recommendations regarding optimal fluoride concentrations in drinking water for community water systems in 1962. That recommendation was a range of 0.7 mg/L to 1.2 mg/L. At that time, fluoridated water was the only source of fluoride for most people. In addition, it was believed that children in warmer climates drank more water than those in colder climates; therefore a range was recommended due to climate variations in the U.S.

Fluoridation in Connecticut began on a statewide level in 1965 with the enactment of Section 19a-38 of the CT General Statutes. This statute requires public water systems that serve 20,000 or more persons to maintain their water with a fluoride content of between 0.8mg/L to 1.2 mg/L.

Community water fluoridation is a major factor responsible for the decline in prevalence (occurrence) and severity of dental caries (tooth decay) during the second half of the 20th century. For adolescents, the prevalence of dental caries in at least one permanent tooth (excluding third molars) decreased from 90% among those aged 12–17 years in the 1960s to 60% among those aged 12–19 years in 1999–2004; during that interval, the number of permanent teeth affected by dental caries (i.e., decayed, missing, and filled) declined from 6.2 to 2.6, respectively. Adults also have benefited from community water fluoridation; the average number of affected teeth decreased from 18 among 35- to 44-year-old adults in the 1960s to 10 among 35-to 49-year-old adults in 1999–2004.

According to a 10 year study conducted in 1977 by the New Haven Department of Health, tooth decay among school children was reduced by 52.4% following ten years of fluoridation of the public water system in that city. Prior to the initiation of fluoridation in New Haven in 1967, only 20% of children aged 6-7 years (1 in 5) had not experienced a cavity and only 1.4% of 14-16 year olds were caries free.

Results of recent studies conducted by the Connecticut Department of Public Health, demonstrate that 60% of third grade children are caries free and 14% of adults aged 65 and over have lost all of their natural teeth.

There are now multiple sources of fluoride, such as toothpaste, mouthwash, professional fluoride treatments, as well as consuming products made with fluoridated water. The result has been an increased level of fluorosis seen in national surveys, which in the U.S. is mainly in its very mild to mild form; barely visible white markings on tooth enamel that are not harmful to the teeth or overall health. Dental fluorosis can only occur in children under the age of 8-9 when the teeth are forming, with the most common cause being children regularly ingesting too much toothpaste while brushing.

A HHS panel was convened in 2010 to review the 1962 recommendation because of new data relative to changes in the prevalence of dental fluorosis, the relationship between water intake and outdoor temperature in children (research now demonstrates that water consumption in children no longer varies in different regions based on ambient air temperatures) and the contribution of fluoride in drinking water to total fluoride exposure in the United States. This panel assessed the best available science and concluded that community water fluoridation remains an effective public health strategy beyond that provided by other fluoride products.

In April 2015, HHS issued a new recommendation, based on the panel report, to update and replace the 1962 recommendation. In this guidance, the optimal concentration of fluoride in drinking water is the concentration that provides the best balance of protection from dental caries while limiting the risk of dental fluorosis. The new recommendation of 0.7mg/L replaces the range of 0.7 mg/L to 1.2 mg/L

More than 3,000 studies or research papers have been published on the subject of fluoridation. Few topics have been as thoroughly researched as fluoridation. The overwhelming weight of the evidence—plus more than 65 years of experience—supports the safety and effectiveness of this public health practice. Fluoridation is a proven, safe, and effective way to prevent decay. Community water fluoridation is one of the most practical, cost-effective, equitable and safe measures to ensure all members of the community have access to fluoride regardless of age, education, income or access to routine dental care. Because Community Water Fluoridation has resulted in a dramatic decline in the prevalence and severity of tooth decay, it has been named as one of the 10 great public health achievements of the 20th century by the Centers for Disease Control and Prevention (CDC.)

Studies conducted after the introduction of other sources of fluoride, especially fluoride toothpaste, shows that the beneficial effects across the lifespan from community water fluoridation were still apparent.

Fluoridation is endorsed by leading scientific, public health, medical and dental stakeholders such as: American Academies of Pediatrics, Physicians Assistants, Nutrition and Dietetics, Family Physicians, Pediatric Dentists; American Medical Association; AARP; CDC; The National Academies, Institute of Medicine; U. S. Public Health Service; American Public Health Association; Mayo Clinic; World Health Organization; American Dental and Dental Hygiene Associations; Associations of State and Territorial Dental Directors and Health Officials and Oral Health America.

Although there have been tremendous gains made in the reduction of dental caries due to fluoridation, tooth decay remains a significant public health issue in Connecticut. Community water fluoridation remains a necessary building block in the prevention of an almost entirely preventable disease.

- **Origin of Proposal __X__ New Proposal ____ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Energy and Environmental Protection Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) *TBD- potential cost savings to those towns who are considered public water supplies*
State *Several studies at the state level have compared Medicaid costs for treatment of tooth decay in fluoridated and non-fluoridated communities. In Louisiana, for example, mean treatment costs were $67 lower among preschoolers living in fluoridated vs. non-fluoridated parishes. A similar analyses in New York state found that the difference in costs of caries-related procedures among children and adolescents living in fluoridated and non-fluoridated counties was about $24. A Colorado study showed that water fluoridation saved the state nearly $149 million by avoiding unnecessary treatment costs. The study found that the average savings were roughly $61 per person.*
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The new HHS recommendation ensures the protective benefits of tooth decay prevention, while also reducing the risk of fluorosis in communities that fluoridate. It is prudent for Connecticut to be in alignment with the new recommendation for multiple reasons: *1) Public Water Systems will realize a cost savings in lowering the amount of fluoride additive in their water supply, while still ensuring all individuals in their communities are receiving the proven benefits of fluoride.* *2) The new recommendation was proposed in 2011 and major health or medical organizations, such as the CDC, American Dental Association, American Academy of Pediatrics, the Institute of Medicine and the American Public Health Association reaffirmed their support for fluoridation.* *3) 91% of Connecticut residents receiving public water will continue to receive the benefits of fluoridated water at the optimal level.* *4) The Community Preventive Services Task Force and CDC strongly recommend community water fluoridation as an evidence-based population based decay prevention intervention.*

AN ACT CONCERNING FLUORIDATION OF PUBLIC WATER SUPPLIES

Section 1. Section 19a-38 of the general statutes is repealed and the following is substituted in lieu thereof:

[Wherever the fluoride content of public water supplies] A water company, as defined in section 25-32a, serving twenty thousand or more persons [supplies less than eight-tenths of a milligram per liter of fluoride, the person, firm, corporation or municipality having jurisdiction over the supply] shall add a measured amount of fluoride to the water so as to maintain a fluoride content [of between eight-tenths of a milligram per liter and one and two-tenths milligrams per liter] that is not more than one-tenth greater nor more than one-tenth of a milligram per liter less than the United States Public Health Service's Recommendation for Fluoride Concentration in Drinking Water for the Prevention of Dental Caries, Public Health Reports, Volume 130, p. 1 (2015, July-August), as amended from time to time.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: HCQS
Agency Analyst/Drafter of Proposal: Chris Andresen

Title of Proposal **AAC Concerning Infection Control in Dental Settings**
Statutory Reference 20-126c, 20-126l(g), 20-114
Proposal Summary This proposal would include the failure to adhere to CDC's dental office infection control guidelines as grounds for discipline against a dental license and implement a requirement for dentists and dental hygienists to complete infection control continuing education. The language also requires that all dental assistants take and pass the Dental Assistant National Board, Inc.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The Department has seen a number of infection control violations in dental practices, and recognized a lack of knowledge among practitioners during investigations. This proposal would put in statute the requirement for dentists and dental hygienists to complete continuing education specific to infection control, and, require dentists to adhere to CDC infection control guidelines. This proposal would include statutory langue stating failure for a dentist to adhere to CDC infection control guidelines could be grounds for disciplinary action against a dental license. The proposal also includes basic infection control training requirements for all dental assistants.

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact NO FISCAL IMPACT

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The Department has seen an increase in infection control violations in dental settings. Requiring dentists, dental hygienists, and dental assistants to complete infection control continuing education may assist in protecting the public by increasing practitioner knowledge on appropriate infection control measures. Adding infection control violations as grounds for possible discipline against a dental license will protect the public by encouraging dentists to adhere to and implement the CDC infection control practices for dentistry guidelines.

Insert fully drafted bill here

Sec. 20-114. Disciplinary action by Dental Commission concerning dentists and dental hygienists. (a) The Dental Commission may take any of the actions set forth in section 19a-17 for any of the following causes: (1) The presentation to the department of any diploma, license or certificate illegally or fraudulently obtained, or obtained from an institution that is not reputable or from an unrecognized or irregular institution or state board, or obtained by the practice of any fraud or deception; (2) proof that a practitioner has become unfit or incompetent or has been guilty of cruelty, incompetence, negligence or indecent conduct toward patients; (3) conviction of the violation of any of the provisions of this chapter by any court of criminal jurisdiction, provided no action shall be taken under section 19a-17 because of such conviction if any appeal to a higher court has been filed until the appeal has been determined by the higher court and the conviction sustained; (4) the employment of any unlicensed person for other than mechanical purposes in the practice of dental medicine or dental surgery subject to the provisions of section 20-122a; (5) the violation of any of the provisions of this chapter or of the regulations adopted hereunder or the refusal to comply with any of said provisions or regulations; (6) the aiding or abetting in the practice of dentistry, dental medicine or dental hygiene of a person not licensed to practice dentistry, dental medicine or dental hygiene in this state; (7) designating a limited practice, except as provided in section 20-106a; (8) engaging in fraud or material deception in the course of professional activities; (9) the effects of physical or mental illness, emotional disorder or loss of motor skill, including, but not limited to, deterioration through the aging process, upon the license holder; (10) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (11) failure to comply with the continuing education requirements set forth in section 20-126c; (12) failure of a holder of a dental anesthesia or conscious sedation permit to successfully complete an on-site evaluation conducted pursuant to subsection (c) of section 20-123b; (13) failure to provide information to the Department of Public Health required to complete a health care provider profile, as set forth in section 20-13j; [or] (14) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in section 20-126d; or (15) failure to adhere to the 2003 Centers for Disease Control and Prevention Guidelines for Infection Control in Dental Health Care Settings or any subsequent version of these guidelines. A violation of any of the provisions of this chapter by any unlicensed employee in the practice of dentistry or dental hygiene, with the knowledge of the employer, shall be deemed a violation by the employer. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his or her physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17.

Sec. 20-126c(b) Except as otherwise provided in this section, a licensee applying for license renewal shall earn a minimum of twenty-five contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall (1) be in an area of the licensee's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include not less than one contact hour of training or education in (A) any four of the ten mandatory topics for continuing education activities prescribed by the commissioner pursuant to this subdivision, (**B)** **infection control in a dental setting,** and [(B)] **(C)** prescribing controlled substances and pain management**.** For registration periods beginning on and after October 1, 2011, the Commissioner of Public Health, in consultation with the Dental Commission, shall on or before October 1, 2010, and biennially thereafter, issue a list that includes ten mandatory topics for continuing education activities that will be required for the following two-year registration period. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Dental Association or state, district or local dental associations and societies affiliated with the American Dental Association; national, state, district or local dental specialty organizations or the American Academy of General Dentistry; a hospital or other health care institution; dental schools and other schools of higher education accredited or recognized by the Council on Dental Accreditation or a regional accrediting organization; agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation; local, state or national medical associations; a state or local health department; or the Accreditation Council for Graduate Medical Education. Eight hours of volunteer dental practice at a public health facility, as defined in section 20-126l, may be substituted for one contact hour of continuing education, up to a maximum of ten contact hours in one twenty-four-month period.

20-126l(g) Each licensed dental hygienist applying for license renewal shall earn a minimum of sixteen hours of continuing education within the preceding twenty-four-month period. Such continuing education shall include not less than one hour of training or education in infection control in a dental setting. The subject matter for the additional continuing education shall reflect the professional needs of the licensee in order to meet the health care needs of the public. Continuing education activities shall provide significant theoretical or practical content directly related to clinical or scientific aspects of dental hygiene. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, that are offered or approved by dental schools and other institutions of higher education that are accredited or recognized by the Council on Dental Accreditation, a regional accrediting organization, the American Dental Association, a state, district or local dental association or society affiliated with the American Dental Association, the National Dental Association, the American Dental Hygienists Association or a state, district or local dental hygiene association or society affiliated with the American Dental Hygienists Association, the Academy of General Dentistry, the Academy of Dental Hygiene, the American Red Cross or the American Heart Association when sponsoring programs in cardiopulmonary resuscitation or cardiac life support, the United States Department of Veterans Affairs and armed forces of the United States when conducting programs at United States governmental facilities, a hospital or other health care institution, agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation, local, state or national medical associations, or a state or local health department. Eight hours of volunteer dental practice at a public health facility, as defined in subsection (a) of this section, may be substituted for one hour of continuing education, up to a maximum of five hours in one two-year period. Activities that do not qualify toward

meeting these requirements include professional organizational business meetings, speeches delivered at luncheons or banquets, and the reading of books, articles, or professional journals. Not more than four hours of continuing education may be earned through an on-line or other distance learning program.

Sec. 20-112a. Dental assistants. **(a)** A licensed dentist may delegate to dental assistants such dental procedures as the dentist may deem advisable, including the taking of dental x-rays if the dental assistant can demonstrate successful completion of the dental radiography portion of an examination prescribed by the Dental Assisting National Board, but such procedures shall be performed under the dentist's supervision and control and the dentist shall assume responsibility for such procedures; provided such assistants may not engage in: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medications that require the written or oral order of a licensed dentist or physician; (4) the administration of local, parenteral, inhalation or general anesthetic agents in connection with any dental operative procedure; (5) the taking of any impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; (6) the placing, finishing and adjustment of temporary or final restorations, capping materials and cement bases; or (7) the practice of dental hygiene as defined in section 20-126l.

(b) On and after January 1, 2018, all dental assistants must demonstrate successful completion of the infection control portion of the Dental Assisting National Board's infection control exam.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal: Public Health Laboratory

Agency Analyst/Drafter of Proposal: Elise Kremer

Title of Proposal:
Newborn Screening for Adrenoleukodystrophy

Statutory Reference:
CGS, 19a-55

Proposal Summary :
This proposal would provide for the implementation of Adrenoleukodystrophy (ALD) testing at Connecticut's Public Health Laboratory (PHL). Currently, 66 disorders are screened for through the PHL's Newborn Screening (NBS) Laboratory program, and babies with a critical laboratory result that may be indicative of a disorder are triaged and tracked through the NBS Tracking program. Public Act 13-242 mandated that the Department of Public Health (DPH) implement screening for ALD, at such time as specified conditions were met. It was the determination of DPH that the requisite conditions had not been met, and ALD screening was not implemented at that time. Subsequently, Public Act 15-5 enacted provisions for DPH to contract out for ALD testing services to the state of New York, effective October 1, 2015. At this juncture, DPH believes that the requisite conditions for ALD implementation in Connecticut have been met. Specifically, on August 27, the Advisory Committee on Heritable Disorders in Newborns and Children met and conducted a systematic review of the evidence regarding NBS for ALD. Through this evidence-based review, the Committee recommended to the Secretary of Health and Human Services that ALD be added to the Recommended Uniform Screening Panel (RUSP) for NBS. DPH is seeking to implement ALD screening in the PHL, thereby avoiding the fragmentation and delays that would inevitably result from outsourcing this testing. The PHL would implement this testing using the methodology developed by the Centers for Disease Control and Prevention (CDC), for which CDC's technical support and a rigorous quality assurance/proficiency testing program will be available. DPH will be submitting a budget option to provide the resources necessary to implement this new testing program.

A draft of legislative language is below.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Newborn screening (NBS) is a population-based public health program. Sound public policy dictates that the NBS program not be outsourced and fragmented, and that Department of Public Health (DPH) carry out all screening consistent with its current statutory responsibility for 66 disorders. DPH's program is a coordinated, integrated

system of testing, tracking, diagnosis/treatment, and program evaluation. DPH is best positioned to deliver comprehensive, timely, and effective services. Each process within DPH's well-proven system adds value, contributing to an extraordinary level of quality assurance that is in the best interests of our newborns. Some of these processes are:

- The birth hospital enters demographic data in DPH's electronic system for downloading to the PHL's NBS system. A bar code generated by the system is affixed to the sample for unique identification.
- DPH has worked with birthing hospitals to improve specimen transit time. As samples arrive at the PHL, the barcode is scanned, matching the sample to the electronic data. Testing can begin essentially immediately.
- PHL NBS Tracking staff monitors to ensure that a specimen is received for every infant identified in electronic submission. Electronic data are also cross-referenced against birth registry records. An on-line application is also available to birthing hospitals for their own tracking of specimen receipt at the PHL. Tracking to ensure that babies are not missed becomes even more important when the baby is pre-term, low birth weight, or ill, and may be transferred from the birthing hospital to another hospital for specialty care.
- PHL staff reviews each sample for acceptability. Unsatisfactory specimens (abraded, super-saturated, not enough specimen, expired specimen collection card) are reported to NBS Tracking staff. Tracking staff is responsible for ensuring that the appropriate care provider is notified and that a satisfactory specimen is collected and re-submitted. The unsatisfactory rate is currently approximately 1%, which equates to 375 such follow-ups per year.
- The PHL has a rigorous process for monitoring/ensuring Quality Control and Quality Assurance through Proficiency and Quality Control testing administered by the Centers for Disease Control Newborn Screening Department. The NSQAP CDC program for X-ALD is expected to officially begin in the fall of 2015. This would allow for a uniform system for monitoring of the quality of the testing carried out for this disorder, which is not available under the current testing approach as the program is not yet implemented at the national level.
- Tracking staff ensures that each infant with a critical laboratory value that may indicate a disorder is triaged for definitive diagnosis and treatment. Tracking staff also actively follows up to collect data on treatment/interventions and outcomes.
- All data are reported, supporting the surveillance efforts of DPH programs and of the national repository of NBS data.

Implementing ALD testing at the PHL will maintain a NBS system which is seamlessly integrated to provide continuity among all services. Potential problems with outsourcing will be eliminated, as follows:

- Collecting two samples, sent to two different laboratories. Hospitals will have one-stop shopping at the PHL. Only one specimen will need to be collected and submitted to one laboratory. All results will be reported on a single PHL test report. Simplifying the system for submitters will eliminate a significant source of errors. Additionally, collection of a second specimen to be sent out-of-state would expose babies to an unnecessary repetition of an invasive and painful procedure during the vulnerable neonatal period.
- Differences between Connecticut and New York testing and follow-up programs. All infants will receive an identical level of screening in the PHL's program, with a uniform panel of analytes tested for all infants born in Connecticut. The PHL's mutation screening protocol will be based on the population-based ALD validation study of Connecticut newborns that the PHL will conduct.
- Tracking. Without resources devoted to active, intensive tracking, there is a grave risk that infants will be missed, either to screening itself or to follow-up when screening reveals a critical laboratory value that may be indicative of a disorder.

Through mandatory universal screening and follow-up diagnostic services, it is expected that approximately 1:20,000 newborns will be diagnosed with ALD. There is growing evidence that early identification of ALD and early initiation of medical management slows the progression of neurological deterioration that, in untreated babies, leads to loss of mobility and communicative ability. This reduction in morbidity in turn increases lifespan. Without early identification and interventions such as bone marrow transplantation for the childhood cerebral form of ALD, death usually occurs within 1 to 10 years of the onset of symptoms. Scientific evidence is mounting that newborn screening for ALD does improve outcomes, as well as quality and length of life.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: None Agency Contact (name, title, phone): N/A Date Contacted: N/A Approve of Proposal ___ YES ___NO ___Talks Ongoing N/A
Summary of Affected Agency's Comments N/A
Will there need to be further negotiation? __ YES ___NO _X__ N/A

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None
State The fiscal impact will be further detailed in the budget option. It is estimated that the cost will include 1 FTE (Chemist 2@ $65,603 annually), $70,000 for lab consumables annually, and approximately $10,000 in one-time start-up costs for system modifications in Maven/LIMS and updates to parent/provider educational materials..
Federal None
Additional notes on fiscal impact None at this time.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

If enacted, this proposal would ensure that uniform policies and protocols are established for all NBS conducted for babies born in Connecticut.

Section 19a-55 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-55. (Formerly Sec. 19a-21b). Newborn infant health screening. Tests required. Fees. Exemptions. Regulations. (a) The administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581, a test for phenylketonuria and other metabolic diseases, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia, severe combined immunodeficiency disease, adrenoleukodystrophy and such other tests for inborn errors of metabolism as shall be prescribed by the Department of Public Health. The tests shall be administered as soon after birth as is medically appropriate. If the mother has had an HIV-related test pursuant to section 19a-90 or 19a-593, the person responsible for testing under this section may omit an HIV-related test. The Commissioner of Public Health shall (1) administer the newborn screening program, (2) direct persons identified through the screening program to appropriate specialty centers for treatments, consistent with any applicable confidentiality requirements, and (3) set the fees to be charged to institutions to cover all expenses of the comprehensive screening program including testing, tracking and treatment. The fees to be charged pursuant to subdivision (3) of this subsection shall be set at a minimum of fifty-six dollars. The Commissioner of Public Health shall publish a list of all the abnormal conditions for which the department screens newborns under the newborn screening program, which shall include screening for amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-CoA dehydrogenase (MCAD).

(b) In addition to the testing requirements prescribed in subsection (a) of this section, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to (1) every such infant in its care a screening test for (A) cystic fibrosis, (B) [severe combined immunodeficiency disease], and [(C)] critical congenital heart disease, and (2) any newborn infant who fails a newborn hearing screening, as described in section 19a-59, a screening test for cytomegalovirus, provided such screening test shall be administered within available appropriations on and after January 1, 2016. Such screening tests shall be administered as soon after birth as is medically appropriate.

[(c) On and after the occurrence of the following: (1) The development and validation of a reliable methodology for screening newborns for adrenoleukodystrophy using dried blood spots

and quality assurance testing methodology for such test or the approval of a test for adrenoleukodystrophy using dried blood spots by the federal Food and Drug Administration; and (2) the availability of any necessary reagents for such test, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care a test for adrenoleukodystrophy.]

(c) [(d)] The administrative officer or other person in charge of each institution caring for newborn infants shall report any case of cytomegalovirus that is confirmed as a result of a screening test administered pursuant to subdivision (3) of subsection (b) of this section to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health.

(d) **[**(e)] The provisions of this section shall not apply to any infant whose parents object to the test or treatment as being in conflict with their religious tenets and practice. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/7280
E-mail: devaughn.ward@ct.gov jill.kennedy@ct.gov

Lead agency division requesting this proposal Healthcare Quality and Safety Branch/Facilities Licensing and Investigations:

Agency Analyst/Drafter of Proposal: Barbara Cass

Title of Proposal: AAC Nursing Home Administrators

Statutory Reference: Section 1. 19a-511. Nursing home administrators to supervise homes. Definitions

Proposal Summary:
Amend CGS 19a-511 to clarify that the nursing home administrator is accountable for the overall management and services provided in the nursing home.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

While Public Health Code section 19-13-D8t (f) Administrator (3) includes in part, "The administrator shall be responsible for the overall management of the facility," it does not address overall accountability of a nursing home's operation and responsibility to a vulnerable population. The code of federal regulations 42 CFR 483.75 directs that "A facility must be administered a in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." Amending section 19a-511 provides for a greater and strict accountability in caring for Connecticut's vulnerable nursing home residents and ensures that each beneficiary of nursing home care is able to at the very least maintain their highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Additionally, amending section 19a-511 will align the expectations of the Administrator with the CFR.

◊ **Origin of Proposal** ☐ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

This is a resubmission, House bill 6887 did not make it out of the Public Health Committee. Leading Age Connecticut had concerns with the mandate.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Aging
Agency Contact (*name, title, phone*): Pam Toohey
Date Contacted: Click here to enter text.

Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
Click here to enter text.

State
Click here to enter text.

Federal
Click here to enter text.

Additional notes on fiscal impact
Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Insert fully drafted bill here

Section 1. Section 19a-511 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

As used in this section and sections **[**19a-511**]** 19a-512 to 19a-520, inclusive, "chronic and convalescent nursing home" means an institution licensed under this chapter and "nursing home administrator" means the person in general administrative charge of a nursing home. All nursing homes licensed under this chapter shall be under the supervision of a licensed nursing home administrator. The nursing home administrator shall be responsible for the quality and safety of all services provided in a nursing home.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Regulatory Services Branch, Environmental Health Section

Agency Analyst/Drafter of Proposal: Francesca Provenzano

Title of Proposal
An Act Concerning Reporting of Radon Test Results

Statutory Reference
19a-14b. Radon mitigators, diagnosticians and testing companies. Regulations.

Proposal Summary
Revise 19a-14b to require analytical measurement services providers (i.e., laboratories) and approved radiological laboratories (radon in water analysis service providers) to report radon results to the CT DPH so that we can collect meaningful data. Revise 19a-14b to require residential mitigation service providers (i.e., radon mitigation contractors) to uniformly report radon mitigation system installations throughout CT for all residential mitigation systems.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

This proposal is being submitted because the DPH has no current means or authority to collect residential radon testing and radon reduction activities in Connecticut. As the state's health agency, we are expected to identify health problems and provide informed answers to citizens. The first step would be in objectively identifying the extent of risk associated with a known carcinogen – we collect data for lesser risks. This proposal is being submitted to determine the scope and incidence of the largest environmental health risk in CT - radon. As the leading cause of lung cancer for non-smokers, it is imperative we begin collecting standardized data. We have invested federal dollars in the development of a radon surveillance system, thus reducing any barriers at the DPH for implementing these requirements. The burden associated with reporting is limited to analytical measurement service providers (laboratories), and residential mitigation service providers (radon mitigation contractors). There are no reporting requirements, burdens or delays associated with this legislation for home inspectors, realtors, or home buying and selling.

Radon is the second leading cause of lung cancer in the United States and is associated with 15,000 to 22,000 lung cancer deaths each year. That is greater than the annual number of deaths for several common cancers including cancer of the ovaries, liver, brain, stomach, or melanoma (Field 2005). Most of the radon-induced lung cancer cases occur among smokers due to a strong combined effect of smoking and radon. Current smokers or ever smokers who are exposed to radon have an exponentially higher risk of developing lung cancer compared to never-smokers exposed to radon. The majority of radon related lung cancer deaths will occur among persons exposed to indoor radon concentrations below commonly used indoor radon reference levels (< 4 pCi/L) (National Cancer Institute, 2011). In view of the latest scientific data, in 2009, the World Health Organization (WHO) proposed a reference level of 100 Bq/m^3 (3.7 pCi/L) to minimize health hazards due to indoor radon exposure. Testing is the only way to know if your home has elevated radon levels. All health authorities recommend radon testing and encourage corrective action when necessary.

Originally, miner studies were relied upon to illustrate the association between radon exposure and lung cancer risk. Case-control studies are now preferred, since over 40 case-control studies have been conducted. Of note are the case-control studies that researchers have pooled; thirteen in the European Union (Darby et al. 2005, 2006) and seven in North America (Krewski, et al. 2005, 2006). Each of the individual studies is smaller, so by pooling the case-control studies researchers are able to acquire a greater number of cases, and more statistically valid risk estimates and associations (WHO, 2009).

The North American and European pooling studies indicate that radon is responsible for 10-18% of the lung cancer burden in the U.S. *The disease burden is even greater for ever-smokers or current smokers.* Furthermore, recent research on radon-induced lung cancer risk among the American Cancer Society cohort (Turner, et.al., 2011) found that study participants who lived in US counties with an average radon concentration above the EPA action level of 4 pCi/L (148 Bq/m^3) experience a 34% increase in lung cancer risk relative to those that lived in counties with average radon levels below the EPA action level. The map, below, illustrates that four of the counties in CT are high radon potential zones, and three counties are moderate potential radon zones. This same study also found that lung cancer *mortality* risk varied depending upon where participants lived. *In the Northeast, there was a 31% increase in the risk of lung cancer mortality observed per 100 Bq/m^3 increase in radon.*

The CT DPH has developed a web-based surveillance system to enable laboratory reporting and practitioner reporting of radon-related measurement and mitigation practices in CT. We have developed a means for importing laboratory rosters for all radon measurement results, so that reporting time by private companies, and staff time is minimal. Currently, the CT DPH does not collect radon-related data. As a public health agency, we can change that. Radon is the leading cause of lung cancer in the US for non-smokers. Furthermore, real estate laws and real estate transactions call for the disclosure of radon test results, but there is no government entity that actually collects this information.

Multiple states throughout the US collect radon measurement and mitigation data. We are developing a surveillance system under the Department's Consilience-Maven system and environmental public health tracking system to electronically collect this data. This data will enable us to fully ascertain lung cancer risks associated with radon for CT residents, and make informed policy decisions. Without reporting requirements radon risks and risk reductions will continue to be unknown or skewed to DPH-related activities. There is no state agency that collects and provides this information to the public to make informed decisions.

- **Origin of Proposal ___ New Proposal X Resubmission**

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?*

The CT Realtors Association and Home Builders Association opposed this legislation. Comments submitted by the CT Realtors Association indicated that this expense for home inspectors and cause a delay in real estate transactions. This legislation does not impact home inspection services, the time associated with buying or selling a home, or reporting on the part of regular home inspectors. The reports would be submitted monthly to the Department by analytical measurement services providers (entities that operate as laboratories and are nationally-certified). Another concern was that the information would be shared openly. Since this data is being collected to determine the risk of morbidity and mortality, it is subject to confidentiality statutes and regulations (19a-25). Revisions to the language were made, after meeting with the Realtors Association and Home Inspector groups (ASHI, and CAHI).

The CT Home Builders Association opposed the bill because they believed it would impact home construction practices in CT. DPH staff contacted Mr. Ethier to alert him that the legislation does not pertain to building or home construction, but rather, to radon testing (when it occurs) in residential properties.

(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
Yes. DPH staffs met with the CT Realtors Association, and ASHI and CAHI members to review the legislation and address concerns. The definition of Analytical Measurement Service Providers was clarified as only those entities that perform analytical services, and who are also nationally-certified. This limitation was not recognized initially by the interest groups. As such, a home inspector placing a passive radon test device (e.g., activated charcoal, or alpha-track device) would not be subject to reporting. Most home inspectors use passive devices and would not need to report to the Department. The proposed language was also revised as follows:

(a) Reporting of radon measurement results by analytical services providers was limited to monthly reporting only – former language asked for more rapid reporting of high radon test results;
(b) Language pertaining to confidentiality was explicitly included in the proposal to reduce concerns about disclosure of reported results to the general public or others.

(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
The initial proposal was drafted by staff in DPH. There are no advocacy groups for radon in the state. Efforts have been made by the DPH to convene interest groups, but sustainability became an issue.

(4) *What was the last action taken during the past legislative session?*
The provision was removed from DPH's "Various Revisions" bill by the Public Health Committee.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
No municipal mandate.

State
The Department of Public Health will use existing resources to carry out the environmental risk surveillance work. The work will result in the ability of the program to target limited resources by making informed decisions.

Federal

Will utilize State Indoor Radon Grant funds to support a position within the program to conduct disease surveillance, data entry, and reporting.
Additional notes on fiscal impact *Analytical laboratories can readily provide the Department with tables containing the information described under statute; in some instances they already do report the information to the local director of health. This is not a burden to the laboratories.* *Home inspectors who are nationally-certified and operate as analytical measurement service providers account for possibly 10-20 individuals statewide. Only those 10-20 individuals would report to the Department because they are nationally-certified and using devices that provide real-time field-based electronic results. This has little to no impact on home inspectors statewide. The information is maintained as confidential health data and would not be released to the public in any identifiable format. The information would be received on a monthly basis, and is not delaying real estate transaction, because the parties associated with the real estate transaction – home buyer/seller, realtor and inspector are not impacted by this proposal.*

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 19a-14b of the general statutes is repealed and the following is substituted in lieu thereof:

Section 19a-14b. Radon mitigators, diagnosticians and testing companies. [Regulations]:

(a) For the purposes of this section and sections 20-420 and 20-432, the following terms shall have the following meanings unless the context clearly denotes otherwise:

(1) "Radon diagnosis" means evaluating buildings found to have levels of radon gas that are higher than the guidelines promulgated by this state or the United States Environmental Protection Agency and recommending appropriate remedies to eliminate radon.

(2) "Radon mitigation" means taking steps including, but not limited to, installing ventilation systems, sealing entry routes for radon gas and installing subslab depressurization systems to reduce radon levels in buildings.

(3) "Analytical measurement service providers" means companies or individuals that have their own analysis capability for radon measurement but may or may not offer measurement services directly to the public.

(4) "Residential measurement service providers" means individuals that offer services that include, but are not limited to, detector placement and home inspection and consultation but do not have their own analysis capability and utilize the services of an analytical measurement service provider for their detector analysis.

(5) "Residential mitigation service providers" means individuals that offer services that include, but are not limited to, radon diagnosis or radon mitigation.

(b) The Department of Public Health shall maintain a list of companies or individuals that are included in current lists of national radon proficiency programs <u>whose businesses are located in Connecticut</u>

and registered as such by the Secretary of State. Companies and individuals who do not comply with subsections (c) through (e) below, or who do not maintain current national certification, or registration with the Department of Consumer Protection as required under section 20-420 of the Connecticut General Statutes, shall be removed from the list.

[(c) The Department of Public Health shall adopt regulations, in accordance with chapter 54, concerning radon in drinking water that are consistent with the provisions contained in 40 CFR 141 and 142.**]**

(c) Each analytical measurement service provider shall, by the fifteenth day of each month, submit to the Commissioner of Public Health a comprehensive report that includes all radon in air test results analyzed by such company or individual in the prior month. The analytical measurement service provider shall report to the Commissioner of Public Health the following information pertaining to the radon test device and radon test result in a format prescribed by the Department: (1) the analytical measurement service provider name, company, and address analyzing and reporting the radon test data; (2) the residential address of the test location including street number, street name, town, and zipcode; (3) the building level where the radon test was placed for the testing period designated as basement, first floor, second floor, or other designated floor number; (4) the purpose of the radon test such as a routine test, a real estate transaction test, a post-mitigation radon test, or a diagnostic radon test used by a residential mitigation service provider for diagnosing the source of existing high radon levels; (5) the dates and times for both deployment and retrieval of the radon test device; (6) the date of analysis; (7) the analytical radon test result reported in pCi/L; and (8) such other information as the Commissioner may require.

(d) For all radon in water test results analyzed by laboratories approved under Connecticut General Statute section 19a-29a, and in accordance with the reporting requirements of section 19a-37, the approved laboratory shall report all radon in water test results to the Commissioner monthly. The report shall include (1) the name, address, city and state of the approved laboratory that analyzed the sample; (2) the individual who collected the sample designated as one of the following: analytical measurement service provider, residential measurement service provider, licensed home inspector, or homeowner; and (3) the analysis results for the water sample in units of picocuries per liter (pCi/L). Radon in water analysis laboratories shall be responsible for collecting all of the information described in this section for Commissioner reporting purposes.

(e) Each residential mitigation service provider legally operating in Connecticut that conducts radon mitigation for air or water shall submit to the Commissioner of Public Health a comprehensive report for each system installed that includes: (1) the name and address of the residential mitigation service provider company for each installed radon control system; (2) the name of the residential mitigation service provider; (3) the full residential address including number, street, town and zip code where the radon mitigation system was installed; (4) the type of mitigation system installed designated as “air” or “water”; (5) the date the mitigation system was installed, (6) the post-mitigation radon results; and (7) such other information as the Commissioner may require. Residential mitigation services provider shall submit the residential radon mitigation system not later than thirty days from completion of the installation on a form prescribed by the Commissioner, or, by entering the data directly into a secure electronic surveillance system provided by the Commissioner.

(f) Radon data and information collected under this section shall be maintained as confidential in accordance with section 19a-25.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: HQSB/FLIS
Agency Analyst/Drafter of Proposal: Barbara Cass, R.N., Section Chief

Title of Proposal **AAC Revisions to The Definition of A Mental Health Facility**
Statutory Reference **19a-490(g)**
Proposal Summary **The definition of a "mental health facility" as defined in Connecticut General Statutes, Section 19a-490 shall be revised to reflect the proposed regulations which define mental health facilities as a facility where mental health services are provided to persons eighteen years of age or older and substance use services are provided to persons of any age. Services may be provided in a day treatment or residential setting**
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable: *(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* *(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* *(3) Have certain constituencies called for this action?* *(4) What would happen if this was not enacted in law this session?*

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

Section 19a-490(g) "Mental health facility" means any facility [for the care or treatment of mentally ill or emotionally disturbed persons, or any mental health outpatient treatment facility that provides treatment to persons sixteen years of age or older who are receiving services from the Department of Mental Health and Addiction Services, but does not include family care homes for the mentally ill] where mental health services are provided to persons eighteen years of age or older and substance use services are provided to persons of any age. Services may be provided in a day treatment or residential setting ; for purposes of this subsection, mental health services is defined as means services that may be provided to a person to ameliorate mental, emotional, and behavioral and substance use dependency issues;

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: HQSB/FLIS
Agency Analyst/Drafter of Proposal: Barbara Cass, R.N., Section Chief

Title of Proposal **AAC Revisions to The Definitions of A Residential Care Home**
Statutory Reference **19a-521**
Proposal Summary **The definition of a "residential care facility" shall be revised to incorporate the changes that were made to the *Medicaid Program: State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment , and Home and Community-Based Setting Requirements for Community First Choice and Home and Community Based Service Waivers pursuant to Final Rule CMS 2249-F and CMS 2296-F.***
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The Medicaid Program: State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community Based Service Waivers pursuant to Final Rule CMS 2249-F and CMS 2296-F dated January 16, 2014 ensures that individuals receiving long term services and supports through home and community based services have full access to the benefits of community living and the opportunity to receive services in the most appropriate setting. One such setting is the Residential Care Home (RCH) which is a social model rather than a medical model.

Many residents currently residing in the RCH setting in Connecticut receive the RCH model of care services through the aforementioned waiver program. However, the current definition and regulations may be a potential barrier to further eligibility for this level of care. Revising the definition, until such time that Connecticut Public Health Code, section 19-13-D6 can be revised mayl not impact any current and future beneficiaries of the waiver program that reside in RCH's.

- **Origin of Proposal ___ New Proposal ___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

Sec. 19a-521. (Formerly Sec. 19-602). Nursing home facilities. Definitions. As used in this section and sections 19a-522 to 19a-534a, inclusive, 19a-536 to 19a-539, inclusive, 19a-550 to 19a-554, inclusive, and 19a-562a, unless the context otherwise requires:

(1) "Nursing home facility" means any nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or 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;

(2) "Department" means the Department of Public Health;

(3) "Commissioner" means the Commissioner of Public Health or the commissioner's designated representative; and

(4) "Residential care home" means a[n] community residence that provides a person centered service model [establishment] that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/7280
E-mail: devaughn.ward@ct.gov jill.kennedy@ct.gov

Lead agency division requesting this proposal Healthcare Quality and Safety Branch/Facilities Licensing and Investigations Section:

Agency Analyst/Drafter of Proposal: Barbara Casse

Title of Proposal: AAC Revisions to the Process for Citations in Chronic and Convalescent Nursing Homes

Statutory Reference: Section 1. 19a-524. Citations issued for certain violations. Section 2. 19a-525. Contest of citation. Information conference. Hearing. Final order. Section 3. 19a-527. Classification of violations.

Proposal Summary:
Revises sections 19a-524 and 19a-525 to provide transparency regarding responsibilities of the Department and the Licensee pursuant to an informal conference; Amends section 19a-527 to increase fines for Class A and Class B violations in nursing home facilities.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Changes to Section 19a-525 as currently written has created ambiguity regarding the responsibilities of both parties. The new language provides time frames which will provide greater structure to the process

The current threshold for Class A and B violations as provided for in Section 19a-527 have not been reviewed for greater than 20 years. Examples of a class B violation include: failure to monitor patient condition and/or carry out patient care plan; failure to monitor patient condition and/or patient accident/incident; to conformance with federal, state and local regulations and/or failure to monitor patient condition and/or patient accident/incident. These violations were taken directly from the 4th quarter of the 2014 regulatory action report which is on the department's website at: http://www.ct.gov/dph/cwp/view.asp?a=4061&q=534952 When a Class A or B violation is found, a

facility is fined a civil penalty which is determined by using a special formula that includes: #s of affected patients, # of occurrences of the violation; is this a repeat violation from a previous visit etc.

◊ **Origin of Proposal** ☐ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Resubmission of proposal, the bill (HB 6887) did not make it out of the Public Health Committee. Leading Age Connecticut had concerns about the potential for increased fines.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Aging
Agency Contact (*name, title, phone*): Pam Toohey
Date Contacted: Click here to enter text.

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
Click here to enter text.

State
Click here to enter text.

Federal
Click here to enter text.

Additional notes on fiscal impact
Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Click here to enter text.

Insert fully drafted bill here

Section 1. Section 19a-524 of the general statutes is repealed and the following is substituted in lieu thereof:

If, upon review, investigation or inspection pursuant to section 19a-498, the Commissioner of Public Health determines that a nursing home facility or residential care home has violated any provision of section 17a-411, 19a-491a to 19a-491c, inclusive, 19a-493a, 19a-521 to 19a-529, inclusive, 19a-531 to 19a-551, inclusive, or 19a-553 to 19a-555, inclusive, or any regulation in the Public Health Code or regulation relating to licensure or the Fire Safety Code relating to the operation or maintenance of a nursing home facility or residential care home, which violation has been classified in accordance with section 19a-527, he or she [shall] may immediately issue or cause to be issued a citation to the licensee of such nursing home facility or residential care home. Governmental immunity shall not be a defense to any citation issued or civil penalty imposed pursuant to sections 19a-524 to 19a-528, inclusive. Each such citation shall be in writing, shall provide notice of the nature and scope of the alleged violation or violations and shall be sent by certified mail to the licensee at the address of the nursing home facility or residential care home in issue. A copy of such citation shall also be sent to the licensed administrator at the address of the nursing home facility or residential care home.

Section 2. Section 19a-525 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The administrator of the nursing home facility or residential care home, or his or her designee, shall, within [three] five days, excluding Saturdays, Sundays and holidays, of receipt of the citation by the licensee, notify the commissioner if the licensee contests the citation. If the administrator fails to so notify the commissioner within such [three] five-day period, the citation shall be deemed a final order of the commissioner, effective upon the expiration of said period.

(b) If any administrator of a nursing home facility or residential care home, or his or her designee, notifies the commissioner that the licensee contests the citation, the commissioner shall provide [within five days of such notice, excluding Saturdays, Sundays and holidays,] an informal conference between the licensee and the commissioner. At the conclusion of the informal conference, the commissioner shall, within five business days, notify the licensee of the outcome of such conference. Upon such notice, [If] if the licensee and commissioner fail to reach an agreement at such conference, the commissioner shall set the matter down for a hearing as a contested case in accordance with chapter 54[, not more than five nor less than three days

after such conference, with notice of the date of such hearing to the administrator not less than two days before such hearing, provided the minimum time requirements may be waived by agreement]. The commissioner shall[, not later than three days, excluding Saturdays, Sundays and holidays,] after the conference if agreement is reached at such conference, or after the hearing, issue a final order, based on findings of fact, affirming, modifying or vacating the citation.

Sec. 3. Section 19a-527 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Citations issued pursuant to section 19a-524 for violations of statutory or regulatory requirements shall be classified according to the nature of the violation and shall state such classification and the amount of the civil penalty to be imposed on the face thereof. The Commissioner of Public Health shall, by regulation in accordance with chapter 54, classify violations as follows:

[(a)**]** (1) Class A violations are conditions that the Commissioner of Public Health determines present an immediate danger of death or serious harm to any patient in the nursing home facility or residential care home. For each class A violation, a civil penalty of not more than **[**five**]** ten thousand dollars may be imposed;

[(b)**]** (2) Class B violations are conditions that the Commissioner of Public Health determines present a probability of death or serious harm in the reasonably foreseeable future to any patient in the nursing home facility or residential care home, but that he or she does not find constitute a class A violation. For each **[**such**]** Class B violation, a civil penalty of not more than **[**three**]** five thousand dollars may be imposed.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Department of Public Health
Liaison: DeVaughn Ward/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: HQSB/FLIS
Agency Analyst/Drafter of Proposal: Barbara Cass, R.N., Section Chief

Title of Proposal **AAC Technical Revisions Enforcement Regulations Utilizing A Temporary Manager**
Statutory Reference **19a-494**
Proposal Summary **When significant violations have been identified during federal inspection activity, a valuable tool utilized in achieving and sustaining compliance has been the use of a Temporary Manager. The addition of a Temporary Manager to the Department's list of disciplinary action that may be taken, would be very helpful in extreme situations.**
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable: *(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* *(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* *(3) Have certain constituencies called for this action?* *(4) What would happen if this was not enacted in law this session?*

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

Sec. 19a-494. (Formerly Sec. 19-579). Disciplinary action. (a) The Commissioner of Public Health, after a hearing held in accordance with the provisions of chapter 54, may take any of the following actions, singly or in combination, in any case in which the commissioner finds that there has been a substantial failure to comply with the requirements established under this chapter, the Public Health Code or licensing regulations:

(1) Revoke a license or certificate;

(2) Suspend a license or certificate;

(3) Censure a licensee or certificate holder;

(4) Issue a letter of reprimand to a licensee or certificate holder;

(5) Place a licensee or certificate holder on probationary status and require him to report regularly to the department on the matters which are the basis of the probation;

(6) Restrict the acquisition of other facilities for a period of time set by the commissioner;

(7) Issue an order compelling compliance with applicable statutes or regulations of the department; [or]

(8) Impose a directed plan of correction; or [.]

(9) Temporary Manager. (a) which term has the meaning as defined in 42 CFR 488.415

(b) Notice of the hearing to the holder of a license or certificate shall be effected by registered or certified mail or by personal service, setting forth the particular reasons for the proposed action and fixing a date, not less than thirty days from the date of such mailing or service, at which the holder of such license or certificate shall be given an opportunity for a prompt and fair hearing, and witnesses may be subpoenaed by either party for such hearing. Such hearing may be conducted by the Commissioner of Public Health, a deputy commissioner, or by a member of the Department of Public Health, designated by said commissioner. On the basis of such hearing, or upon default of the holder of such license or certificate, the person conducting such hearing shall specify his findings and conclusions, and said department may, upon the basis of such findings and conclusions take any action authorized by this section that it deems necessary. A copy of such decision shall be sent by registered or certified mail or served personally upon the holder of such license or certificate.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Regulatory Services Branch – Environmental Health Section

Agency Analyst/Drafter of Proposal:
Ryan Tetreault, Supervising Environmental Analyst– Private Well Program

Title of Proposal
Testing of Water Quality in Wells for Semi-Public Use

Statutory Reference
CGS § 19a-37 Regulation of water supply wells and springs. Information and requirements re testing of private residential wells.

Proposal Summary
To allow statutory authority for DPH to establish regulations for water quality testing requirements of semi-public wells.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Subsection (a) of the existing statutes allows for DPH to establish regulations for protection and location of new water supply wells for residential construction or for semipublic use. Subsection (b) gives authority for DPH to establish regulations for water quality testing of a private residential well. Currently there is no authority within Section §19a-37 specific to DPH establishing regulations for testing of water quality in a new well for semipublic use. Semipublic use wells can supply hundreds and sometimes thousands of people in a day and currently there are no requirements in the statutes for water quality testing. It's important to note that these semipublic wells do not meet the definition of a public water supply well because they either do not supply 25 or more people daily or do not supply people for 60 or more days per year. Examples of semipublic wells include 1) a well supplying an agricultural fairground where the well supplies thousands of people that attends the fair that operates for 3 or 4 days per year and is not supplied by a public water system, 2) an office building with 24 employees, or 3) an apartment building with eight, two-bedroom units that has a design population of 24 people per RCSA Section 16-262m-8(a)(3). The changes to the statute will make a technical correction to ensure new semipublic wells are also tested for water quality by qualified individuals to ensure the water being supplied to the public is safe.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** – No agencies impacted

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) 0
State 0
Federal 0
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Subsection b of Section 19a-37 of the Connecticut General Statutes is amended to read as follows:

(b) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, for the testing of water quality in private residential wells and wells for semipublic use. Any laboratory or firm which conducts a water quality test on a private well serving a residential property or well for semipublic use shall, not later than thirty days after the completion of such test, report the results of such test to (1) the public health authority of the municipality where the property is located, and (2) the Department of Public Health in a format specified by the department, provided such report shall not be required if the party for whom the laboratory or firm conducted such test informs the laboratory or firm that the test was not conducted within six months of the sale of such property. No regulation may require such a test to be conducted as a consequence or a condition of the sale, exchange, transfer, purchase or rental of the real property on which [the] a private residential well is located. For purposes of this section, "laboratory or firm" means an environmental laboratory registered by the Department of Public Health pursuant to section 19a-29a.

Subsection f of Section 19a-37 of the Connecticut General Statutes is amended to read as follows:

(f) The local director of health may require a private residential well or well for semipublic use to be tested for arsenic, radium, uranium, radon or gross alpha emitters, when there are reasonable grounds to suspect that such contaminants are present in the groundwater. For purposes of this subsection, "reasonable grounds" means (1) the existence of a geological area known to have naturally occurring arsenic, radium, uranium, radon or gross alpha emitter deposits in the bedrock; or (2) the well is located in an area in which it is known that arsenic, radium, uranium, radon or gross alpha emitters are present in the groundwater.

Subsection g of Section 19a-37 of the Connecticut General Statutes is amended to read as follows:

(g) Except as provided in subsection (h) of this section, the collection of samples for determining the water quality of private residential wells or wells for semipublic use may be made only by (1) employees of a laboratory or firm certified or approved by the Department of Public Health to test drinking water, if such employees have been trained in sample collection techniques, (2) certified water operators, (3) local health departments and state employees trained in sample collection techniques, or (4) individuals with training and experience that the Department of Public Health deems sufficient.

Subsection h of Section 19a-37 of the Connecticut General Statutes is amended to read as follows:

(i) The local director of health may require private residential wells or wells for semipublic use to be tested for pesticides, herbicides or organic chemicals when there are reasonable grounds to suspect that any such contaminants might be present in the groundwater. For purposes of this subsection, “reasonable grounds” means (1) the presence of nitrate-nitrogen in the groundwater at a concentration greater than ten milligrams per liter, or (2) that the private residential well or well for semipublic use is located on land, or in proximity to land, associated with the past or present production, storage, use or disposal of organic chemicals as identified in any public record.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/7280
E-mail: devaughn.ward@ct.gov jill.kennedy@ct.gov

Lead agency division requesting this proposal Healthcare Quality and Safety Branch/Facilities Licensing and Investigations:

Agency Analyst/Drafter of Proposal: Barbara Cass

Title of Proposal: AAC The Administration Of Methadone For Chemical Maintenance For Residents Residing In Nursing Homes

Statutory Reference: New

Proposal Summary:

As treatment for opioid dependence increases utilizing Methadone for chemical maintenance, the probability of such individuals requiring the care and services provided in a nursing facility also increases. Currently, depending where that individual is in their chemical maintenance treatment plan will determine if they are permitted to "take home bottles" for self- administration at the nursing home. However, illness or other barriers may impact an individual's "take home bottle" status and/or present a challenge in ensuring consistent treatment with a medication in which therapeutic levels are maintained. This act would mitigate the challenges associated with the administration of Methadone in the long term care setting .

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Click here to enter text.

◊ Origin of Proposal ☐ New Proposal ☐ Resubmission

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Mental Health and Addiction Services **Agency Contact (*name, title, phone*):** Doreen DelBianco **Date Contacted:** Click here to enter text. Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* Click here to enter text.
State Click here to enter text.
Federal Click here to enter text.
Additional notes on fiscal impact Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Click here to enter text.

Insert fully drafted bill here

(NEW) A substance abuse treatment facility licensed as an institution pursuant to section 19a-490 of the Connecticut General Statutes providing medication assisted treatment for opioid addiction shall be permitted to provide methadone delivery and related substance use treatment services to persons in the Chronic and Convalescent Nursing Homes licensed pursuant to section 19a-493 of the General Statutes. The Department of Public Health may waive the Regulations of the Connecticut State Agencies if the Commissioner of Public Health determines that such waiver would not endanger the health safety

or welfare of any patient. The commissioner may impose conditions upon granting the waiver that assure the health safety and welfare of the patients, or may revoke the waiver upon a finding that the health, safety or welfare of any patient has been jeopardized. The substance abuse treatment facility shall make such request for the waiver in a form and manner prescribed by the Commissioner.

Agency Legislative Proposal - 2016 Session

Document Name (e.g.): **GRE will fill in**
State Agency: **Connecticut Department of Public Health**
Liaison: **DeVaughn Ward/Jill Kennedy** Phone: **(860) 509-7246/(860) 509-7280** E-mail: **DeVaughn.ward@ct.gov;jill.Kennedy@ct.gov**
Lead agency division requesting this proposal: **Regulatory Services Branch/Drinking Water Section**
Agency Analyst/Drafter of Proposal: **Lori Mathieu, Public Health Section Chief (860) 509-7343**
Title of Proposal An Act Concerning the Freedom of Information Act
Statutory Reference Section 1: § 1-210(b)(19)(ix) Section 2: (NEW)
Proposal Summary To provide further clarification regarding which records are required to be withheld under FOIA and which records may be disclosed, which will in turn streamline the FOIA process and help public agencies to respond to FOIA requests in a timely manner. By requiring persons who submit water company records to public agencies to identify those records the person believes are protected from disclosure pursuant to *Conn. Gen. Stat.* § 1-210(b)(19)(ix), the public agencies will be in a better position to determine which records contain or reveal information the disclosure of which may result in a security risk to a water company.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? (3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

- **Origin of Proposal _X_ New Proposal _ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies** Affected (please list for each affected agency)

Agency Name: **Department of Administrative Services (DAS)**

Agency Contact (name, title, phone): **Jeffrey R. Beckham, Staff Counsel/Director of Communications, (860) 713-5195**

Date Contacted: **August 6, 2015**

Approve of Proposal ___ YES ___ NO _**X**_ Talks Ongoing

Summary of Affected Agency's Comments

The Department of Public Health (DPH) received verbal preliminary review and an endorsement to move forward from DAS. DAS agreed with the path taken by DPH to streamline FOIA processing

Will there need to be further negotiation? _X_ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

None.

State

None.

Federal

None.

Additional notes on fiscal impact

By clarifying the records that are required to be withheld and those that may be disclosed, the state will save money.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The proposal will enable the Department of Public Health (DPH) and other public agencies to respond more quickly to Freedom of Information Act (FOIA) requestors with respect to certain records enumerated in the proposal because such proposal will clarify which records are required to be withheld and which may be disclosed under *Conn. Gen. Stat.* § 1-210(d).

Section 1. Section 1-210(b)(19)(ix) of the general statutes is repealed and the following is substituted in lieu thereof:

(ix) With respect to a water company, as defined in section 25-32a, that provides water service: Vulnerability assessments and risk management plans, [operational] documents or portions of documents that contain procedures for sabotage prevention and response, and any plans, [portions of water supply plans submitted pursuant to section 25-32d that contain or reveal information the disclosure of which may result in a security risk to a water company, inspection] reports, technical specifications, and other materials, including materials that contain the location of transmission mains and tunnels, source water intakes and treatment, that [depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply] contain or reveal information the disclosure of which may result in a security risk to a water company provided this section shall not apply to the disclosure of water quality reports and information regarding a water company's margin of safety, including information regarding the amount of available water and safe daily yield, that only disclose the town or municipality in which the source or sources of supply referenced in such reports or information are located and do not disclose more specific location information, such as the specific address at which such source or sources of supply are located;

Sec. 2. (NEW)

Any person who believes that information submitted to a public agency is exempt from disclosure pursuant to section 1-210(b)(19)(ix), as amended by this Act, shall submit such information to the public agency in a manner prescribed by the agency, along with an explanation with supporting facts as to why the public agency shall keep such information protected from disclosure pursuant to section 1-210(b)(19)(ix).

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal: Practitioner Licensing and Investigations Section

Agency Analyst/Drafter of Proposal: Chris Andresen/Steve Carragher

Title of Proposal
An Act Concerning the Hairdresser Application Fee

Statutory Reference 20-254

Proposal Summary
This proposal will update the application fee for hairdresser licensing without examination to make it consistent with the required fee for licensing by examination.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
The department is currently charging out of state applicants the same application fee as applicants for examination, even though the statutes differ. This proposal will make the fees the same, regardless of basis for licensure. We believe this statute was missed when public act 09-3 (section 231, section 20-253) was passed to increase the fees for hairdresser licensure from $50.00 to $100.00

- **Origin of Proposal** **X New Proposal** **___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) 0
State $0 as we are currently collecting this fee as part of routine operations.
Federal $0
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

Sec. 20-254. License without examination. Any person who holds a license at the time of application as a registered hairdresser and cosmetician, or as a person entitled to perform similar services under different designations in any other state, in the District of Columbia, or in a commonwealth or territory of the United States, and who was issued such license on the basis of successful completion of a program of education and training in hairdressing and cosmetology and an examination shall be eligible for licensing in this state and entitled to a license without examination

upon payment of a fee of **[fifty]** **one hundred** dollars**.** No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

If the issuance of such license in any other state, in the District of Columbia, or in a commonwealth or territory of the United States did not include an examination, an applicant who has legally practiced cosmetology for at least five years in a state outside of Connecticut shall be eligible for licensure if the applicant submits satisfactory evidence of education and experience and upon payment of a fee of **[fifty]** **one hundred dollars**. Evidence of experience shall include 1) an original certification from the out of state licensing agency demonstrating at least 5 years of licensure, 2) Letters from former employers, co-workers, or clients that satisfactorily describe the applicant's experience in the state for at least five years, and 3) Copy of tax returns which indicate cosmetology as occupation. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal: **Public Health Systems Improvement**

Agency Analyst/Drafter of Proposal: **Kristin Sullivan x7126**

Title of Proposal
Biomedical Research Grants in Aid Program Transfer

Statutory Reference
19a-32c Biomedical Research Trust Fund. Transfers from Tobacco Settlement Fund. Grants-in-aid.

Proposal Summary
Transfer the DPH Biomedical Research Grant in Aid program from the Department of Public Health to Connecticut Academy of Science and Engineering

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The Biomedical Research Grant in Aid program provides funding to eligible Connecticut entities conducting biomedical research. The reason for this proposal is that a significant change has occurred in available resources to administer the program. The current DPH program administrator was a state funded employee that retired on June 1, 2015. The money allocated for program administration (2% of the balance in the fund) is not enough to cover staffing and necessary expenses for the program.

The program administrator's role was to ensure proper contract and fiscal management of the program. Due to the complex nature of the research proposals, this included contracting with the CT Academy of Science and Engineering (CASE) for scientific expertise in review and recommendations for awards. Currently there are 29 awards to manage from 2013 to 2015.

Additionally, a recent review of program accomplishments and researcher feedback conducted by CASE indicated that the program has positive economic impact for the state and can be significantly enhanced with administrative flexibility and greater consistency with the National Institutes of Health. Given the complex nature of research projects funded, the state's investment can be best protected with program administration from an entity that has biomedical research expertise and a flexible administrative environment. .

- **Origin of Proposal ___ New Proposal _X__ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

The initial proposal had fiscal implications that could not be addressed during the legislative session.

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

There has been a significant discussion with legislative sponsors and other major players with respect to state agency fiscal and staffing constraints, and needs of the biomedical research program

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

Senator Joseph Crisco, CASE, CT Innovations, UCONN Health Center, Yale University and other entities that conduct biomedical research.

(4) What was the last action taken during the past legislative session?

Funding was allocated for biomedical research for the 2015 and 2016 budget years.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: CT Academy of Science and Engineering
Agency Contact (name, title, phone): Richard H. Strauss, Executive Director, 860-571-7135
Date Contacted: 8/28/15

Approve of Proposal __X_ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

CASE proposes to be responsible for the administration and operation of the CT Biomedical Research Grant Program and upon our request has provided a cost proposal. From 2009-2015, CASE has conducted peer review process annually to review the proposals and make recommendations of grant funding to DPH. Also upon request by DPH, they conducted a review of the program and highlights since its inception which was published in August, 2014. (See full proposal attached).

Will there need to be further negotiation? _X_ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
N/A

State

Annual CASE Administrative and Management Fee (FY2017): $120,000. This fee is for the administration and operation of the Program for FY2017 and includes all expenses for the CASE project director and project staff, peer reviewers and the Project Tasks, as may be necessary. In addition, the fee includes payment for the value of the CASE Committee. It is noted that the members of the CASE Committee provide their service to the Academy on a pro-bono basis.

This funding and transfer of the program for full time administration of the Biomedical Grant in Aid Program includes the following responsibilities: a) grant award contracting; b) grant management; c) grantee reporting and trailer reporting (for 7 years after grant completion to capture real outcomes); d) annual reporting on the program; and e) Stakeholder briefing for interested parties on key grantee accomplishments and annual grant award process.

Federal
N/A

Additional notes on fiscal impact

The trailer reporting and Stakeholder briefing will help to improve the quality of the biomedical research program and address issues raised as part of administrative processes as well as provide more information on outcomes of the state's investment.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Transfer of the program to CASE will be beneficial to researchers and the state investment as it will help address concerns about program rigidity. As a state agency, DPH is constrained by statewide rules and regulations of open bids and contracting. Additionally, biomedical research is part of CASE's business and therefore they have a wealth of subject matter expert in this area to make appropriate funding and investment decisions for the state.

In a conference call with CT Innovations held on 9/11/15, they indicated that a grant program does not fit with their mission. They would be interested if the statutory language broadened the audience and instruments for funding. For example, allowing CI to provide loans and receive royalties that can be re-invested; and providing funding to private companies doing promising work in similar biomedical research areas.

Section 19a-32c of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-32c. Biomedical Research Trust Fund. Transfers from Tobacco Settlement Fund. Grants-in-aid. There is created a Biomedical Research Trust Fund which shall be a separate nonlapsing fund. The trust fund may accept transfers from the Tobacco Settlement Fund and may apply for and accept gifts, grants or donations from public or private sources to enable the account to carry out its objectives. The [Commissioner of Public Health] Executive Director of the Connecticut Academy of Science and Engineering may make grants-in-aid from the trust fund to eligible institutions for the purpose of funding biomedical research in the fields of heart disease, cancer and other tobacco-related diseases, Alzheimer's disease, stroke and diabetes. Each fiscal year, the total amount of moneys deposited in the account shall be used by the [Commissioner of Public Health] Executive Director of the Connecticut Academy of Science and Engineering for such grants-in-aid, provided such grants-in-aid shall not exceed fifty per cent of the total amount held in the trust fund as of the date such grants-in-aid are approved. Not more than two per cent of the total available amount held in the trust fund shall be made available to the [Department of Public Health] Executive Director of the Connecticut Academy of Science and Engineering for administration expenses relating to the trust fund and making the grants-in-aid. The [Commissioner of Public Health] Executive Director of the Connecticut Academy of Science and Engineering shall develop an application for grants-in-aid under this section and may receive applications from eligible institutions for such grants-in-aid. For purposes of this section, "eligible institution" means an entity that has its principal place of business located in the state and is (1) a nonprofit, tax-exempt academic institution of higher education, or (2) a hospital that conducts biomedical research.

CASE Biomedical Research Grant PROPOSAL

DATE: August 28, 2015

BACKGROUND

Connecticut State Statute 19a-32c, authorized the Connecticut Department of Public Health (DPH) Commissioner to award grants-in-aid from the non-lapsing Biomedical Research Trust Fund to eligible institutions for the purpose of funding a Biomedical Research Program (Program) in the fields of heart disease, cancer and other tobacco-related diseases, and Alzheimer's disease, stroke and diabetes. From 2005 – 2015 through 10 RFP processes DPH awarded approximately $20.1 million to 67 research projects with grants averaging $300.5K. Grant recipients submit interim progress and final progress reports of their research to the DPH. DPH has administered this Program from its inception. From 2009 – 2015 the Connecticut Academy of Science and Engineering conducted the peer review process annually to review the proposals and make recommendations of grant funding to DPH.

For FY2016 the state did not provide funding for the Program. For FY2017 and beyond, DPH is interested in contracting for services to administer and operate the Program. Therefore, at the request of DPH, the Connecticut Academy of Science and Engineering prepared the following proposal.

PROJECT SCOPE

Objective:

The Connecticut Academy of Science and Engineering (CASE) will be responsible for the administration and operation of the Connecticut Biomedical Research Grant Program (Program).

Overview:

1. A CASE Biomedical Research Grant Program Committee (CASE Committee) appointed by CASE will oversee the Program. The Committee will review and approve the annual RFP, grantee progress and final reports, and an annual Program report. Members of the Committee will serve on a pro-bono basis, and include CASE members and others.
2. A Peer Review Committee (PRC) will be appointed by CASE including a Chair, and Co-Chairs to review and select proposals to be funded, including a review of the budgets of selected proposals to determine amount to be funded.
3. CASE staff will manage all aspects of the Program.

Project Tasks:

The following tasks be included in the project work scope annually:

1. Selection of CASE Committee
2. Selection of Peer Review Committee and contracting for reviewer services
3. RFP Process
    a. Develop RFP using the DPH 2015 RFP as a baseline for the new RFP
    b. Issue RFP
    c. Conduct a bidders conference
    d. Compliance review of all proposals. Notify Principal Investigof acceptance/rejection of proposal for consideration for funding.
4. Peer Review Process
    a. Utilize current proposal review process and scoring system for peer review process; and review and revise annually
    b. Assign reviewers, chair and co-chairs proposals to review
    c. Conduct PRC orientation session
    d. Distribute proposals to PRC for review and scoring
    e. Manage reviewer responses and track scoring – initiate proposal scoring reconciliation per process, when required

f. Conduct Chair/Co-Chair proposal scoring review meeting to select proposals for discussion at PRC Proposal Selection Meeting. Develop proposal discussion plan and secure consent of discussion plan from PRC.
g. Conduct PRC Proposal Selection Meeting. Select proposals to be funded, and funding amount with adjustments to proposal budgets for each selected proposal based on total annual funding available
h. Notify applicants of the proposals that were reviewed of results of proposal selection process

5. Grant Award Contracting
   a. Develop grant award contract, using DPH grant award contract as baseline.
   b. Execute grantee/CASE contracts for all selected proposals
6. Grant Management
   a. Secure grantee progress report at one year project benchmark for two-year grant. CASE Committee to review and approve.
   b. Secure grantee final report at project completion. CASE Committee to review and approve.
   c. Process requests for extension of grant term through CASE Committee, as necessary
   d. Process requests for time extension for progress and final reports, as necessary.
   e. Issue grant terminations as necessary through CASE Committee.

7. Grantee Trailer Reporting
   a. Grant terms and conditions will include a provision requiring grantee "trailer" reporting for a minimum of seven years following grant completion. *Note: The purpose of trailer reporting is to have grantees report on their accomplishments related to the research conducted for a period of time long enough to capture the outcomes and value of the funding provided to support the research.*
   b. Trailer reporting will be done by electronic survey.
   c. Prior grants completed that meet the seven year time frame will be included in the trailer reporting.
   d. CASE will provide trailer reporting for the period it is under contract for service with DPH.
8. Annual Reporting
   a. CASE will publish an annual Program Report (PDF) summarizing the process and results, including accomplishments from the trailer reporting from grantees.
9. Stakeholder Briefing
   a. An Annual Stakeholder Briefing for interested parties on key grantee accomplishments and the annual grant award process will be scheduled.

Schedule: Annual Schedule: July 1 – June 30.

Project Fee:

1. Annual CASE Administrative and Management Fee (FY2017): $120,000
   a. The CASE Project fee the administration and operation of the Program for FY2017 includes all expenses for the CASE project director and project staff, peer reviewers and the Project Tasks, as may be necessary. In addition, the fee includes payment for the value of the CASE Committee. It is noted that the members of the CASE Committee provide their service to the Academy on a pro-bono basis.
   b. The Project Fee will be paid to CASE upon execution of a contract services with DPH.
2. Grant Funding: In addition to the Annual CASE Administrative and Management Fee, the state shall provide funding for the award of grants. Grant funding shall be provided to CASE by agreement, with funds provided to CASE held for disbursement to grant awardees. CASE shall maintain a separate Connecticut Biomedical Research Grant Program Fund Account. The CASE agreement shall provide the terms for fund financial reporting.

CONTRACTING – STANDARDIZATION TRANSACTION: The following information is provided for DPH's information for contracting purposes. CASE contracts for services may be processed utilizing a Standardization Transaction methodology as authorized by the Department of Administrative Services utilizing the process specified below.

Department of Administrative Services Standardization Transaction with the Connecticut Academy of Science and Engineering:

- *Standardization Transaction #3785 – Extension #2, 5-year term: 7/21/14 to 7/21/19; In accordance with Section 4a-58 of Connecticut General Statutes.*
- *Process: (1) establish scope of services and fee; (2) secure internal agency approvals; (3) process a purchase requisition referring to the Academy's standardization transaction number (3785) for services to be provided*

A Personal Services Agreement is not required. DAS contact is Carol Wilson, Assistant Procurement Manager, DAS, 860-713-5093, E-Mailto: carol.wilson@ct.gov

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
HCQS

Agency Analyst/Drafter of Proposal:
Chris Andresen

Title of Proposal
Updates to midwifery statute

Statutory Reference 20-86

Proposal Summary
This proposal proposal updates the certifying bodies for midwives and midwifery education

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The Department realized that the midwifery certifying bodies in statute need to be updated by adding the term "or any successor" to the statute. So we don't have the same issue as we did with the Massage Therapist last year.

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact NO FISCAL IMPACT

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This will update the statutes to align with current midwifery certifying bodies.

20-86a. Definitions

(2) "Nurse-midwife" means a person who has demonstrated competence to practice nurse-midwifery through successful completion of an educational program accredited by the [American College of Nurse-Midwives] Accreditation Commission for

Midwifery Education and who is certified by the [American College of Nurse-Midwives] American Midwifery Certification Board, and is licensed under the provisions of this chapter.

Sec. 20-86c. Requirements for licensure. Fee. The Department of Public Health may issue a license to practice nurse-midwifery upon receipt of a fee of one hundred dollars, to an applicant who (1) is eligible for registered nurse licensure in this state, under sections 20-93 or 20-94; (2) holds and maintains current certification from the [American College of Nurse-Midwives] American Midwifery Certification Board; and (3) has completed thirty hours of education in pharmacology for nurse-midwifery. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Sec. 20-86i. Temporary practice of graduates of nurse-midwifery programs. Nothing in this chapter shall be construed to prohibit graduates of nurse-midwifery programs approved by the [American College of Nurse-Midwives] Accreditation Commission for Midwifery Education from practicing midwifery for a period not to exceed (1) ninety calendar days after the date of graduation, or (2) the date upon which the graduate is notified that he or she has failed the licensure examination, whichever is shorter, provided (A) such graduate nurses are working in a hospital or organization where adequate supervision, as determined by the Commissioner of Public Health, is provided, and (B) such hospital or other organization has verified that the graduate nurse has successfully completed a midwifery program approved by the [American College of Nurse-Midwives] Accreditation Commission for Midwifery Education.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
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Lead agency division requesting this proposal:
HCQS

Agency Analyst/Drafter of Proposal:
Chris Andresen

Title of Proposal
Updating social work statute

Statutory Reference 20-195q(c)

Proposal Summary
This proposal would remove the non-prohibited activity in this section that allows an unlicensed person with a masters or doctoral degree in social work to gain social work experience under supervision related to becoming an LCSW. The newly implemented LMSW requires someone holding a doctoral or masters degree to be licensed as an LMSW to work under professional supervision to gain this experience.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The state law for licensed masters level social workers was implemented in 2015. The language proposal will remove language that provides an exception for someone to work in the role of an LMSW without a license to gain the experience needed to become an LCSW.

- **Origin of Proposal** **___ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This proposal will eliminate a loophole for an unlicensed person with a social work degree from working in the role of an LMSW without a license

Sec. 20-195q. Use of title. Certain activities not prohibited. (a) No person shall (1) use the title "licensed master social worker" or any initials associated with such title, or (2) advertise services under the description of a licensed master social worker, as defined in section 20-195m, unless such person is licensed as a master social worker pursuant to this chapter.

(b) No person shall (1) use the title “licensed clinical social worker” or any initials associated with such title, or (2) advertise services under the description of a licensed clinical social worker, as defined in section 20-195m, unless such person is licensed as a clinical social worker pursuant to this chapter.

(c) Nothing in this section shall prohibit: (1) A student enrolled in a doctoral or master’s degree program accredited by the Council on Social Work Education from performing such work as is incidental to his course of study, provided such person is designated by a title which clearly indicates his status as a student; [(2) a person holding a doctoral or master’s degree from a program accredited by the Council on Social Work Education from gaining social work experience under professional supervision, provided such activities are necessary to satisfy the work experience required by section 20-195n and such person is designated as “social work intern”, “social work trainee” or other title clearly indicating the status appropriate to his level of training;] [(3)] (2) a person licensed or certified in this state in a field other than clinical social work from practicing within the scope of such license or certification; [(4)] (3) a person enrolled in an educational program or fulfilling other state requirements leading to licensure or certification in a field other than social work from engaging in work in such other field; [(5)] (4) a person who is employed or retained as a social work designee, social worker, or social work consultant by a nursing home or rest home licensed under section 19a-490 and who meets the qualifications prescribed by the department in its regulations from performing the duties required of them in accordance with state and federal laws governing those duties; [(6)] (5) for the period from October 1, 2010, to October 1, 2013, inclusive, a master social worker from engaging in independent practice; [(7)] (6) a social worker from practicing community organization, policy and planning, research or administration that does not include engaging in clinical social work or supervising a social worker engaged in clinical treatment with clients; and [(8)] (7) individuals with a baccalaureate degree in social work from a Council on Social Work Education accredited program from performing nonclinical social work functions.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

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Lead agency division requesting this proposal:
Office of Health Care Access

Agency Analyst/Drafter of Proposal:
Kimberly Martone

Title of Proposal
An Act Concerning Various Revisions To The Office of Health Care Access Statutes

Statutory Reference
Section 1: 19a-486d. Sale of nonprofit hospitals: Disapproval by commissioner. Powers of commissioner
Section 2: P.A. 15-146 (Section 29)
Section 3: P.A. 15-146 (Section 39)
Section 4: 19a-638. Certificate of Need. When required and not required. Requests for office determination. Policies, procedures and reglations.
Section 5: 19a-508c. Hospital and health system facility fees charged for outpatient services at hospital-based facilities. Notice.
Section 6: 19a-486i. Definitions. Notice to the Attorney General of certain mergers, acquitions and other transactions. Report.
Section 7: 19a-632. Calculation of assessment and costs.
Section 8: 19a-632a. Payment of assessment by electronic funds transfer.
Section 9: 19a-634. State-wide health care facility utilization study. State-wide health care facilities and services plan. Inventory of health care facilities, equipment and services.
Section 10. 19a-639a. Certificate of need application process. Issuance of decision. Public Hearings. Policies, procedures and regulations.
Section 11. 19a-653. Failure to file data or information. Civil penalty. Notice. Extension. Hearing. Appeal. Deduction from Medicaid payments.
Section 12. 19a-673a. Repeal

Proposal Summary
Sec. 1. The proposed change will expand and clarify the payment process for the purchaser of a nonprofit hospital for purposes of OHCA hiring a consultant to assist in processing the CON application.
Sec. 2. The proposed change will expand and clarify the payment process for the purchaser of a nonprofit hospital with respect to OHCA hiring a consultant to conduct a cost and market impact review.
Sec. 3. The proposed change will eliminate the exception for replacement of imaging equipment (see Sec. 4).
Sec. 4. The proposed change will add the language eliminated in Sec. 3 to the CON exceptions currently included in subsection (b) of 19a-638.
Sec. 5. The proposed change adds language to avoid the filing of patient-specific information with the office.
Sec. 6. The proposed change clarifies that the term hospital is the same as defined by 19a-646(a)(3).
Secs. 7 and 8. The proposed change extends the late fee period for late assessment payments.
Sec. 9. The proposed change removes the mandate that OHCA develop an inventory questionnaire to obtain certain information and also combines the statewide healthcare facilities and services plan and the utilization study into one report.
Sec. 10. The proposed change eliminates the need for OHCA to draft regulations regarding hospital debt

collections.
Sec. 11. The proposed change increases the CON application fee from $500 to $1,000.
Sec. 12. The proposed change changes the standard for imposing a civil penalty from willful to negligent.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Sec. 1. Pursuant to 19a-486d, OHCA may contract with a consultant to assist in the processing of any CON application pertaining to the sale of a nonprofit hospital to a for-profit entity. The current wording of 19a-486d provides that the purchaser of the hospital is required to pay for the costs of the consultant. However, it does not establish a procedure for ensuring payment to the consultant. In an effort to provide payment assurance to the consultant, OHCA is proposing that the purchaser be required to establish and fund an escrow account upon the filing of its CON application with each of the consultant's bills paid out of the escrow account.

Sec. 2. Pursuant to section 29 of P.A. 15-146, OHCA must contract with a consultant to perfume a cost and market impact review for any CON application pertaining to the sale of a nonprofit hospital. The current language provides that the purchaser of the hospital is required to pay for the costs of the consultant. However, it does not establish a procedure for ensuring payment to the consultant. In an effort to provide payment assurance to the consultant, OHCA is proposing that the purchaser be required to establish and fund an escrow account upon the filing of its CON application with each of the consultant's bills paid out of the escrow account.

Secs. 3 and 4. Section 39 of P.A. 15-146 added an exception to subsection (a) of 19a-638 for the replacement of imaging equipment. However, exceptions to CON requirements are contained in subsection (b) or 19a-638. Therefore, section 3 proposes the removal of the exception language from subsection (a) of 19a-638 and section 4 adds the exception language to subsection (b) of 19a-638, where the other exceptions are located. In addition to the relocation, the proposed change clarifies that a piece of imaging equipment may be replaced with any other type of imaging equipment, as enumerated in subdivision (10) of subsection (a) of 19a-639, without CON review. Adding this exception as proposed will also require the person relocating the imaging equipment to notify OHCA of its relocation. This will assist OHCA in maintaining an accurate inventory of imaging equipment within the State.

Sec. 5. Section 19a-508c, as amended by P.A. 15-146 requires notice to patients regarding the imposition of facility fees. A copy of such notice must be filed with OHCA to be posted on OHCA's website. The proposed change specifies that the notice should be worded in a general manner and not specify any individual patient. This will avoid duplicate notices being filed with OHCA as well as eliminate the possibility of patient specific information being published on OHCA's website.

Sec. 6. Currently, OHCA receives certain information and reports certain information on 28 hospitals as defined in Section 19a-646(a)(3) of the Connecticut General Statutes. The change included in section 6 clarifies that only the hospitals currently reviewed by OHCA, as defined by 19a-646(a)(3), have to submit the required report. Additionally, section 6 allows for certain reports to be provided by January 15th of each year since the reporting is for the prior calendar year. This will allow for complete reporting on the previous year.

Secs. 7 and 8. The change in section 7 lengthens the two percent late fee period from five to seven days in order to provide OHCA an increase in time to provide notification to hospitals who have not remitted their

payment by the assessment due date. The Department of Public Health Fiscal Services Department (DPH-Fiscal) receives notification of hospital assessment payment transmittals from the State of Connecticut Office of the State Treasurer (OTST). DPH-Fiscal notifies OHCA of the delinquency and in turn, OHCA must provide notification to the hospital(s). The turnaround time for notification between OTST and DPH-Fiscal can take as much as three or more days affording OHCA very little time in providing notification to delinquent hospitals for the two percent late fee period which currently is only five days. OHCA has experienced some hospitals making their payment by the first five day late fee period (a 2% penalty) but OHCA has already notified the hospitals that they owe a 5% percent late fee penalty. The proposed change should alleviate these timing problems.

Sec. 9. The proposed change included in section 9 removes the mandate that OHCA develop an inventory questionnaire to obtain certain information. Instead, the proposed change allows OHCA more flexibility in the form being used to collect the information without actually eliminating the task of collecting the information. Additionally, OHCA proposes changing the frequency of collecting the information from biennially to every three years. Some of the information collected in the inventory questionnaire is collected by OHCA via other resources at various times of the year. As a result, OHCA has found that performing an inventory biennially is too frequent. Moreover, the proposed changes will combine the statewide healthcare facilities and services plan and the utilization study into one report since the utilization information is currently being presented in the statewide healthcare facilities and services plan and this will eliminate the redundancy of the reports published by OHCA.

Sec. 10. Connecticut's debt collection statutes are detailed with respect to the requirements and limitations on debt collection. Moreover, there are no specific standards in place for debt collections specific to hospitals. Therefore, section 10 eliminates the need for OHCA to draft regulations regarding hospital debt collections.

Sec. 11. Recently, OHCA has been tasked with an expansion of its statutory authority thereby increasing its workload. Moreover, OHCA has seen a reduction in staff with no increase expected. Section 11 proposes an increase in the CON application filing fee so that a certain portion of that fee can be utilized directly by OHCA for the expenses related to additional staff resources, including outside resources.

Sec. 12. Over the past several years OHCA has issued several notices of its intent to impose a civil penalty for the failure of a health care facility to file a CON. These matters have come before OHCA for hearing purposes and each time the civil penalty was waived due to OHCA's inability to establish a willful motive on the part of the health care facility. It has been OHCA's experience that a health care facility can overcome the willful standard simply by stating under oath that it did not intend to usurp the CON process. While OHCA has no reason to doubt the health care facilities' truth and veracity, it believes the standard should be lessened so as to impart the seriousness of filing CON applications and data in a timely fashion.

- **Origin of Proposal _X__ New Proposal ___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Section 19a-486d of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner shall deny an application filed pursuant to subsection (d) of section 19a-486a unless the commissioner finds that: (1) The affected community will be assured of

continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing; (2) in a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (3) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral; and (4) certificate of need authorization is justified in accordance with chapter 368z. The commissioner may contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The commissioner shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. Upon the filing of an application pursuant to subsection (d) of section 19a-486a, the purchaser shall establish an escrow account, established pursuant to a formal escrow agreement provided by the office, for the purpose of paying the bills submitted by the commissioner. The purchaser shall initially fund the escrow account with one hundred fifty thousand dollars. The [purchaser] escrow agent shall pay such bills out of the escrow account, directly to the consultant or legal expert, no later than thirty days after the date of receipt of [such] each bill[s] by the purchaser.

(b) The commissioner may, during the course of a review required by this section: (1) Issue in writing and cause to be served upon any person, by subpoena, a demand that such person appear before the commissioner and give testimony or produce documents as to any matters relevant to the scope of the review; and (2) issue written interrogatories, to be answered under oath, as to any matters relevant to the scope of the review and prescribing a return date that would allow a reasonable time to respond. If any person fails to comply with the provisions of this subsection, the commissioner, through the Attorney General, may apply to the superior court for the judicial district of Hartford seeking enforcement of such subpoena. The superior court may, upon notice to such person, issue and cause to be served an order requiring compliance. Service of subpoenas ad testificandum, subpoenas duces tecum, notices of deposition and written interrogatories as provided in this subsection may be made by personal service at the usual place of abode or by certified mail, return receipt requested, addressed to the person to be served at such person's principal place of business within or without this state or such person's residence.

Section 2 Section XXX of the general statutes is repealed and the following is substituted in lieu thereof:

Commented [KJ1]: This was a new section in 2015 need to add section # in when codified in January

(a) The Office of Healthcare Access division within the Department of Public Health shall conduct a cost and market impact review in each case where (1) an application for a certificate of need filed pursuant to section 19a-638 of the general statutes, as amended by this act, involves the transfer of ownership of a hospital, as defined in section 19a-639 of the general statutes, as amended by this act, and (2) the purchaser is a hospital, as defined in section 19a-490 of the general statutes, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars,

or a hospital system, as defined in section 19a-486i of the general statutes, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or any person that is organized or operated for profit.

(b) Not later than twenty-one days after receipt of a properly filed certificate of need application involving the transfer of ownership of a hospital filed on or after December 1, 2015, as described in subsection (a) of this section, the office shall initiate such cost and market impact review by sending the transacting parties a written notice that shall contain a description of the basis for the cost and market impact review as well as a request for information and documents. Not later than thirty days after receipt of such notice, the transacting parties shall submit to the office a written response. Such response shall include, but need not be limited to, any information or documents requested by the office concerning the transfer of ownership of the hospital. The office shall have the powers with respect to the cost and market impact review as provided in section 19a-633 of the general statutes.

(c) The office shall keep confidential all nonpublic information and documents obtained pursuant to this section and shall not disclose the information or documents to any person without the consent of the person that produced the information or documents, except in a preliminary report or final report issued in accordance with this section if the office believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such information and documents shall not be deemed a public record, under section 1-210 of the general statutes, and shall be exempt from disclosure.

(d) The cost and market impact review conducted pursuant to this section shall examine factors relating to the businesses and relative market positions of the transacting parties as defined in subsection (d) of section 19a-639 of the general statutes, as amended by this act, and may include, but need not be limited to: (1) The transacting parties' size and market share within its primary service area, by major service category and within its dispersed service areas; (2) the transacting parties' prices for services, including the transacting parties' relative prices compared to other health care providers for the same services in the same market; (3) the transacting parties' health status adjusted total medical expense, including the transacting parties' health status adjusted total medical expense compared to that of similar health care providers; (4) the quality of the services provided by the transacting parties, including patient experience; (5) the transacting parties' cost and cost trends in comparison to total health care expenditures state wide; (6) the availability and accessibility of services similar to those provided by each transacting party, or proposed to be provided as a result of the transfer of ownership of a hospital within each transacting party's primary service areas and dispersed service areas; (7) the impact of the proposed transfer of ownership of the hospital on competing options for the delivery of health care services within each transacting party's primary service area and dispersed service area including the impact on existing service providers; (8) the methods used by the transacting parties to attract patient volume and to recruit or acquire health care professionals or facilities; (9) the role of each transacting party in

serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within each transacting party's primary service area and dispersed service area; (10) the role of each transacting party in providing low margin or negative margin services within each transacting party's primary service area and dispersed service area; (11) consumer concerns, including, but not limited to, complaints or other allegations that a transacting party has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (12) any other factors that the office determines to be in the public interest.

(e) Not later than ninety days after the office determines that there is substantial compliance with any request for documents or information issued by the office in accordance with this section, or a later date set by mutual agreement of the office and the transacting parties, the office shall make factual findings and issue a preliminary report on the cost and market impact review. Such preliminary report shall include, but shall not be limited to, an indication as to whether a transacting party meets the following criteria: (1) Currently has or, following the proposed transfer of operations of the hospital, is likely to have a dominant market share for the services the transacting party provides; and (2) (A) currently charges or, following the proposed transfer of operations of the hospital, is likely to charge prices for services that are materially higher than the median prices charged by all other health care providers for the same services in the same market, or (B) currently has or, following the proposed transfer of operations of a hospital, is likely to have a health status adjusted total medical expense that is materially higher than the median total medical expense for all other health care providers for the same service in the same market.

(f) The transacting parties that are the subject of the cost and market impact review may respond in writing to the findings in the preliminary report issued in accordance with subsection (e) of this section not later than thirty days after the issuance of the preliminary report. Not later than sixty days after the issuance of the preliminary report, the office shall issue a final report of the cost and market impact review. The office shall refer to the Attorney General any final report on any proposed transfer of ownership that meets the criteria described in subsection (e) of this section.

(g) Nothing in this section shall prohibit a transfer of ownership of a hospital, provided any such proposed transfer shall not be completed (1) less than thirty days after the office has issued a final report on a cost and market impact review, if such review is required, or (2) while any action brought by the Attorney General pursuant to subsection (h) of this section is pending and before a final judgment on such action is issued by a court of competent jurisdiction.

(h) After the office refers a final report on a transfer of ownership of a hospital to the Attorney General under subsection (f) of this section, the Attorney General may: (1) Conduct an investigation to determine whether the transacting parties engaged, or, as a result of completing the transfer of ownership of the hospital, are expected to engage in unfair methods of competition, anti-competitive behavior or other conduct in violation of chapter 624 or 735a of the general statutes or any other state or federal law; and (2) if appropriate, take action

under chapter 624 or 735a of the general statutes or any other state law to protect consumers in the health care market. The office's final report may be evidence in any such action.

(i) For the purposes of this section, the provisions of chapter 735a of the general statutes may be directly enforced by the Attorney General. Nothing in this section shall be construed to modify, impair or supersede the operation of any state antitrust law or otherwise limit the authority of the Attorney General to (1) take any action against a transacting party as authorized by any law, or (2) protect consumers in the health care market under any law. Notwithstanding subdivision (1) of subsection (a) of section 42-110c of the general statutes, the transacting parties shall be subject to chapter 735a of the general statutes.

(j) The office shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. The office shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639 of the general statutes, as amended by this act. Upon the filing of an application involving the transfer of ownership of a hospital, the purchaser shall establish an escrow account, established pursuant to a formal escrow agreement provided by the office, for the purpose of paying the bills for the independent consultant. The purchaser shall initially fund the escrow account with two hundred thousand dollars. [Such]The [purchaser] escrow agent shall pay such bills out of the escrow account, directly to the independent consultant, not later than thirty days after receipt of each bill by the purchaser. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57 of the general statutes, sections 4-212 to 4-219, inclusive, of the general statutes and section 4e-19 of the general statutes shall not apply to any agreement executed pursuant to this subsection.

(k) Any employee of the office who directly oversees or assists in conducting a cost and market impact review shall not take part in factual deliberations or the issuance of a preliminary or final decision on the certificate of need application concerning the transfer of ownership of a hospital that is the subject of such cost and market impact review.

(l) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, concerning cost and market impact reviews and to administer the provisions of this section. Such regulations shall include definitions of the following terms: "Dispersed service area", "health status adjusted total medical expense", "major service category", "relative prices", "total health care spending" and "health care services". The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner publishes notice of intention to adopt the regulations on the Department of Public Health's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Section 3. Subdivision (10) of subsection (a) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof:

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except (A) as provided for in subdivision (22) of subsection (b) of this section[, and (B) a certificate of need issued by the office shall not be required where such scanner is a replacement for a scanner that was previously acquired through certificate of need approval or a certificate of need determination];

Section 4 Section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) A certificate of need issued by the office shall be required for:

(1) The establishment of a new health care facility;

(2) A transfer of ownership of a health care facility;

(3) A transfer of ownership of a group practice to any entity other than a physician or group of physicians, except when the parties have signed a sale agreement to transfer such ownership on or before September 1, 2014;

(4) The establishment of a freestanding emergency department;

(5) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;

(6) The establishment of an outpatient surgical facility, as defined in section 19a-493b, or as established by a short-term acute care general hospital;

(7) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(8) The termination of an emergency department by a short-term acute care general hospital;

(9) The establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except as provided for in subdivision (22) of subsection (b) of this section;

(11) The acquisition of nonhospital based linear accelerators;

(12) An increase in the licensed bed capacity of a health care facility;

(13) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(14) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, or by a short-term acute care general hospital; and

(15) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended.

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, nursing homes and rest homes, as defined in subsection (c) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490;

(6) Home health agencies, as defined in section 19a-490;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630;

(12) School-based health centers, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment with any other type of imaging equipment, as identified in subdivision (10) of subsection (a) of this section, if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the office of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license; or

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans.

(c) (1) Any person, health care facility or institution that is unsure whether a certificate of need is required under this section, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c shall send a letter to the office that describes the project and requests that the office make a determination as to whether a certificate of need is required. In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c. A person, health care facility or institution making such request shall provide the office with any information the office requests as part of its determination process.

(d) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. Final regulations shall be adopted by December 31, 2011.

Section 5. Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Affiliated provider" means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school, as defined in section 33-182aa, that is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member;

(2) "Campus" means: (A) The physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(5) "Hospital" has the same meaning as provided in section 19a-490;

(6) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

(7) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility; and

(8) "Provider" means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services.

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider;

(2) (A) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) On and after January 1, 2016, each billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the Medicare facility fee reimbursement rate for the same service as a comparison; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the

patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction.

[(d)**]** (e) The written notice described in subsections (b) **[**and (c)**]** to (d), inclusive, and (h) to (j), inclusive, of this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges.

[(e)**]** (f) (1) For nonemergency care, if a patient's appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

[(f)**]** (g) Subsections (b) to **[**(e)**]** (f), inclusive, of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

[(g)**]** (h) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting areas, stating that: (1) The hospital-based facility is part of a hospital or health system, and (2) if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based.

[(h)**]** (i) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.

(j) (1) On and after January 1, 2016, if any transaction, as described in subsection (c) of section 19a-486i, as amended by this act, results in the establishment of a hospital-based facility at which facility fees will likely be billed, the hospital or health system, that is the purchaser in such transaction shall, not later than thirty days after such transaction, provide written notice, by first class mail, of the transaction to each patient served within the previous three years by the health care facility that has been purchased as part of such transaction.

(2) Such notice should be worded to be general in nature and not specific to the individual patient and shall include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is part of a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that is the purchaser of the health care facility;

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility;

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

(F) A statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

(3) A copy of the written notice, which is general in nature and not specific to any patient, in accordance with this subsection shall be filed with the Office of Health Care Access. Said office shall post a link to such notice on its Internet web site.

(4) A hospital, health system or hospital-based facility shall not collect a facility fee for services provided at a hospital-based facility that is subject to the provisions of this subsection from the date of the transaction until at least thirty days after the written notice required pursuant to this subsection is mailed to the patient or a copy of such notice is filed with the Office of Health Care Access, whichever is later. A violation of this subsection shall be considered an unfair trade practice pursuant to section 42-110b.

(k) Notwithstanding the provisions of this section, on and after January 1, 2017, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department, located off-site from a hospital campus, or (2) outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.

(l) (1) Each hospital, as defined in Section 19a-646(a)(3) of the Connecticut General Statutes, and their affiliated [and] health system shall report not later than July 1, 2016, and annually

thereafter to the Commissioner of Public Health concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and location of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by Medicare, Medicaid or under private insurance policies, (D) for each facility, the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee revenue and, for each such procedure or service, the total amount of revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures for which facility fees are charged based on patient volume. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

(2) The commissioner shall publish the information reported pursuant to subdivision (1) of this subsection, or post a link to such information, on the Internet web site of the Office of Health Care Access.

Section 6 Section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Affiliation" means the formation of a relationship between two or more entities that permits the entities to negotiate jointly with third parties over rates for professional medical services;

(2) "Captive professional entity" means a professional corporation, limited liability company or other entity formed to render professional services in which a beneficial owner is a physician employed by or otherwise designated by a hospital or hospital system;

(3) "Hospital" has the same meaning as provided in section 19a-490;

(4) "Hospital system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance or membership, or (B) a hospital and any entity affiliated with such hospital through ownership, governance or membership;

(5) "Health care provider" has the same meaning as provided in section 19a-17b;

(6) "Medical foundation" means a medical foundation formed under chapter 594b;

(7) "Physician" has the same meaning as provided in section 20-13a;

(8) "Person" has the same meaning as provided in section 35-25;

(9) "Professional corporation" has the same meaning as provided in section 33-182a;

(10) "Group practice" means two or more physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care,

consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians; and

(11) "Primary service area" means the smallest number of zip codes from which the group practice draws at least seventy-five per cent of its patients.

(b) At the same time that any person conducting business in this state that files merger, acquisition or any other information regarding market concentration with the Federal Trade Commission or the United States Department of Justice, in compliance with the Hart-Scott-Rodino Antitrust Improvements Act, 15 USC 18a, where a hospital, hospital system or other health care provider is a party to the merger or acquisition that is the subject of such information, such person shall provide written notification to the Attorney General of such filing and, upon the request of the Attorney General, provide a copy of such merger, acquisition or other information.

(c) Not less than thirty days prior to the effective date of any transaction that results in a material change to the business or corporate structure of a group practice, the parties to the transaction shall submit written notice to the Attorney General of such material change. For purposes of this subsection, a material change to the business or corporate structure of a group practice includes: (1) The merger, consolidation or other affiliation of a group practice with (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (2) the acquisition of all or substantially all of (A) the properties and assets of a group practice, or (B) the capital stock, membership interests or other equity interests of a group practice by (i) another group practice that results in a group practice comprised of eight or more physicians, or (ii) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (3) the employment of all or substantially all of the physicians of a group practice by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system; and (4) the acquisition of one or more insolvent group practices by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system.

(d) (1) The written notice required under subsection (c) of this section shall identify each party to the transaction and describe the material change as of the date of such notice to the business or corporate structure of the group practice, including: [(1)] (A) A description of the nature of the proposed relationship among the parties to the proposed transaction; [(2)] (B) the names and specialties of each physician that is a member of the group practice that is the subject of the proposed transaction and who will practice medicine with the resulting group practice, hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by, or otherwise affiliated with such hospital or hospital system following the effective date of the transaction; [(3)] (C) the names of the business entities that are to provide services following the effective date of the transaction; [(4)] (D) the address for each location where such services are to be provided; [(5)] (E) a description of the services to be provided at each such location; and [(6)] (F) the primary service area to be served by each such location.

(2) Not later than thirty days after the effective date of any transaction described in subsection (c) of this section, the parties to the transaction shall submit written notice to the Commissioner of Public Health. Such written notice shall include, but need not be limited to, the same information described in subdivision (1) of this subsection. The commissioner shall post a link to such notice on the Department of Public Health's Internet web site.

(e) Not less than thirty days prior to the effective date of any transaction that results in an affiliation between one hospital or hospital system and another hospital or hospital system, the parties to the affiliation shall submit written notice to the Attorney General of such affiliation. Such written notice shall identify each party to the affiliation and describe the affiliation as of the date of such notice, including: (1) A description of the nature of the proposed relationship among the parties to the affiliation; (2) the names of the business entities that are to provide services following the effective date of the affiliation; (3) the address for each location where such services are to be provided; (4) a description of the services to be provided at each such location; and (5) the primary service area to be served by each such location.

[(e)] (f) Written information submitted to the Attorney General pursuant to subsections (b) to [(d)] (e), inclusive, of this section shall be maintained and used by the Attorney General in the same manner as provided in section 35-42.

[(f)**]** (g) Not later than December 31, 2014, and annually thereafter by January 15th, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

[(g)**]** (h) Not later than December 31, 2014, and annually thereafter by January 15th, each group practice comprised of thirty or more physicians that is not the subject of a report filed under subsection **[**(f)**]** (g) of this section shall file with the Attorney General and the Commissioner of Public Health a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

(i) Not later than December 31, 2015, and annually thereafter by January 15th, each hospital , as defined in Section 19a-646(a)(3) of the Connecticut General Statutes and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

Section 7. Section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) On or before September first, annually, the Office of Health Care Access shall determine (1) the total net revenue of each hospital for the most recently completed hospital fiscal year beginning October first; and (2) the proposed assessment on the hospital for the state fiscal year. The assessment on each hospital shall be calculated by multiplying the hospital's percentage share of the total net revenue specified in subdivision (1) of this subsection times the costs of the office, as determined in subsection (b) of this section.

(b) The costs of the office shall be the total of (1) the amount appropriated for expenses for the operation of the office for the fiscal year, as estimated by the Comptroller, (2) the cost of fringe benefits for office personnel for such year, as estimated by the Comptroller, (3) the amount of expenses for central state services attributable to the office for the fiscal year as estimated by the Comptroller, and (4) the estimated expenditures on behalf of the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, provided for purposes of this calculation the amount of expenses for the operation of the office for the fiscal year as estimated by the Comptroller, plus the cost of fringe benefits for personnel, the amount of expenses for said central state services for the fiscal year as estimated by the Comptroller, and said estimated expenditures from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the office.

(c) On or before December thirty-first, annually, for each fiscal year, each hospital shall pay the office twenty-five per cent of its proposed assessment, adjusted to reflect any credit or amount due under the recalculated assessment for the preceding state fiscal year as determined pursuant to subsection (d) of this section or any reapportioned assessment pursuant to subsection (b) of section 19a-631. The hospital shall pay the remaining seventy-five per cent of its assessment to the office in three equal installments on or before the following March thirty-first, June thirtieth and September thirtieth, annually.

(d) Immediately following the close of each state fiscal year the commissioner shall recalculate the proposed assessment for each hospital based on the costs of the office in accordance with subsection (b) of this section using the actual expenditures made by the office during that fiscal year and the actual expenditures made on behalf of the office from the Capital Equipment Purchase Fund pursuant to section 4a-9. On or before August thirty-first, annually, the office shall render to each hospital a statement showing the difference between the respective recalculated assessment and the amount previously paid. On or before September thirtieth, the commissioner, after receiving any objections to such statements, shall make such adjustments which in said commissioner's opinion may be indicated and shall render an adjusted assessment, if any, to the affected hospitals. Adjustments to reflect any credit or amount due under the recalculated assessment for the previous state fiscal year shall be made to the proposed assessment due on or before December thirty-first of the following state fiscal year.

(e) If any assessment is not paid when due, the commissioner shall impose a fee equal to (1) two per cent of the assessment if such failure to pay is for not more than [five]seven days, (2) five per cent of the assessment if such failure to pay is for more than [five]seven days but not more than fifteen days, or (3) ten per cent of the assessment if such failure to pay is for more than fifteen days. If a hospital fails to pay any assessment for more than thirty days after the date when due, the commissioner may, in addition to the fees imposed pursuant to this subsection, impose a civil penalty of up to one thousand dollars per day for each day past the initial thirty days that the assessment is not paid. Any civil penalty authorized by this subsection shall be imposed by the commissioner in accordance with subsections (b) to (e), inclusive, of section 19a-653.

(f) The office shall deposit all payments received pursuant to this section with the State Treasurer. The moneys so deposited shall be credited to the General Fund and shall be accounted for as expenses recovered from hospitals.

Section 8. Section 19a-632a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) For purposes of this section, "electronic funds transfer" has the same meaning as provided in section 12-685.

(b) The Department of Public Health may require a hospital to pay an assessment levied pursuant to section 19a-632 by way of an approved method of electronic funds transfer.

(c) A hospital making an electronic funds transfer pursuant to this section shall initiate such transfer in a timely fashion to ensure that a bank account designated by the department is credited by electronic funds transfer for the amount of the assessment required to be made by such method on or before the date such assessment is due.

(d) Where an assessment is required to be made by electronic funds transfer, any payment made by a method other than electronic funds transfer shall be treated as an assessment not made in a timely manner, and any payment made by electronic funds transfer, where the bank account designated by the department is not credited for the amount of the assessment on or before the date such assessment is due, shall be treated as an assessment not made in a timely manner. Any assessment treated under this subsection as an assessment not made in a timely manner shall be subject to a penalty in accordance with subsection (e) of this section.

(e) Where any assessment is treated under subsection (d) of this section as an assessment not made in a timely manner because it is made by means other than electronic funds transfer, there shall be imposed a penalty equal to ten per cent of the assessment required to be made by electronic funds transfer. Where any assessment made by electronic funds transfer is treated under subsection (d) of this section as an assessment not made in a timely manner because the bank account designated by the department is not credited by electronic funds transfer for the amount of the assessment on or before the date such assessment is due, there shall be imposed a penalty equal to (1) two per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for not more than [five]seven days; (2) five per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than [five]seven days but not more than fifteen days; or (3) ten per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than fifteen days.

(f) The department shall deposit all payments received pursuant to this section with the State Treasurer. The moneys so deposited shall be credited to the General Fund and shall be accounted for as expenses recovered from hospitals.

Section 9. Section 19a-634 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) [The Office of Health Care Access shall conduct, on a biennial basis, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing

committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b)] The [office] Office of Health Care Access, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection 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 health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The state-wide health care facilities and services plan shall include a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities and services plan not less than once every two years.

[(c)](b) For purposes of conducting the[the state-wide health care facility utilization study and] state-wide health care facilities and services plan and the state-wide health care facility utilization study, the office shall establish and maintain an inventory of all health care facilities, the equipment identified in subdivisions (9) and (10) of subsection (a) of section 19a-638, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638. The office [shall develop]may utilize an inventory questionnaire to obtain the following information: (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 or scans performed in a calendar year. The inventory shall be completed [biennially]every three years by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data.

Section 10. Section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) An application for a certificate of need shall be filed with the office in accordance with the provisions of this section and any regulations adopted by the Department of Public Health. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee of [five hundred] one thousand dollars. Five hundred dollars of each application fee shall be credited to the office's account, and be available for expenditure by the office for the expenses of internal and external staff resources.

(b) Prior to the filing of a certificate of need application, the applicant shall publish notice that an application is to be submitted to the office in a newspaper having a substantial circulation in the area where the project is to be located. Such notice shall (1) be published (A) not later than twenty days prior to the date of filing of the certificate of need application, and (B) for not less than three consecutive days, and (2) contain a brief description of the nature of the project and the street address where the project is to be located. An applicant shall file the certificate of need application with the office not later than ninety days after publishing notice of the application in accordance with the provisions of this subsection. The office shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

(c) Not later than five business days after receipt of a properly filed certificate of need application, the office shall publish notice of the application on its web site. Not later than thirty days after the date of filing of the application, the office may request such additional information as the office determines necessary to complete the application. The applicant shall, not later than sixty days after the date of the office's request, submit the requested information to the office. If an applicant fails to submit the requested information to the office within the sixty-day period, the office shall consider the application to have been withdrawn.

(d) Upon determining that an application is complete, the office shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the department. In addition, the office shall post such notice on its web site. The date on which the office posts such notice on its web site shall begin the review period. Except as provided in this subsection, (1) the review period for a completed application shall be ninety days from the date on which the office posts such notice on its web site; and (2) the office shall issue a decision on a completed application prior to the expiration of the ninety-day review period. The review period for a completed application that involves a transfer of a group practice, as described in subdivision (3) of subsection (a) of section 19a-638, when the offer was made in response to a request for proposal or similar voluntary offer for sale shall be sixty days from the date on which the office posts notice on its web site. Upon request or for good cause shown, the office may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the office shall issue a decision on the completed application prior to the expiration of the extended review period. If the office holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this section, the office shall

issue a decision on the completed application not later than sixty days after the date the office closes the public hearing record.

(e) Except as provided in this subsection, the office shall hold a public hearing on a properly filed and completed certificate of need application if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the application. For a properly filed and completed certificate of need application involving a transfer of ownership of a group practice, as described in subdivision (3) of subsection (a) of section 19a-638, when an offer was made in response to a request for proposal or similar voluntary offer for sale, a public hearing shall be held if twenty-five or more individuals or an individual representing twenty-five or more people submits a request, in writing, that a public hearing be held on the application. Any request for a public hearing shall be made to the office not later than thirty days after the date the office determines the application to be complete.

(f) The office may hold a public hearing with respect to any certificate of need application submitted under this chapter. The office shall provide not less than two weeks' advance notice to the applicant, in writing, and to the public by publication in a newspaper having a substantial circulation in the area served by the health care facility or provider. In conducting its activities under this chapter, the office may hold hearing on applications of a similar nature at the same time.

(g) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. [Final regulations shall be adopted by December 31, 2011.]

Section 11. Section 19a-653 of the General Statutes is repealed and the following is substituted in lieu thereof:

(a) Any person or health care facility or institution that is required to file a certificate of need for any of the activities described in section 19a-638, and any person or health care facility or institution that is required to file data or information under any public or special act or under this chapter or sections 19a-486 to 19a-486h, inclusive, or any regulation adopted or order issued under this chapter or said sections, which [willfully] negligently fails to seek certificate of need approval for any of the activities described in section 19a-638 or to so file within prescribed time periods, shall be subject to a civil penalty of up to one thousand dollars a day for each day such person or health care facility or institution conducts any of the described activities without certificate of need approval as required by section 19a-638 or for each day such information is missing, incomplete or inaccurate. Any civil penalty authorized by this

section shall be imposed by the Department of Public Health in accordance with subsections (b) to (e), inclusive, of this section.

(b) If the Department of Public Health has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section or subsection (e) of section 19a-632, it shall notify the person or health care facility or institution by first-class mail or personal service. The notice shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the amount of the civil penalty or penalties to be imposed; (4) the initial date of the imposition of the penalty; and (5) a statement of the party's right to a hearing.

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days from the date of mailing of the notice to make written application to the office to request (1) a hearing to contest the imposition of the penalty, or (2) an extension of time to file the required data. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The Department of Public Health may grant an extension of time for filing the required data or mitigate or waive the penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

(d) A final order of the Department of Public Health assessing a civil penalty shall be subject to appeal as set forth in section 4-183 after a hearing before the office pursuant to subsection (c) of this section, except that any such appeal shall be taken to the superior court for the judicial district of New Britain. Such final order shall not be subject to appeal under any other provision of the general statutes. No challenge to any such final order shall be allowed as to any issue which could have been raised by an appeal of an earlier order, denial or other final decision by the Department of Public Health.

(e) If any person or health care facility or institution fails to pay any civil penalty under this section, after the assessment of such penalty has become final the amount of such penalty may be deducted from payments to such person or health care facility or institution from the Medicaid account.

Section 12. Section 19a-673a of the general statutes is repealed.

[**Sec. 19a-673a. Regulations re uniform debt collection standards for hospitals.** The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to establish uniform debt collection standards for hospitals.]

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal:
Population Health Statistics and Surveillance

Agency Analyst/Drafter of Proposal:
Lisa Kessler

Title of Proposal
An Act Concerning Who is Eligible to Marry

Statutory Reference 46b-20a Eligibility to marry

Proposal Summary

Fix the language so that a married couple cannot re-marry each other.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? ***Yes***
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? ***N/A***
(3) Have certain constituencies called for this action? ***No***
(4) What would happen if this was not enacted in law this session? ***Marriage record keeping in Connecticut will continue to be faulty.***

- **Origin of Proposal ___ New Proposal ___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None
State None
Federal None
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The laws regarding marriage were substantially changed in 2009 in order to accommodate same sex marriage. At that time, a new section was added to the marriage laws, C.G.S. section 46b-20a, regarding who was eligible to marry. Subdivision (1) of the law allows someone to marry if they are not already married or in a similar legally recognized relationship, unless the parties to the marriage will be the same as the parties to such other marriage or relationship. This means that the same couple may marry multiple times.

The law was likely written this way in order to overcome barriers that same sex couples encountered, and the varying rights that were granted to same sex couples from state to state. Though the law granted protections, it also created a system that fostered disorganized record keeping, and legal complications for marrying couples.

Following the recent Supreme Court decision that allows same sex couples to marry nationwide giving equal rights to all marrying couples, this provision is no longer as necessary, and the Department is proposing its repeal in order to improve marriage record keeping practices, and eliminate the potential legal complications that couples may encounter when determining the date of their marriage.

Subdivision (1) of Section 46b-20a of the general statutes is repealed and the following is substituted in lieu thereof:

A person is eligible to marry if such person is:

(1) Not a party to another marriage, or a relationship that provides substantially the same rights, benefits and responsibilities as a marriage, entered into in this state or another state or jurisdiction, unless the parties to the marriage will be the same as the parties to such other [marriage or] relationship;

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.Kennedy@ct.gov

Lead agency division requesting this proposal: Public Health Laboratory

Agency Analyst/Drafter of Proposal: Elise Kremer

Title of Proposal:
Integration of Newborn Screening at Public Health Laboratory

Statutory Reference:
CGS, 19a-55

Proposal Summary :
This proposal would provide for the integration of Cystic Fibrosis (CF) testing at the Public Health Laboratory (PHL). Currently, 66 disorders are screened for through the PHL's Newborn Screening (NBS) Laboratory program, and babies with a critical laboratory result that may be indicative of a disorder are triaged and tracked through the NBS Tracking program. A single disorder, CF, is screened for at Yale-New Haven Hospital and University of Connecticut Health Center (UCHC). This lack of integration for CF raises many concerns, some of which are documented in an independent assessment done jointly by the Centers for Disease Control and Prevention (CDC), the Association of Public Health Laboratories (APHL), and two state newborn screening directors (state subject matter experts) jointly nominated by CDC and APHL (see attached). This proposal would bring CF testing in-house at the PHL, and ensure that all babies are screened via a uniform methodology for a uniform panel of mutations and using uniform cut-off criteria, and are tracked via a consistent protocol to ensure definitive diagnosis and treatment.

A draft of legislative language is below.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:
(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Newborn screening (NBS) is a population-based public health program. Sound public policy dictates that the NBS program not be outsourced and fragmented, and that Department of Public Health (DPH) carry out all screening consistent with its current statutory responsibility for 66 disorders. DPH's program is a coordinated, integrated system of testing, tracking, diagnosis/treatment, and program evaluation. DPH is best positioned to deliver comprehensive, timely, and effective services. Each process within DPH's well-proven system adds value, contributing to an extraordinary level of quality assurance that is in the best interests of our newborns. Some of

these processes are:

- The birth hospital enters demographic data in DPH's electronic system for downloading to the PHL's NBS system. A bar code generated by the system is affixed to the sample for unique identification.
- DPH has worked with birthing hospitals to improve specimen transit time. As samples arrive at the PHL, the barcode is scanned, matching the sample to the electronic data. Testing can begin essentially immediately.
- PHL NBS Tracking staff monitors to ensure that a specimen is received for every infant identified in electronic submission. Electronic data are also cross-referenced against birth registry records. An on-line application is also available to birthing hospitals for their own tracking of specimen receipt at the PHL. Tracking to ensure that babies are not missed becomes even more important when the baby is pre-term, low birth weight, or ill, and may be transferred from the birthing hospital to another hospital for specialty care.
- PHL staff reviews each sample for acceptability. Unsatisfactory specimens (abraded, super-saturated, not enough specimen, expired specimen collection card) are reported to NBS Tracking staff. Tracking staff is responsible for ensuring that the appropriate care provider is notified and that a satisfactory specimen is collected and re-submitted. The unsatisfactory rate is currently approximately 1%, which equates to 375 such follow-ups per year.
- The PHL has a rigorous process for monitoring/ensuring Quality Control and Quality Assurance through Proficiency and Quality Control testing administered by the Centers for Disease Control Newborn Screening Department. This would allow for a uniform system for monitoring of the quality of the testing carried out for the various mutations for this disorder, which is not available under the current testing approach.
- Tracking staff ensures that each infant with a critical laboratory value that may indicate a disorder is triaged for definitive diagnosis and treatment. Tracking staff also actively follows up to collect data on treatment/interventions and outcomes.
- All data are reported, supporting the surveillance efforts of DPH programs and of the national repository of NBS data.

Consolidating Cystic Fibrosis (CF) testing at the PHL will maintain a NBS system which is seamlessly integrated to provide continuity among all services. Current problems will be eliminated, as follows:

- Collecting two samples, sent to two different laboratories. Hospitals will have one-stop shopping at the PHL. Only one specimen will need to be collected and submitted to one laboratory. All results will be reported on a single PHL test report. Simplifying the system for submitters will eliminate a significant source of errors. Additionally, collection of the second specimen currently exposes babies to an unnecessary repetition of an invasive and painful procedure during the vulnerable neonatal period.
- Inconsistency between Yale and UCHC in mutation screening panel. All infants will receive an identical level of screening in the PHL's program, with a uniform panel of mutations tested for all infants born in Connecticut. The PHL's mutation screening protocol will be based on the population-based CF validation study of Connecticut newborns that the PHL will conduct.
- Availability of data to support state and federal surveillance. Data from the testing institutions are not being reported to DPH or federal NBS data repositories, and are not available to support surveillance and other programmatic efforts.
- Tracking. Without resources devoted to active, intensive tracking, there is a grave risk that infants will be missed, either to screening itself or to follow-up when screening reveals a critical laboratory value that may be indicative of a disorder.

Through mandatory universal screening and follow-up diagnostic services, it is expected that approximately 12 newborns per year will be diagnosed with CF. Early identification of CF and early initiation of medical management improves growth over the short term and reduces infections. This reduction in morbidity in turn increases lifespan. Scientific evidence is mounting that newborn screening for CF does improve outcomes, as well as quality and length of life.

The necessary funds are already available to establish and maintain the needed infrastructure within the PHL. The current testing institutions are charging submitting hospitals at least $15 per infant tested. The PHL can provide a value-enhanced and more robust service for the same cost per infant. Increasing DPH's newborn

screening fee by $15 and dedicating the additional revenues to support the program would render DPH's fiscal note cost-neutral.

- **Origin of Proposal _X_ New Proposal ___ Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: University of Connecticut Health Center
Agency Contact (name, title, phone): N/A
Date Contacted: N/A

Repeated efforts to establish communication with UCHC over the years that this testing has been in place, and most recently to attempt to engage their participation in the CDC/APHL assessment, have been unsuccessful.

Approve of Proposal ___ YES ___NO ___Talks Ongoing N/A

Summary of Affected Agency's Comments
N/A

Will there need to be further negotiation? _X__ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

None

State

Staffing, equipment and testing supplies

Federal

None

Additional notes on fiscal impact

Currently, hospitals pay a fee to Yale or UCHC for this testing. It is proposed that this fee be added to the current

NBS fee of $98, to offset the costs of the CF program at the PHL.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

If enacted, this proposal would ensure that uniform policies and protocols are established for all NBS conducted in the PHL.

Section 19a-55 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581, a test for phenylketonuria and other metabolic diseases, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia, severe combined immunideficiency disease and such other tests for inborn errors of metabolism as shall be prescribed by the Department of Public Health. The tests shall be administered as soon after birth as is medically appropriate. If the mother has had an HIV-related test pursuant to section 19a-90 or 19a-593, the person responsible for testing under this section may omit an HIV-related test. The Commissioner of Public Health shall (1) administer the newborn screening program, (2) direct persons identified through the screening program to appropriate specialty centers for treatments, consistent with any applicable confidentiality requirements, and (3) set the fees to be charged to institutions to cover all expenses of the comprehensive screening program including testing, tracking and treatment. The fees to be charged pursuant to subdivision (3) of this subsection shall be set at a minimum of fifty-six dollars. The Commissioner of Public Health shall publish a list of all the abnormal conditions for which the department screens newborns under the newborn screening program, which shall include screening for amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-CoA dehydrogenase (MCAD).

(b) In addition to the testing requirements prescribed in subsection (a) of this section, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to (1) every such infant in its care a screening test for (A) cystic fibrosis, On or after January 1, 2017, the screening test for cystic fibrosis shall be conducted by the Department of Public Health and the administrative officer or other person in charge of each institution shall cause all specimens for such testing to be delivered to said department, together with a fee to be prescribed by said department, (B) [severe combined immunodeficiency

disease,] and [(C)] critical congenital heart disease, and (2) any newborn infant who fails a newborn hearing screening, as described in section 19a-59, a screening test for cytomegalovirus, provided such screening test shall be administered within available appropriations on and after January 1, 2016. Such screening tests shall be administered as soon after birth as is medically appropriate.

(c) On and after the occurrence of the following: (1) The development and validation of a reliable methodology for screening newborns for adrenoleukodystrophy using dried blood spots and quality assurance testing methodology for such test or the approval of a test for adrenoleukodystrophy using dried blood spots by the federal Food and Drug Administration; and (2) the availability of any necessary reagents for such test, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care a test for adrenoleukodystrophy.

(d) The administrative officer or other person in charge of each institution caring for newborn infants shall report any case of cytomegalovirus that is confirmed as a result of a screening test administered pursuant to subdivision (3) of subsection (b) of this section to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health.

(e) The provisions of this section shall not apply to any infant whose parents object to the test or treatment as being in conflict with their religious tenets and practice. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Agency Legislative Proposal - 2016 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
GRE will fill in

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Department of Public Health

Liaison: DeVaughn Ward/Jill Kentfield
Phone: (860) 509-7246/(860) 509-7280
E-mail: DeVaughn.ward@ct.gov/ jill.kentfield@ct.gov

Lead agency division requesting this proposal:
TB, HIV, STD, & Viral Hepatitis Program – HIV Prevention

Agency Analyst/Drafter of Proposal:
Gina D'Angelo

Title of Proposal
HIV Statutes and Regulations Proposed Changes 2016

Statutory Reference

1. ***Sec. 19a-124. Needle and syringe exchange programs.***
2. ***Sec. 19a-581. Definitions.***
3. ***Sec. 19a-582. General consent required for HIV-related testing. Counseling requirements. Exceptions.***
4. ***Sec. 19a-583. Limitations on disclosure of HIV-related information.***
5. ***Sec. 19a-593. Testing of pregnant women and newborns. Notification and documentation requirements.***
6. ***Repealers: 19a-54a, 19a-121a, 19a-124a,19a-594***

Proposal Summary

1. **Sec. 19a-124.**
   a. **Addition of Hepatitis C in addition to HIV because people who inject drugs are at risk for both.**
   b. **Addition of overdose prevention services. Addition of overdose prevention as a tool to save lives of those injecting or using opioids is a critical component of any program for people who inject drugs.**
   c. **Change to not limit services to the three cities with highest HIV incidence but also allow for programs in areas with high rates of injection drug use and overdose. Data reflects pockets of rural injection drug use in Connecticut and pockets of overdoses occurring in rural/suburban areas as well. Data can be provided upon request. By changing this statute DPH has more latitude to ensure services are funded where there is the greatest need.**
   d. **Removal of the number 30 in regards to the number of syringes in a starter pack for new clients so as to conform to the needs of the client.**
   e. **Changes to evaluation components to match current program criteria outlined in RFPs and contracts.**
2. **Sec. 19a-581. Adds a definition of Community-based HIV Testing Provider as a tester who conducts HIV testing in a non-clinical setting. DPH currently funds over 20 agencies to provide Outreach, HIV Testing and Linkage Services.**
3. **Sec. 19a-582.**
   a. **Adds a section that will align with the general consent law and allow outreach workers who conduct testing in community settings (vans, parks, bars, etc.) to obtain verbal rather than written consent and document such consent in a local use field on the HIV Test Form. The tester would still inform the person being tested about the test, testing procedure and testing method before**

obtaining verbal consent. However, the specific HIV consent form would be eliminated as it has been a barrier to testing in the field. Also, the forms are signed and collected and kept at organizations seemingly unnecessarily. The law requiring informed written consent was passed in a time when there was more stigma, discrimination and lawsuits over HIV testing and information. In addition, the HIV rapid test is a screening tool. Informed or general consent could be obtained for any preliminary positive result before drawing blood for a confirmatory lab test.

4. **Sec. 19a-583. Makes a technical change to Replace "HIV" with "AIDS Virus."**
5. **Sec. 19a-593. Add section (c) on reporting requirements for testing of newborns, previously found in Sec. 19a-594 because it is a better fit.**
6. **Repealers.**

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Section 1. Sec. 19a-124.

a. **Language should reflect current practice terminology.**
b. **Addition of language on Hepatitis C because injection drug users are at risk of contracting the virus and HIV and Hepatitis C programs and services are now integrated.**
c. **Addition of overdose prevention as these services are now integrated with HIV services for injection drug users.**
d. **Data suggests that areas outside of 3 major cities have high rates of injection drug use and overdose and would benefit from funding for services. Increases in drug abuse, injection, and opioid overdoses in suburban communities led to a study of injection drug users residing in suburban communities in Southwestern Connecticut. The study conducted by Dr. Robert Heimer at Yale, found that injectors' knowledge about HIV is poor and statistically no better than it is regarding either hepatitis or overdose, which differs from findings from studies of urban injectors in Connecticut. This suggests that the HIV-centric prevention messages targeted to urban injectors have failed to reach their suburban counterparts. Furthermore, individuals seem to have limited awareness of their HIV or hepatitis infection status. For Hepatitis C, serological testing revealed that almost half of those tested in the study had been infected. For Hepatitis B, one-fifth of those infected with remained carriers, and two in five injectors remained susceptible. Given the ease of Hepatitis transmission further epidemic spread is likely.**

Drug overdoses, another major cause of morbidity and mortality among drug injectors, were commonplace. Data on opioid poisonings suggest similar increases in drug abuse and injection drug use in Southwestern Connecticut suburbs. Between 1997 and 2007, 794 overdose deaths attributed to heroin or other opioids were reported in Fairfield and New Haven Counties. Approximately 40 % of these occurred among residents in 35 small cities and towns, with particularly high rates (>30 per 100,000 residents) in several smaller communities.

These data reveal an ongoing need for expansion to non-urban areas of a broad range of programs, especially those that incorporate approaches to promote safe injection, hepatitis testing and vaccination against HBV, and overdose prevention and response trainings.

In addition, programs in two Connecticut cities with high incidence of injection drug use, Willimantic and New London have expressed interest and need in implementing SSP programs. They are both currently doing so with limited resources and support because neither are located in one of the three cities with the highest incidence of HIV.

e. **Removal of the cap of 30 syringes distributed in starter packs for clients is based on a review of best practices. The New York City Department of Public Health and Mental Hygiene convened a**

group of experts on syringe exchange and published a report on best practices that confirmed the importance of not placing caps or limiting the number of syringes distributed. Access to syringes allow for secondary distribution which allows more injectors to have access to sterile equipment and lessens the opportunities for disease transmission, such as HIV and hepatitis C. One study out of Beth Israel Medical Center in New York found that 89% of the 131 Syringe Exchange Programs in the US that are known to the North American Syringe Exchange Network, allowed secondary exchange and 69% gave extra supplies to clients in 2007.
Changes to evaluation components in order to match current program criteria.

Section 2. Sec. 19a-581. Technical changes, language changes and changes in programs and services to match current practice.

Section 3. Sec. 19a-582. Allowing informed verbal consent that is documented rather than written consent for HIV testing (rapid screening) in outreach settings will eliminate barriers to testing imposed by doing paperwork in the field. In 2006, CDC revised HIV Testing Recommendations to eliminate the requirement for separate informed consent in healthcare settings. Guidelines on HIV Counseling, Testing, and Referral for persons at high risk for HIV who receive testing in nonclinical settings (e.g., at community-based organizations.) were set in 2001 and apply to Outreach, Testing and Linkage Programs funded by DPH. The following is the CDC language pertaining to consent: Obtain informed consent before HIV testing. Informed consent before HIV testing is essential. Information regarding consent may be presented orally or in writing and should use language the client can understand. Accepting or refusing testing must not have detrimental consequences to the quality of care offered. Documentation of informed consent should be in writing, preferably with the client's signature. State or local laws and regulations governing HIV testing should be followed. The DPH HIV Prevention Program proposes requiring funded HIV testers to document consent in a local use field on the HIV test form eliminating a separate signed/written consent form in the field.

Section 4. Sec. 19a-583. Technical change of outdated language.
Section 5. Sec. 19a-593. Section (c) on reporting requirements for testing of newborns was previously found in Sec. 19a-594, the rest of which is outdated and being suggested for Repeal.

<u>Section 6. Repealers</u>. Sec. 19a-54a. This registry does not exist in practice.
Sec. 19a-121a. This change will align this statute with the DPH's current RFP process. Local Health Departments are eligible to apply for funds through the same RFP process as other individuals and organizations under 19a-121. There is not a separate allotment of funds just for them.
Sec. 19a-124a. Program change. At the beginning of the program, vans were donated to Programs to initially start syringe services . With recent cuts to the HIV Preventions funds over the years, there is no longer funding to support the donation of vans and still support staff to operate their programs. Since the request for proposal for Syringe exchange services in 2012, all vans currently in operation with DPH funded contractors were purchased with program funds and part of the syringe services budget.
Sec. 19a-594. Program change. Due to prenatal and newborn screening laws enacted in 1999, there is no longer a need for an awareness campaign or funding to sustain one. These laws have led to the prevention of mother to child transmission in Connecticut. From 2008-2013, of the 218 babies born to HIV+ women in Connecticut; none of the newborns have been reported positive

- **Origin of Proposal** **_x__ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

These statutes/regulations will have programmatic or policy impact. The rest only involve technical or language changes.

Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care. The impact will be that all victims of sexual assault regardless of gender will be entitled to the same standards of care outlined in the statute.

Sec. 19a-124. Needle and syringe exchange programs. The impact will be on the clients seeking syringe access services with the expansion of services and the addition of other areas of the state where services can be accessed. It will also allow for more comprehensive and ancillary services rather than just needle exchange. It will also give DPH more latitude over where services are funded.

Sec. 19a-582. ***General consent required for HIV-related testing. Counseling requirements. Exceptions.*** The impact for the clients will be eliminating barriers to testing. One barrier to eliminate is the requirement of written consent to HIV Testing (rapid screening) in the field. The impact on HIV outreach testers will be the elimination of extra paperwork in the field and in the office. Another impact is the de-stigmatization of HIV.

Insert fully drafted bill here

Section 1. Section 19a-124 of the general statues is repealed and the following is substituted in lieu thereof:

(a) The Department of Public Health shall establish, within available appropriations, a needle and syringe exchange programs in [the three cities having the highest total number of the human immunodeficiency virus infections among injection drug users.] order to enhance health outcomes of people who inject drugs in any community impacted by the human immunodeficiency virus or Hepatitis C. The department shall establish protocols in accordance with the provisions of subsection (b) of this section. The department may authorize [similar] programs [in other areas of the state], as determined by the commissioner, through local health departments or other local organizations.

(b) The programs shall: (1) Be incorporated into existing human immunodeficiency virus and Hepatitis C prevention programs [in the selected cities]; (2) provide for free and confidential exchanges of needles and syringes and (A) provide that program participants receive an equal number of needles and syringes for those returned; and (B) provide that first-time applicants to the program receive an initial packet of [thirty] needles and syringes, educational material and a list of drug counseling services; [and] (3) offer education on [the transmission of] the human immunodeficiency virus [and], Hepatitis C and overdose prevention measures and assist program participants in obtaining drug treatment services[.]; (4) provide referral for substance abuse counseling or treatment; and (5) provide referrals for medical or mental health care.

(c) The department shall require programs to include an evaluation component [establish requirements] to monitor (1) number of syringes distributed and collected [(1) return rates of

needles and syringes distributed], (2) program participation rates, [and] (3) the number of participants who are referred to treatment [the number of participants who are motivated to enter treatment as a result of the program and the status of their treatment.], and (4) the incidence of human immunodeficiency virus from injection drug use.

(d) Any organization conducting a needle and syringe exchange program shall submit a report evaluating the effectiveness of the program to the Department of Public Health.

Section 2. Section 19a-581 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in this chapter except where the context otherwise requires:

(1) "Department" means the Department of Public Health;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "AIDS" means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;

(4) "HIV infection" means infection with the human immunodeficiency virus [or any other related virus identified as a probable causative agent of AIDS;] as defined by the Centers for Disease Control of the United States Public Health Service;

(5) "HIV-related illness" means any illness that may result from or may be associated with human immunodeficiency virus infection;

(6) "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of human immunodeficiency virus infection;

(7) "Protected individual" means a person who has been counseled regarding HIV infection, is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or HIV-related illness;

(8) "Confidential HIV-related information" means any information pertaining to the protected individual or obtained pursuant to a release of confidential human immunodeficiency virus-related information, concerning whether a person has been counseled regarding HIV infection, has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify a person as having one or more of such conditions, including information pertaining to such individual's partners;

(9) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual or a person authorized to consent to health care for the individual and which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information, unless such authorization

specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential human immunodeficiency virus-related information and complies with the requirements of this subdivision;

(10) "Partner" means an identified spouse or sex partner of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual;

(11) "Health facility" means an institution, as defined in section 19a-490, blood bank, blood center, sperm bank, organ or tissue bank, clinical laboratory or facility providing care or treatment to persons with psychiatric disabilities or persons with intellectual disability or a facility for the treatment of substance abuse;

(12) "Health care provider" means any physician, dentist, nurse, provider of services for persons with psychiatric disabilities or persons with intellectual disability or other person involved in providing medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan;

(13) "Community-based HIV Testing Provider" means any individual or organization that provides human immunodeficiency virus testing services for persons at risk of HIV infection who are identified and tested in non-clinical settings.

[(13)] (14) "Significant risk of transmission" means [sexual activity that involves] the transfer of one person's blood, semen, vaginal or cervical secretions to another person through sexual activity or the sharing of needles during [intravenous] injection drug use. The department may further define significant risk of transmission in regulations adopted pursuant to section 19a-589;

[(14)] (15) "Significant exposure" means a parenteral exposure such as a needle stick or cut, or mucous membrane exposure such as a splash to the eye or mouth, to blood or a cutaneous exposure involving large amounts of blood or prolonged contact with blood, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis. The department may further define significant exposure in regulations adopted pursuant to section 19a-589;

[(15)] (16) "Exposure evaluation group" means at least three impartial health care providers, at least one of whom shall be a physician, designated by the chief administrator of a health facility, correctional facility or other institution to determine if a health care or other worker has been involved in a significant exposure. No member of the group shall be directly involved in the exposure. The department may further define exposure evaluation group in regulations adopted pursuant to section 19a-589.

Section 3. Section 19a-582 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as required pursuant to section 19a-586, a person who has provided general consent as described in this section for the performance of medical procedures and tests is not required to also sign or be presented with a specific informed consent form relating to medical procedures or tests to determine human immunodeficiency virus infection or antibodies to human immunodeficiency virus. General consent shall include instruction to the patient that: (1) As part

of the medical procedures or tests, the patient may be tested for human immunodeficiency virus, and (2) such testing is voluntary and that the patient can choose not to be tested for human immunodeficiency virus or antibodies to human immunodeficiency virus. General consent that includes HIV-related testing shall be obtained without undue inducement or any element of compulsion, fraud, deceit, duress or other form of constraint or coercion. If a patient declines an HIV-related test, such decision by the patient shall be documented in the medical record. The consent of a parent or guardian shall not be a prerequisite to testing of a minor. The laboratory shall report the test result to the person who orders the performance of the test.

(b) A person ordering the performance of an HIV-related test shall not be held liable for ordering a test without specific informed consent if a good faith effort is made to convey the instruction required pursuant to subsection (a) of this section.

(c) At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV-related test shall provide the subject of the test or the person authorized to consent to health care for the subject with counseling or referrals for counseling, as needed: (1) For coping with the emotional consequences of learning the result; (2) regarding the discrimination problems that disclosure of the result could cause; (3) for behavior change to prevent transmission or contraction of HIV infection; (4)to inform such person of available medical treatments and medical services; (5)regarding local or community-based human immunodeficiency virus/ acquired immune deficiency syndrome support services agencies; (6) to work towards the goal of involving a minor's parents or legal guardian in the decision to seek and in the ongoing provision of medical treatment; and (7) regarding the need of the test subject to notify his partners and, as appropriate, provide assistance or referrals for assistance in notifying partners; except that if the subject of the test is a minor who was tested without the consent of his parents or guardian, such counseling shall be provided to such minor at the time of communicating such test result to such minor. A health care provider or health facility shall not withhold test results from the protected individual. The protected individual may refuse to receive his test result but the person ordering the performance of the test shall encourage him to receive the result and to adopt behavior changes that will allow him to protect himself and others from infection.

(d) The provisions of this section shall not apply to the performance of an HIV-related test:

(1) By licensed medical personnel when the subject is unable to grant or withhold consent and no other person is available who is authorized to consent to health care for the individual and the test results are needed for diagnostic purposes to provide appropriate urgent care, except that in such cases the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided as soon as practical;

(2) By a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals, provided if the test results are communicated to the subject, the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided;

(3) For the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and is unable to be retrieved by the researcher;

(4) On a deceased person when such test is conducted to determine the cause or circumstances of death or for epidemiological purposes;

(5) In cases where a health care provider or other person, including volunteer emergency medical services, fire and public safety personnel, in the course of his occupational duties has had a significant exposure, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his occupation, (B) the worker completes an incident report within forty-eight hours of exposure identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline human immunodeficiency virus test within seventy-two hours of the exposure and is negative on that test, (D) the patient's or person's physician or, if the patient or person does not have a personal physician or if the patient's or person's physician is unavailable, another physician or health care provider has approached the patient or person and sought voluntary consent and the patient or person has refused to consent to testing, except in an exposure where the patient or person is deceased, (E) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that the worker has a significant exposure to the blood of a patient or person and the patient or person, or the patient's or person's legal guardian, refuses to grant informed consent for an human immunodeficiency virus test. If the patient or person is under the care or custody of the health facility, correctional facility or other institution and a sample of the patient's blood is available, said blood shall be tested. If no sample of blood is available, and the patient is under the care or custody of a health facility, correctional facility or other institution, the patient shall have a blood sample drawn at the health facility, correctional facility or other institution and tested. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorized the human immunodeficiency virus testing of a patient or other person, nor the health facility, correctional facility or other institution, nor any person in a health facility or other institution who relies in good faith on the group's determination and performs that test shall have any liability as a result of his action carried out pursuant to this section, unless such person acted in bad faith. If the patient or person is not under the care or custody of a health facility, correctional facility or other institution and a physician not directly involved in the exposure certifies in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that a significant exposure has occurred, the worker may seek a court order for testing pursuant to subdivision (8) of this subsection, (F) the worker would be able to take meaningful immediate action, if results are known, which could not otherwise be taken, as defined in regulations adopted pursuant to section 19a-589, (G) the fact that an human immunodeficiency virus test was given as a result of an accidental exposure and the results of that test shall not appear in a patient's or person's medical record unless such test result is relevant to the medical care the person is receiving at that time in a health facility or correctional facility or other institution, (H) the counseling described in subsection (c) of this section shall be provided but the patient or person may choose not to be informed about the result of the test, and (I) the cost of the human immunodeficiency virus test shall be borne by the employer of the potentially exposed worker;

(6) In facilities operated by the Department of Correction if the facility physician determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, provided no reasonable alternative exists that will achieve the same goal;

(7) In facilities operated by the Department of Correction if the facility physician and chief administrator of the facility determine that the behavior of the inmate poses a significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility and no reasonable alternative exists that will achieve the same goal. No involuntary testing shall take place pursuant to subdivisions (6) and (7) of this subsection until reasonable effort has been made to secure informed consent. When testing without consent takes place pursuant to subdivisions (6) and (7) of this subsection, the counseling referrals and notification of test results described in subsection (c) of this section shall, nonetheless be provided;

(8) Under a court order which is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the HIV-related test result which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for a test result against the privacy interests of the test subject and the public interest which may be disserved by involuntary testing, (B) pleadings pertaining to the request for an involuntary test shall substitute a pseudonym for the true name of the subject to be tested. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court, (C) before granting any such order, the court shall provide the individual on whom a test result is being sought with notice and a reasonable opportunity to participate in the proceeding if he is not already a party, (D) court proceedings as to involuntary testing shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice;

(9) When the test is conducted by any life or health insurer or health care center for purposes of assessing a person's fitness for insurance coverage offered by such insurer or health care center; or

(10) When the test is subsequent to a prior confirmed test and the subsequent test is part of a series of repeated testing for the purposes of medical monitoring and treatment, provided (A) the patient has previously given general consent that includes HIV-related tests, (B) the patient, after consultation with the health care provider, has declined reiteration of the general consent, counseling and education requirements of this section, and (C) a notation to that effect has been entered into the patient's medical record.

(11) By community-based human immunodeficiency virus testing providers conducting HIV testing in non-clinical and/or outreach settings when they have received and documented verbal consent.

Section 4. Section 19a-583 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person who obtains confidential HIV-related information may disclose or be compelled to disclose such information, except to the following:

(1) The protected individual, his legal guardian or a person authorized to consent to health care for such individual;

(2) Any person who secures a release of confidential HIV-related information;

(3) A federal, state or local health officer when such disclosure is mandated or authorized by federal or state law;

(4) A health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual or when confidential HIV-related information is already recorded in a medical chart or record and a health care provider has access to such record for the purpose of providing medical care to the protected individual;

(5) A medical examiner to assist in determining the cause or circumstances of death;

(6) Health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews;

(7) A health care provider or other person in cases where such provider or person in the course of his occupational duties has had a significant exposure to HIV infection, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his occupation, (B) the worker completes an incident report within forty-eight hours of exposure, identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline human immunodeficiency virus test within seventy-two hours of the exposure and is negative on that test for the presence of <u>the [AIDS virus] human immunodeficiency virus</u>, (D) the patient's or person's physician or, if the patient or person does not have a personal physician or if the patient's or person's physician is unavailable, another physician or health care provider has approached the patient or person and sought voluntary consent to disclosure and the patient or person refuses to consent to disclosure, except in an exposure where the patient or person is deceased, (E) the worker would be able to take meaningful immediate action as defined in regulations adopted pursuant to section 19a-589 which could not otherwise be taken, (F) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (E) of this subdivision are met and that a worker has a significant exposure to the blood of a patient or person and the patient or person or the patient's or person's legal guardian refuses to consent to release of the information. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorizes the disclosure of confidential HIV-related information nor the health facility, correctional facility or other institution nor any person in a health facility, correctional facility or other institution who relies in good faith on the group's determination and discloses the result shall have any liability as a result of his action carried out under this section, unless such persons acted in bad faith. If the information is not held by a health facility, correctional facility or other institution, a physician not directly involved in the exposure has

certified in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (E) of this subdivision are met and that a significant exposure has occurred;

(8) Employees of hospitals for mental illness operated by the Department of Mental Health and Addiction Services if the infection control committee of the hospital determines that the behavior of the patient poses a significant risk of transmission to another patient of the hospital. Disclosure shall only be allowed if it is likely to prevent or reduce the risk of transmission and no reasonable alternatives exist that will achieve the same goal and also preserve the confidentiality of the information. Such "reasonable alternatives" include counseling the patient concerning behaviors that pose a risk of transmission and other efforts to prevent or address the behaviors that pose a significant risk of transmission without disclosing the patient's human immunodeficiency virus status or other confidential HIV-related information. Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information to achieve the purpose authorized by this subdivision;

(9) Employees of facilities operated by the Department of Correction to provide services related to HIV infection or if the medical director and chief administrator of the facility determine that the behavior of an inmate poses significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility. Such a disclosure shall only be made if it is specifically required to enable the inmate to receive such services or is likely to prevent or reduce the risk of transmission and no reasonable alternatives exist that will achieve the same goal and also preserve the confidentiality of the information. Such "reasonable alternatives" include counseling the inmate concerning behaviors that pose a risk of transmission or other efforts to prevent or address the behaviors that pose a significant risk of transmission without disclosing the patient's human immunodeficiency virus status or other confidential HIV-related information. Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information to achieve a purpose authorized by this subdivision;

(10) Any person allowed access to such information by a court order which is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the test results which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy interest of the test subject and the public interest which may be disserved by disclosure which deters future testing or which may lead to discrimination. (B) Pleadings pertaining to disclosure of confidential HIV-related information shall substitute a pseudonym for the true name of the subject of the test. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court. (C) Before granting any such order, the court shall provide the individual whose test result is in question with notice and a reasonable opportunity to participate in the proceedings if he is not already a party. (D) Court proceedings as to disclosure of confidential HIV-related information shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice. (E) Upon the issuance of an order to disclose test results, the court shall impose appropriate safeguards against unauthorized disclosure, which shall specify the persons

who may have access to the information, the purposes for which the information shall be used, and appropriate prohibitions on future disclosure;

(11) Life and health insurers, government payers and health care centers and their affiliates, reinsurers, and contractors, except agents and brokers, in connection with underwriting and claim activity for life, health, and disability benefits;

(12) Any health care provider specifically designated by the protected individual to receive such information received by a life or health insurer or health care center pursuant to an application for life, health or disability insurance; and

(13) A procurement organization, for the purposes of assessing donor suitability pursuant to subsection (c) of section 19a-289m.

(b) No person, except the protected individual, his legal guardian or a person authorized to consent to health care for such individual, to whom confidential HIV-related information is disclosed may further disclose such information, except as provided in this section and sections 19a-584 and 19a-585.

Section 5. Section 19a-593 of the general statute is repealed and the following is substituted in lieu thereof:

(a) Each health care provider giving prenatal care to pregnant women in this state shall inform her, or ascertain from the woman's medical record that such information has already been provided to her, that human immunodeficiency virus testing is a part of routine prenatal care and shall inform her of the health benefits to herself and her newborn of being tested for HIV infection. Such information shall be conveyed along with the counseling required by section 19a-582. The health care provider shall inform the patient that HIV-related information is confidential pursuant to section 19a-583. If the patient provides informed consent to an HIV-related test consistent with section 19a-582, the health care provider responsible for HIV counseling under this section shall perform or arrange to have performed an HIV-related test and document the test result in the medical record.

(b) If, during the current pregnancy, an HIV-related test has not been documented in the patient's medical record at admission for delivery of the baby, then the health care provider responsible for the patient's care shall inform the pregnant woman as required under subsection (a) of this section and shall also inform her of the health benefits to herself and her newborn of being tested for HIV infection either before delivery or within twenty-four hours after delivery and, in the absence of specific written objection, shall cause such test to be administered.

(c) Any health care provider who performs an human immunodeficiency virus test on a newborn under the provisions of sections 19a-90, 19a-555 and 19a-593 shall report the results of such test to the mother of such newborn before the mother leaves the hospital or within forty-eight hours of the birth of such newborn whichever is sooner. Such provider shall refer any women whose newborn tests positive for human immunodeficiency virus to an human immunodeficiency virus case manager and an appropriate health care provider. Such provider shall also give the woman a list of support services for people with human immunodeficiency virus and acquired immune deficiency syndrome.

Section 6.