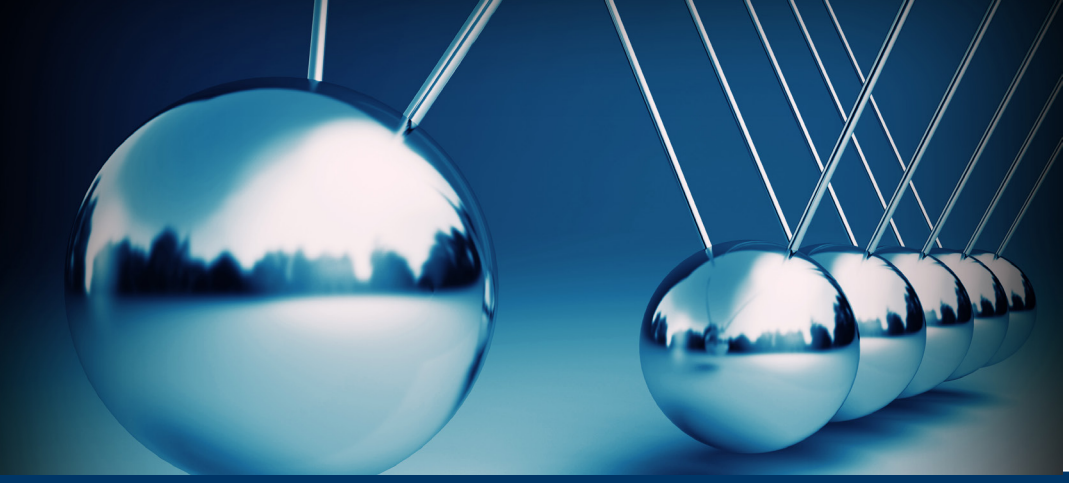

MURTHA MEANS
MORE
INDUSTRY INSIGHT

HEALTH CARE GROUP NEWS

May 2016

PART TWO: THE REST OF SB 351 (NOW PUBLIC ACT 16-95)

By Stephanie S. Sobkowiak and Daniel J. Kagan

While Senate Bill 351, now enacted as Public Act 16-95 (the "Act"), received attention for the limits it placed on physician non-compete provisions, numerous other provisions of the Act are worth highlighting. These provisions include: (1) expanding the entities that can form medical foundations to include entities with partial (at least 60%) physician ownership; (2) expanding the definition of a captive professional entity; (3) requiring hospital bills to include the hospital's cost-to-charge ratio; (4) easing patient notification requirements when providers refer to affiliated providers, and (5) introducing the possibility of future legislation requiring the licensing of urgent care and limited service health clinics. Each of these provisions will be discussed in turn, with a closing follow-up note regarding the non-compete restrictions discussed in our earlier bulletin.

Independent Practice Associations & Medical Foundations

Currently, only Connecticut hospitals, health systems and medical schools can organize and become members of medical foundations, and medical foundations cannot be operated for profit. Now, under the Act, there has been a shift to allow Independent Practice Associations (IPAs), along with other entities with at least 60% physician ownership, to establish nonprofit or for profit medical foundations, so long as they are not owned by a hospital, health system, medical school or medical foundation. This is a very important development as it allows non-physician investors to participate in physician ventures. However, we note that even with the Act's expansion of the types of entities that can establish medical foundations, the rule that an entity can only organize and join one medical foundation remains the same.

The Act defines an IPA as an organization that (1) has owners or members that consist entirely of independent providers, or is owned by a tax exempt state-wide professional medical membership association and controlled by independent providers and (2) provides services to and on behalf of its members or owners, which may include practice management and administrative services such as accounting, payroll, billing, human resources, and information technology. Only a physician may be an owner or member of, or otherwise own or control, directly or indirectly, an IPA.

Continued on page 2

For Questions About Health Care Matters, Please Contact:

Paul E. Knag, Co-chair
Stephanie S. Sobkowiak, Co-chair
Heather O. Berchem
Marcel J. Bernier
Frank M. Capezzera
Dena M. Castricone
Jennifer A. Corvo
Melissa A. Federico
Robert V. Giunta, Jr.
Michael C. Harrington
H. Kennedy Hudner
Daniel J. Kagan
Kenneth L. Levine
David A. Menard
Natale A. Messina
Alfred E. Smith, Jr.
Rachel Faye Smith
David R. Sullivan
Joseph R. Tarby, III
Keith S. Varian

MURTHA CULLINA
MURTHA CULLINA LLP
ATTORNEYS AT LAW MURTHALAW.COM

BOSTON
HARTFORD
NEW HAVEN
STAMFORD
WHITE PLAINS
WOBURN

Furthermore, for the first time, as mentioned above, in addition to IPAs, other entities can form or join a medical foundation even when such entities are not wholly owned by physicians so long as the following requirements are met: (1) the entity must be registered to do business in Connecticut under applicable law, (2) have its principal place of business in Connecticut and (3) have at least 60% of its ownership and control held individually or jointly by either (i) an IPA, (ii) a provider or (iii) a professional partnership, a professional corporation or an LLC that is not a captive professional entity (see expanded definition below) and that is formed to render professional services, where each partner, shareholder or member of the professional entity is a physician. The impact of this addition is that it opens the way for investor participation and ownership in medical foundations by non-physicians. This could prove incredibly useful in establishing an accountable care organization.

With regard to the boards of directors of such medical foundations, the Act prohibits anyone who is employed by, represents or owns or controls a hospital, health system or medical school from serving on the board of a medical foundation formed by an IPA or entity described in the paragraph above.

Medical Foundation Annual Reporting

Currently, each medical foundation must report the following to OHCA on an annual basis: a statement of its mission; a description of the services it provides; a description of any significant change in its services during the preceding year; and other financial information as reported on its most recently filed IRS return of organization exempt from income tax form, or if the medical foundation is not required to file such form, then information substantially similar to what is required on the IRS form.

Effective October 1, 2016, all medical foundations must also report the following: (1) the names and addresses of the organizing members; (2) the name and specialty of the physicians employed by or acting as an agent of the medical foundation and the locations where such persons practice; (3) the name and employer of each board member; (4) a description of the services provided at each location where a physician, employed by or acting as agent of the foundation, practices and (5) a copy of the medical foundation's governing documents and bylaws.

Captive Professional Entities

The Act also expands the definition of a captive professional entity. This expansion will affect the analysis of the reporting and other requirements applicable to certain transactions.

Captive professional entities are physician-owned entities that generally exist to serve a hospital, health system, medical school or medical foundation, and may be directly or indirectly controlled by such entity. Currently, a captive professional entity is formally defined as a professional corporation, LLC or other entity formed to render professional services where the beneficial owner physician is employed by, or otherwise designated by, a hospital or hospital system. Effective October 1, 2016, a partnership may also be a captive professional entity.

In addition, the Act makes clear that if the physician who serves as the beneficial owner of the captive entity is directly or indirectly employed, controlled by, subject to the direction of or otherwise designated by a hospital, health system, medical school, medical foundation or any entity that controls, is controlled by or is under common control with such entities, then the entity will indeed be considered a "captive."

As is currently required, if there is a material change to the business or corporate structure of a group practice, the parties must notify the Attorney General prior to the transaction and DPH after the transaction. The expanded definition of a "captive professional entity" may bring more certainty to when group practice transactions with "captives" must be reported.

Continued on page 3

More Changes to Patient (and other) Notices

Hospitals

Hospitals now need to add yet another component to their bills. Currently, hospitals are required to include in their bills to patients (and to third party payors unless previously provided) an explanation of any items identified by code or initials. Effective October 1, 2016, all hospitals must also include the hospital's cost-to-charge ratio in their bills to patients and in their bills to third party payors, unless such information was previously provided. Hospitals should update their forms accordingly.

Other Providers

Last year, the legislature passed a law requiring a notification to patients when a health care provider referred a patient to an affiliated provider not within the same practice. **Some Good News:** The Act eases the requirements of this notification. Effective July 1, 2016, providers are no longer required to provide each patient with the web site and toll-free telephone number of such patient's specific insurance carrier. Instead, the provider only needs to advise the patient to contact his/her health carrier to obtain information on other in-network providers and the estimated out-of-pocket costs for the referred service.

Potential Licensure of Urgent Care and Limited Service Health Clinics

Lastly, licensure requirments for urgent care and limited service health clinics may be looming. The Act explicitly gives the Health Care Cabinet the authority to study the licensure of urgent care and limited service health clinics. After the Cabinet conducts such study, it can provide a report to the Public Health Committee with recommendations on legislation to establish licensure categories for these types of clinics. We will continue to monitor any developments in this area.

As Promised, Some Non-Compete Follow-Up

In our May 6, 2016 bulletin regarding the Act's non-compete provisions, we stated that the Act has an express carve-out for situations involving partnership or ownership but that the extent of the carve-out is not clear. This remains the case. However, informal guidance suggests that in no circumstances will a physician non-compete be enforceable for a period of longer than one (1) year or for a radius of greater than fifteen (15) miles from the physician's primary site, regardless of whether the physician is "just" an employee or is an owner or partner of the practice. In addition, if an employer terminates a physician without cause then regardless of whether such physician is a partner or owner, or anticipated to be a partner or owner, the physician's non-compete restriction is unenforceable.

Should you have any questions regarding the Act or other areas of health care law, please contact:

Stephanie S. Sobkowiak at (203) 772-7782 or ssobkowiak@murthalaw.com

Paul E. Knag at (203) 653-5407 or pknag@murthalaw.com

Daniel J. Kagan at (203) 772-7726 or dkagan@murthalaw.com