Some California hospitals have reacted to the passage of health care reform by seeking to organize and operate so-called "1206(l) medical foundations." CMA is receiving an increasing number of questions from physicians concerning what these medical foundations are, and what considerations should influence their decision to join. This document1 is intended to provide a general overview of the legal and practical issues that present with "medical foundations," and the discussion that follows is organized into four (4) sections: Background, Legal Considerations, Key Practice and Business Considerations, and CMA Resources.2

1. BACKGROUND

1. What is a "1206(l) medical foundation"?

The term "1206(l) medical foundation" (referred to herein as medical foundation) is intended to describe a clinic that can provide or arrange to furnish medical services without first obtaining a license from the Department of Public Health. In that regard, a medical foundation is like a physician's medical office, which can provide medical services without first obtaining a license from the Department of Public Health.

2. Why are hospitals attempting to create medical foundations?

In the 1990s, medical foundations began to also be formed and operated by hospitals. On the one hand, they can be used as a hospital-physician alignment strategy. In this regard, they potentially can be utilized to address, among other things, declining reimbursements and to make infrastructure investments to improve quality of care. See Charles B. Oppenheim, et al., "Hospital-Physician Alignment Models in California," Cal. Health Law News, Vol. XXVI, Issue 4, 2008. On the other hand, hospitals also can utilize foundations to control physician services and to drive patient care to their facility. Such practices raise many practical and legal concerns (see sections II and III below).

3. Practically speaking, how does a medical foundation operate?

While there is no single organizational paradigm, most medical foundation models share the following operational features that are common to physician medical groups:

---

1 This article was written in part by Anthony Hunter Schiff, J.D., M.P.H., a partner in the law firm of Schiff and Bernstein, APC, in Los Angeles, tschiff@mdhealthlaw.com. Mr. Schiff is also a Professor (Adjunct) in the Department of Health Services, School of Public Health, UCLA, where he teaches health law.

2 CMA also is receiving an increasing number of questions regarding other organization or health care delivery models, such as Accountable Care Organizations (ACOs), Independent Physician Organizations (IPAs), and hospital outpatient clinics. For an overview of these models and various other organizational options for physicians and physician groups, see CMA ON-CALL document #0200, "Medical Practice Options: Overview." For more information on governance issues physicians should consider when joining or forming new medical practice organizations, see CMA ON-CALL document #0239, "Governance Issues for Physician Organizations."
• The lay medical foundation, not the medical group, holds the contracts with third party payers, including health care services plans, which govern the provision of professional and related ancillary services to subscribers of the payers/health plans;

• The medical foundation discharges its obligation to furnish professional medical and surgical services to patients by delegation to its contracted physician group; and

• Medical foundations often attempt to compensate the physicians according to productivity-based formulas that are also designed to create economic integration between and among the providers.

Historically, medical foundations were wholly controlled by physician groups that were not affiliated with hospitals. The legislative history of Section 1206(l) makes clear that the statute was intended to exempt two large multispecialty physician group practices from clinic licensure laws.

However, unlike a traditional medical group, with a physician-only ownership and governance infrastructure, the medical foundation is a non-profit, tax-exempt corporation whose governing board members and, in turn, executive management team, are selected by the sponsoring organization. Today, those sponsors are predominantly hospitals. As such, the "parent hospital" typically controls the governance process and the sponsoring hospital appoints physicians to the governance structure. In short, and despite their colleagues sometimes holding key leadership positions, physicians do not exercise the same degree of professional autonomy when furnishing services to hospital sponsored medical foundation patients as when treating patients in traditional private practice settings. See Andrew J. Demetriou, "Medical Foundations and the Corporate Practice Doctrine: Toward a Rational Approach," Cal Health Law News, (1993).

4. What is the allure of a medical foundation for physicians?

Physicians are not all alike and they are, of course, at different stages of their careers. Some physicians hope the medical foundation will purchase the tangible and intangible assets of a medical practice, thereby allowing them to "cash out" their ownership interests. Others hope to find stability in a larger organization. (Stability is more likely to be realized in an already established foundation.) Other physicians desire to join larger medical organizations that offer reduced call coverage, income stability, access to improved medical technology, and minimal administrative duties. Of course, there are important business and practical issues to consider (see section III below).

5. What is CMA's policy concerning medical foundations?

CMA understands that a medical foundation have the potential to play a role in the development and/or expansion of an integrated health care delivery system. See CMA ON-CALL document #0254, "Medical Foundation: CMA Principles and Guidance." Nonetheless, CMA will continue to oppose any physician-hospital alignment strategy that permits the participating hospital or health system, either directly or through an entity that delivers or arranges to deliver medical services, to improperly infringe on medical judgment and/or the corporate practice of medicine bar. With respect to medical foundations specifically, CMA policy requires that CMA "take all appropriate steps to ensure that the corporate practice of medicine bar is enforced and that no exceptions be made for foundations that do not meet the statutory requirements of Health & Safety Code §1206(l)..." CMA has been active in attempting to enforce each of the requirements of Section 1206(l) before the courts and regulators.
II. LEGAL CONSIDERATIONS

6. How is a medical foundation defined?

A medical foundation is defined by reference to the requirements necessary for exemption from licensure by the Department of Public Health. In particular, Section 1206(l) of the Health & Safety Code exempts from the clinic licensure laws:

A clinic operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, that conducts medical research and health education and provides health care to its patients through a group of 40 or more physicians and surgeons, who are independent contractors representing not less than 10 board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic.

In short, a medical foundation is a clinic operated by a nonprofit corporation that:

- is exempt from taxation in accordance with Section 501(c)(3) of the Internal Revenue Code;
- conducts medical research and health education; and
- provides health care to its patients through a group of:
  - 40 or more physicians and surgeons who are independent contractors,
  - representing not less than 10 board-certified specialties, and
  - at least two-thirds of whom practice full-time at the clinic.

[Emphasis added above.]

7. Why are medical foundations exempt from the clinic licensure laws?

In 1980, the California Legislature made the public policy decision that a multispecialty medical group that operates through an Internal Revenue Code §501(c)(3), non-profit corporation in order to use tax exempt funds for medical research and health education, should not be subject to the jurisdiction of the Department of Health Services (now the Department of Public Health) and/or the clinic licensure and certificate of need requirements. See A.B. 2279 (Calvo 1980). The licensure exemption is a tacit acknowledgement by the California Legislature that a medical foundation is a clinic operated by physicians that, like the traditional medical office, should be exempt from licensure laws that is otherwise applicable to other clinics.

8. What are the major compliance issues for medical foundations under Section 1206(l)?

Despite the brevity of the statute, the requirements of Section 1206(l) are relatively complex. An entity must navigate several statutory requirements to qualify its clinic as a medical foundation, including the following:

- Contract with at least forty (40) physicians, two-thirds of whom must be full time, and that cover at least 10 medical specialties;
- Create, fund and manage a medical research program;
9. Can a Section 501(c)(3) tax-exempt, nonprofit acute care hospital operate a medical foundation as a separate product line or division of the hospital entity?

No. Nevertheless, a few California hospitals and health systems have taken a different view. Some have gone even farther and take the position that a hospital-based outpatient clinic that otherwise meets the requirements of Health & Safety Code §1206(l) can qualify as a medical foundation. This activity is inconsistent with the letter and spirit of Section 1206(l) and, further, would render Health & Safety Code §1206(d) meaningless.

First, Section 1206(l) was intended to exempt from the clinic licensure laws large, multispecialty physician medical group that organizes as a tax-exempt entity in order to raise funds for clinical care, medical research, and health education programs. The law defines a "clinic" as an organized outpatient facility which provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and which may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility. See Health & Safety Code §1200. An acute care hospital is not a "clinic" and, therefore, does not need any statutory exemption from the clinic licensure laws.

Second, an acute care hospital can operate an outpatient clinic without having to comply with the clinic licensure laws. Specifically, Health & Safety Code §1206(d) provides an exemption for any clinic operated by an acute care hospital under its health care facility license. To extend the benefit of Section 1206(l) to an acute care hospital would render nugatory the existing exemption for outpatient hospital clinics, a result that the California Legislature would not have intended and which a California court would not support under principles of statutory construction.

The California Legislature intended to create a very limited exemption from clinic licensure laws for physicians who practice medicine through a nonprofit entity in order to raise funds for medical research and health education activities. The Legislature did not intend to provide a pathway for tax-exempt hospitals to attempt to organize and control a large group of physicians in the outpatient setting and, in doing so, circumvent the corporate practice of medicine prohibition. For more information regarding 1206(d) clinics, see CMA ON-CALL document #0214, "Hospital Outpatient 1206(d) Clinics: Legal Considerations Impacting Physicians."

10. Do the 40 physicians have to be part of the group itself, or can any physician be counted?

At the core of the numeric physician requirement is that the physicians actually be a part of the medical group. It appears that the Legislature intended that the word "group" referred to in Section 1206(l) means one which is formally organized in the traditional sense and consistent with the term's plain meaning –that is, a separate legal entity, either a professional corporation or a partnership, where physicians in the group are able to raise capital, share resources, revenues, and expenses, and obtain other operating efficiencies which are achieved through such a consolidation. Characteristics of a medical group are typically those set forth in Business & Professions Code §650.01, which defines an exemption to the referral prohibition. That law requires that the group (a) consist of two or more physicians who are legally organized as a partnership, professional corporation, or certain other entity, whereby, among other things:
• Each member of the group substantially provides the full range of service that the physician routinely provides;

• Substantially all the services of the licensees of the group are provided through the group and billed in the name of the group; and

• The overhead expenses of and income from the practice are distributed in accordance with methods previously determined by the members of the group.

While this definition (or any other traditional definition) of a medical group does not preclude such groups from affiliating with other physicians for the purposes of on-call coverage and referrals, such affiliated physicians would not be considered part of the group within the plain meaning of the term. Consequently, CMA Legal Counsel reads the statute as requiring that at least 40 physicians (two-thirds of whom must practice on a full-time basis at the clinic) need to be actual members (either owners or employees) of a formally organized group in order for the 40 physician-member group requirement for Medical Foundations to be met. Only through this degree of integration can the medical group provide the important patient protections envisioned by the Legislature in Health & Safety Code §1206(l).

11. What is the nature of the arrangement between the medical foundation and the physicians who provide services to patients?

In order to qualify under Section 1206(l), a medical foundation must provide medical services to its patients through a group of 40 or more physicians. By its plain meaning, and given the purpose underlying the exemption from clinic licensure (i.e., to benefit a multispecialty group of physicians), the statute contemplates that a medical foundation would contract with a single medical group that, in turn, would make available the requisite number of primary care and specialist physicians to furnish professional services to clinic patients. This interpretation is consistent with the type of integration and coordination necessary for the physicians to conduct medical research and health education through the medical foundation. Moreover, this interpretation is also consistent with the principles underlying the corporate practice of medicine prohibition. Unquestionably, the governing board of the nonprofit corporation has less ability to influence the professional judgment of physicians who affiliate with the medical foundation and its patients through an integrated medical group. See Andrew J. Demetriou, "Medical Foundations and the Corporate Practice Doctrine: Toward a Rational Approach" Cal. Health Law News (1993).

12. Is a medical foundation required to have an independent governing board?

Yes. The non-profit medical foundation entity should be governed by individuals who are independent and should not be governed by the identical board that governs the sponsoring organization (i.e., hospital or health system). It is well established that governing board members are fiduciaries and must exercise independent judgment when addressing the financial and clinical issues relating or pertaining to the medical foundation. The judgment of an individual serving on the governing board of the nonprofit corporation that operates the medical foundation could be impermissibly compromised if that individual also serves on the governing board of, or in an executive leadership position with the sponsoring hospital or health system. Undeniably, membership should be determined by reference to the state law rules applicable to the governance of nonprofit corporations and, in particular, to the fiduciary duties that such governing board members owe to the organization.
13. Can a medical foundation staff its clinic with physicians engaged by a medical group that is controlled by the sponsoring hospital or health system?

This activity – the engagement of a so-called "friendly" PC ("professional corporation") medical group – raises serious questions under the corporate practice of medicine prohibition. The legislative history is unmistakably clear that Section 1206(l) is intended to benefit a multispecialty group of physicians who, for fund raising reasons, organize and operate their clinic through a tax-exempt, nonprofit corporation. Correspondingly, the public policy underlying Section 1206(l) would be frustrated if a sponsoring hospital or health system could effectively co-opt the professional judgment of the physicians who render services to clinic patients, which is precisely the risk that presents when the medical group is controlled by a physician whose decision making is not independent due to the sponsoring hospital or health system. For more information, see CMA ON-CALL document #0280, "Corporate Practice of Medicine Bar."

14. What are the requirements for tax-exemption under IRC 501(c)(3)?

In general, an entity must be organized and operated exclusively for charitable purposes, with no part of its earnings inuring to the benefit of a private shareholder or individual, in order to qualify for tax exemption under Internal Revenue Code, 26 U.S.C. §501(c)(3). IRS rulings have provided numerous conditions for health care entities to qualify for a tax exempt status. Physicians are strongly urged to consult with qualified legal counsel because the requirements for qualification and maintenance of Section 501(c)(3) tax-exempt status are extremely detailed and complex.

In particular, the California Legislature enacted Section 1206(l) to benefit the large multispecialty medical group that sought to raise funds for medical research and related activities through charitable donation and through the issue of tax-exempt bonds. That noted, federal tax laws limit the term of a service contract between a nonprofit corporation and a vendor, where the nonprofit corporation issues tax-exempt bonds to finance its operations. See Rev. Proc. 93-19. Specifically, medical foundations enter into professional service agreements ("PSA"). The PSA constitutes a service contract to which the limitations on term would apply if the nonprofit corporation issues tax-exempt bonds to finance the operations of the medical foundation. As such, each physician must be mindful that factors separate and apart from their individual written agreement with the medical group could significantly affect the term of his affiliation with the medical foundation.

For more information on tax exempt requirements, see CMA ON-CALL document #0621, "Kickbacks and Fee-Splitting - Other Laws Used to Deter Payments for Referrals." Significantly, much of the data required of nonprofit entities is gathered and can be analyzed to determine the extent to which they meet these relevant factors. See, for example, www2.guidestar.org/.

III. KEY PRACTICE AND BUSINESS CONSIDERATIONS

Many factors will influence the decision of a physician to affiliate with a medical foundation. The list below, while not exhaustive, identifies several important practice and business factors that each physician should consider when making that decision.

1. Two Transactions: In most instances, affiliation involves concurrent "sale" and "going forward" transactions. In particular, a physician will sell the tangible and intangible assets of his or her medical practice to the medical foundation and, simultaneously affiliate with the medical group (usually as an employee) that, in turn, contracts with the foundation to provide professional services to its patients. Unfortunately, many physicians become distracted by the complexity of sale issues and lose sight of the important "going forward" transaction. For more information regarding legal and financial issues to consider when selling a physician's practice to
an integrated delivery system, see CMA ON-CALL document #0256, "Selling Your Practice to an Integrated Delivery System."

In particular, if the sale proceeds will not fund retirement, then it likely follows that a physician will require a meaningful long term affiliation with the medical foundation in order to meet his or her long term professional practice and financial goals. What happens to a physician upon his termination from the medical group? What happens to all of the physicians upon the termination of the PSA for any reason? Each physician no longer owns the tangible assets necessary to resume his or her private medical practice, whether alone or in tandem with one or more colleagues. How will a physician fund the cost of acquiring new equipment and practice facilities and, possibly, the construction of tenant improvements? What rights, if any, does the medical group have to take over the clinic facilities and equipment if the PSA terminates because the nonprofit corporation no longer intends to operate the medical foundation?

Each physician should think of the affiliation contracts (e.g., the individual medical group employment agreement and the PSA) as pre-nuptial agreements. In that regard, a physician should attempt to negotiate as soft a landing as possible upon dissociation from the medical group for any reason. And, of equal importance, a physician should inquire about the exit provisions in the PSA to determine what precautions, if any, the medical group took to protect the physicians in the event of their dissociation from the medical foundation en masse.

2. Term and Termination: Physician employed by the medical group with the medical foundation will be fundamentally impacted by the term and termination provisions in his individual agreement with the medical group. Correspondingly, the tenure of all of medical group physicians will be affected by the term and termination provisions in the PSA. Importantly, the term of the PSA can be affected by many factors, e.g., the financial health and structure of the sponsoring hospital or health system.

3. Compensation: Each physician should have a written employment agreement that memorializes, among other matters, the compensation payable in exchange of his professional services by the medical group. Is the amount of compensation commercially reasonable? Does the medical group have the unilateral right to modify the compensation? Physicians must also be mindful that the medical group typically relies exclusively on the funds received from the medical foundation to compensate its providers, which arrangement is memorialized in a professional services agreement ("PSA"). Does the PSA require the medical foundation to compensate the medical group in amounts necessary for the medical group to pay the physicians? Can the medical foundation unilaterally amend the PSA? Each physician should understand the dynamics of the compensation methodologies in his or her individual agreement with the medical group as well as in the PSA.

4. Foundation Governance: The members of the governing board of the nonprofit corporation – the entity that operates the medical foundation – have ultimate responsibility for the business affairs of the clinic. Typically, the governing board will delegate day-to-day management and medico-administrative responsibility to the officers of the medical foundation, including the chief executive officer and medical director. Accordingly, the membership profile of the governing board will necessarily impact the individuals selected to serve as officers.

5. Organizational Infrastructure: When considering medical foundation affiliation, a physician should endeavor to understand the dynamics of the organizational infrastructure, including the composition of the governing board members and the qualifications of the officers, in order to assess the extent to which independent physicians will manage the daily affairs of the clinic. For
more information on governance issues physicians should consider, see CMA ON-CALL
document #0239, "Governance Issues for Physician Organizations."

6. **Foundation Capital:** A medical foundation requires significant capital to fund start-up costs
and clinic overhead, including physician compensation, during the "ramp-up" phase. That a
nonprofit hospital or health system can provide an immediate source of "start-up" capital helps to
explain their appeal as sponsoring organizations. However, as with many patriarchal
relationships, dysfunction may be an unavoidable consequence if the sponsoring hospital or
health system overly controls the purse strings and/or the medical foundation is too beholden to
that organization. In addition, the initiatives of the sponsoring hospital or health system can
change over time and, with that change, the allocation of its resources. In short, access to capital
is critical to any organization, especially during the embryonic stages of development.
Accordingly, a physician should attempt to assess the financial health (e.g., sufficient working
capital, cash reserves and access to additional capital) of the medical foundation. In particular, a
physician should recognize the risks associated with any "start-up" medical foundation that relies
on the sponsoring organization to address capital shortfalls.

7. **Medical Research/Health Education:** The medical foundation will need capital in order to
fund the statute required medical research and health education activities. The medical
foundation may be able to partially fund those activities from grants, clinical trial sponsorships
or private donations. However, physicians should be mindful that creating and implementing an
infrastructure conducive to medical research/health education activities in a culture of private
practice medicine is difficult. Accordingly, a physician should evaluate the legacy of medical
research/health education activities of the medical foundation and the physicians affiliated with
the medical group that staffs or will staff the clinic, when evaluating the relative pros and cons of
affiliation.

* * *

**IV. CMA RESOURCES**

Frequently, physicians who are interested in medical foundations are also confronting other related
practice issues. As such, the following is a summary of related topics and CMA resources:

1. CMA ON-CALL document #0280, "Corporate Practice of Medicine Bar;" (Topic: Legal
Considerations)

2. CMA ON-CALL document #0621, "Kickbacks and Fee-Splitting - Other Laws Used to Deter
Payments for Referrals." (Topic: Legal Considerations)

3. CMA ON-CALL document #0256, "Selling Your Practice to an Integrated Delivery System."
(Topic: Key Practice and Business Considerations)

4. CMA ON-CALL document #0239, "Governance Issues for Physician Organizations." (Topic:
Key Practice and Business Considerations)

* * *

The preceding discussion confirms that the legal and practice issues concerning medical foundations are
complex. CMA is unable to provide specific legal advice to each of its more than 35,000 members. While
we hope this information is helpful, physicians are urged to seek the advice of a health care attorney
experienced in these matters when considering the pros and cons of the transactions associated with medical foundation affiliation.

For information on other legal issues, use CMA ON-CALL, or refer to CMA's *California Physician's Legal Handbook*. This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available on a fully searchable CD-ROM, or in a seven-volume, softbound format. To order your copy, call (800) 882-1262 or visit CMA's Bookstore at [www.cmanet.org](http://www.cmanet.org).