



Document #0305

Legal and Practical Considerations Concerning Medical Foundations

CMA Legal Counsel, January 2016

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 following discussion is organized into four (4) sections: **Background, Legal Considerations, Key Practice and Business Considerations, and CMA Resources.** 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 Associations (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 #0310, “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 #0307, “Governance Issues for Physician Organizations.”**

I. 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.

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.

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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).

2. Why are hospitals attempting to create medical foundations?

Although utilized by large medical clinics in 1980, medical foundations also began to 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 declining reimbursements and to make infrastructure investments to improve quality of care. 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:

- ♦ 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. In some instances, payment formulas are designed to create economic integration among the providers.

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 their medical practices, 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, physicians must consider other important business and practical issues (*see* section III below).

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

CMA understands that a medical foundation has the potential to play a role in the development and/or expansion of an integrated health care delivery system. *See* CMA ON-CALL document #0306, “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 violate 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 cause the courts and regulators to enforce each requirements of Section 1206(1).

II. LEGAL CONSIDERATIONS

1. 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.]

2. 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 acknowledgment 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 are otherwise applicable to other clinics.

3. 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;
- ♦ Create, fund and manage a health education program;
- ♦ Obtain tax-exempt status pursuant to IRC §501 (c)(3) from the Internal Revenue Service; and
- ♦ Continuously maintain tax-exempt status.

4. Can a Section 501(c)(3) tax-exempt, non-profit acute care hospital operate a medical foundation as a separate product line or division of the hospital entity?

CMA Legal Counsel interprets Health & Safety Code §1206(l) to preclude such an arrangement. Nevertheless, a few California hospitals and health systems take a different view. Some even take the position that a hospital-based outpatient clinic can attempt to qualify as a medical foundation. This position 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 groups that organize 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 #5401, “Hospital Outpatient 1206\(d\) Clinics: Legal Considerations Impacting Physicians.”](#)

5. What potential antitrust issues present with medical foundations?

The primary purpose of antitrust law is to protect consumer welfare by regulating conduct in order to foster competition. In turn, competition helps stimulate lower prices, higher quality, efficiency, innovation and choice. Thus, federal and state antitrust laws protect consumers by prohibiting

either sellers or buyers from engaging in conduct that would unduly reduce competition in the marketplace.

Consolidation increases concentration and, in turn, the market power of the consolidated entities. The consequent reduction in the number of competitors may result in higher prices and/or poorer service quality. As such, government regulatory agencies monitor consolidations associated with integrative health care arrangements in order to protect consumers against the effects of enhanced, concentrated market power.

The case of *Saint Alphonsus Medical Center—Nampa v. St. Luke’s Health System* (D. Idaho) 2015 U.S.App. Lexis 2098 is particularly significant because it involved a successful challenge to the acquisition by a hospital, *St. Luke’s Health System* (*St. Luke’s*), of a physician practice group, *Saltzer Medical Group* (*Saltzer*). The United States District Court, Idaho, found that the consolidation of *St. Luke’s* and *Saltzer* would give *St. Luke’s* control of nearly 80% of the primary care market in the city of Nampa. The district court ruled that the scope of market power violated antitrust laws because such dominance would allow *St. Luke’s*, unfettered by competitive forces, to increase primary care prices, thereby driving up insurance premiums and patient costs. The district court acknowledged but largely ignored the fact that the consolidation could eventually improve the delivery of health care in the Nampa market. The district court ordered *St. Luke’s* to divest its acquisition of *Saltzer*. The United States Circuit Court of Appeal, Ninth Circuit, affirmed the divestiture order. (*St. Alphonsus Med. Ctr.—Nampa, Inc. v. St. Luke’s Health Sys.* (9th Cir. 2015) 778 F.3d 775.)

Transactions among providers that create financial leverage without sufficient financial or clinical integration raise antitrust concerns. Financial integration among providers involves shared financial data, shared financial risk and reward, mutual dependency on financial outcomes, and aligned financial incentives. Clinical integration among providers, which can but does not necessarily require financial integration, involves shared clinical data, shared patient relationships, mutual dependency on clinical outcomes and

aligned clinical incentives. In July 2003, the F.T.C. challenged a PPO product from Brown & Toland Physicians, a San Francisco-based medical group. The F.T.C. alleged that the PPO product was not sufficient clinically integrated to justify joint payer contract negotiations on behalf of the network providers. In January 2004, the parties settled the dispute with a consent agreement under which Brown & Toland Physicians agreed to improve its clinical integration.

More recently, the California Attorney General has been investigating hospital-physician group affiliations involving several major health systems. According to published reports, the California Attorney General observed a substantial rise in acquisitions of medical groups by hospital-controlled medical foundations and, further, that empirical evidence demonstrates how the cost of medical care has increased artificially as a result of the hospital-physician affiliations through the medical foundation delivery paradigm. The California Attorney General is concerned that hospitals are using medical foundations as platforms to collectively negotiate fees for hospital *and* physician services with third party payors, but without the necessary financial or clinical integration. See Anna Wilde Mathews, *Doctor, Hospital Deals Probed*, THE WALL STREET JOURNAL, September 14, 2012; see Chad Terhune, *State Investigating Medical Consolidations*, LOS ANGELES TIMES, September 15, 2012. For more information on the antitrust laws, see [CMA ON-CALL document #1000, "The Antitrust Laws: What Physicians Can Do."](#)

6. Do the 40 physicians have to be part of the same medical group?

CMA Legal Counsel interprets Health & Safety Code §1206(l) to require the 40 physicians to be affiliated with the same medical group. 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 avail-

able 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.

This interpretation is also consistent with Business & Professions Code §650.02. That section defines a number of exemptions to the state self-referral prohibitions, including an exemption for the office of a group practice. To qualify as a "group," two or more physicians must be legally organized as a partnership, professional corporation, or qualified non-profit entity and where:

- ♦ Each member of the group substantially provides the full range of service that the physician routinely provides, including medical care, through the joint use of shared office space, facilities, equipment, and personnel;
- ♦ Substantially all the services of the members of the group are provided through the group, billed in the name of the group and treated as receipts 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.

Importantly, this interpretation is consistent with the principles underlying the corporate practice of medicine prohibition. The governing board of the medical foundation is much less able to influence the professional judgment of the physicians if the physicians affiliate with the medical foundation 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).

7. 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. Significantly, the Centers for Medicare and Medicaid Services (CMS) in the case of Medicare ACOs requires that the governing body of ACOs be “separate and unique” from the ACO participants, such as health systems. *See* 80 Fed.Reg. at 32717. For more information, *see* [CMA ON-CALL document #0300, “Legal and Practical Considerations Concerning Accountable Care Organizations \(ACOs\).”](#)

8. 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 #0200, “Corporate Practice of Medicine Bar.”](#)

9. Can a medical foundation hold third party payer contracts covering the professional services to be furnished by physicians on behalf of the affiliated medical group?

Many Section 1206(l) medical foundations contract directly with third party payers for the professional services to be furnished by physicians on behalf of their independent contractor medical group. By doing so, however, these medical foundations could be violating the corporate practice of medicine prohibition. Moreover, the affiliated medical group could be aiding and abetting such violation.

The California Court of Appeal addressed this issue in a case where a non-profit corporation that had been formed to conduct medical research subsequently began to contract with Blue Shield to furnish clinical services to patients. *See California Physicians’ Service v. Aoki Diabetes Research Institute* (2008) 163 Cal.App.4th 1506 (*Aoki*). The parties in *Aoki* are Blue Shield of California and Aoki Diabetes Research Institute (ADRI), a non-profit corporation formed in 1986 to conduct medical research into the nature, diagnosis, treatment and cure of metabolic disorders such as diabetes. Thomas Aoki, M.D., the chairman of ADRI, provided medical services to ADRI as an independent contractor. In 1990, ADRI expanded its corporate objective to include the clinical care of patients with metabolic disorders. In 1990, Blue Shield and ADRI executed a group provider contract pursuant to which ADRI agreed to, among other matters, render covered professional services to subscribers of Blue Shield and accept payment directly from Blue Shield as payment in full in respect of the performance of such services (subject to applicable deductible and co-payments).

In 2008, the Court of Appeal concluded that ADRI violated the corporate practice of medicine prohibition by entering into the provider contract with Blue Shield. In doing so, the court rejected the claim by ADRI that the corporate practice of medicine prohibition is inapplicable to non-profit corporations. The court also rejected the argument that the provider contract was between Blue Shield and the physicians furnishing medical services on behalf of ADRI.

The Court of Appeal also confirmed that a contract which violates a regulatory statute is generally void.²

Like ADRI, medical foundations are non-profit corporations that engage in medical research (among other activities). The reasoning of the decision in *Aoki* vis-à-vis the corporate practice of medicine could apply to provider contracts between medical foundations and third party payers. If so, then medical foundations would violate the corporate practice of medicine prohibition by contracting with third party payers for the professional services to be furnished by the independent contractor medical group.

10. 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 Health & Safety Code §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 #1152, “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 identifies several important practice and business factors that each physician should consider when making that decision. Further, physicians are strongly advised to review the underlying Professional Services Agreement (PSA) between the medical group and medical foundation to fully understand the impact that the arrangement will have on them and their practices. In fact, many medical groups impose on their affiliated physicians a contractual obligation to comply with the requirements of the PSA.

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

2. The court also observed that an otherwise illegal contract will be enforced if necessary to avoid the unjust enrichment of one party and the imposition of a disproportionately harsh penalty upon the other party. The court found that the group provider agreement between the parties was illegal. Nevertheless, the court relied on the exception to the general rule and ordered Blue Shield to reimburse ADRI for the professional services furnished to the Blue Shield subscribers. In doing so, the court observed that ADRI had fully performed and that Blue Shield would be unjustly enriched if it was allowed to retain the benefits of such performance without compensation.

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 #0318, “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 prenuptial 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:** Physicians employed by the medical group will be fundamentally impacted by the term and termination provisions in his or her individual group agreement. Importantly, the tenure of all of medical group physicians will also be affected by the term and termination provisions in the PSA. In many instances, termination of the PSA for any reason, including without cause, will trigger the termination of a physician’s group agreement. Importantly,

the term of the PSA can be affected by many factors beyond the control of the medical group; 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? Many agreements allow the physician’s compensation to be changed, even without the physician’s consent. 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 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. **Medical Practice:** The PSA may vest the medical foundation with significant control over the professional judgment of the medical group physicians. For example, the PSA may authorize the medical foundation to develop the professional practice standards, select the group physicians, take disciplinary action against group physicians, control practice locations, and select medical equipment. Such overreaching provisions, especially when combined together, constitute the lay control of medical practices and violates the corporate practice of medicine doctrine. In fact, the medical group should make these types of medical practice decisions. CMA has developed a grid that will help physicians understand the proper allocation of decision-making authority between the medical group and medical foundation consistent with the corporate practice of medicine bar. For a copy of this criteria grid, *see* [CMA ON-CALL document #0202, “Corporate Practice of Medicine Bar: Decision-making Authority for Integrated Entities Criteria.”](#)

5. **Foundation Governance:** The members of the governing board of the tax-exempt 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.

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 #0307, “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. In addition, the agreement may impose open-ended research and charity obligations upon the physician. Accordingly, a physician should evaluate the legacy and extent 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 #5401, “Hospital Outpatient 1206\(d\) Clinics: Legal Considerations Impacting Physicians.”](#) (Topic: Legal Considerations)
2. [CMA ON-CALL document #0200, “Corporate Practice of Medicine Bar.”](#) (Topic: Legal Considerations)
3. [CMA ON-CALL document #1152, “Kickbacks and Fee-Splitting: Other Laws Used to Deter Payments for Referrals.”](#) (Topic: Legal Considerations)
4. [CMA ON-CALL document #0318, “Selling Your Practice to an Integrated Delivery System.”](#) (Topic: Key Practice and Business Considerations)
5. [CMA ON-CALL document #0307, “Governance Issues for Physician Organizations.”](#) (Topic: Key Practice and Business Considerations)

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 41,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA's online health law library, CMA ON-CALL, or refer to the *California Physician's Legal Handbook* (CPLH).

CPLH is a comprehensive health law and medical practice resource containing legal information, including current laws, regulations and court decisions that affect the practice of medicine in California. Written and updated by CMA's Center for Legal Affairs, CPLH is available in an eight-volume, soft-bound print format or through an online subscription to www.cplh.org. To order your copy, call (800) 882-1262 or visit CMA's website at www.cmanet.org.