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medical foundations
one model for hospital-physician alignment

Several states have traditionally adhered to the corporate practice of medicine doctrine, which prohibits corporations (with the exception of hospitals and certain licensed healthcare facilities, such as clinics) from employing physicians to provide physician services. Regardless of whether states that have such a prohibition actively enforce it, many hospitals have chosen to comply.

Captives

Some hospitals have established physician-affiliated practice groups in the form of captive, or friendly professional service corporations or limited liability companies. Although the captives are not technically owned by the hospital, they exist mostly to serve the hospital's mission and are often directly or indirectly controlled by the hospital. By populating the captive's governing board with hospital senior management and having a hospital-employed physician as the sole shareholder of the captive, a hospital can maintain tight control over the affiliated captive without technically violating the corporate practice of medicine prohibition.

This approach has served hospitals well for decades. Recently, however, many captives have experienced significant financial losses in the face of declining physician payment and increasing operating costs for running physician practices. As a consequence, affiliated hospitals often provide cash subsidies to fiscally challenged captives to keep them afloat, creating tax and regulatory risks for the tax-exempt hospital. Captives do not qualify for tax-exempt status (because they are physician owned); therefore, the infusion of capital from a tax-exempt hospital to a for-profit captive creates certain tax and regulatory risks for the tax-exempt hospital. A summary of risks associated with subsidizing hospital-affiliated captives follows.

Tax-exempt issues. The contribution of funds or assets by a tax-exempt hospital to a for-profit entity, such as a captive, may create private benefit issues for the tax-exempt hospital. According to an IRS general counsel memo, private benefit is likely to arise where the financial benefit represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to accomplishing exempt purposes. Although tax-exempt entities are not prohibited from having financial relationships with insiders or private individuals, those relationships must serve a tax-exempt purpose and be reasonable. For example, a subsidy from a tax-exempt

AT A GLANCE

- Some states that enforce a corporate practice of medicine prohibition have created medical foundation statutes allowing hospitals or health systems to own corporations providing physician services.
- Medical foundations may be useful in the coordination of care through employed or contracted physicians.
- Medical foundations that qualify as tax-exempt entities have lower risks associated with tax-exempt rules as long as payments to physicians are reasonable and don't result in private inurement.

hospital to a captive must be reasonable and serve more than an incidental tax-exempt purpose of the hospital. More specifically, if a physician is being paid a salary, but his or her productivity is insufficient to cover his or her salary expenses along with the operational expenses associated with the captive, the tax-exempt entity may not be able to continue to subsidize the captive without jeopardizing its tax-exempt status.

Although arguments may be made that such support is in furtherance of the hospital's tax-exempt purposes and is therefore reasonable, it is also important to examine whether the captive is delivering healthcare services that are consistent with the tax-exempt purpose of the hospital (e.g., percentage of Medicaid patients served and the existence of a financial assistance policy). Determining whether the physicians are insiders and the compensation is reasonable requires factual analysis. Because this high-stakes issue can have significant consequences for the hospital, including possible revocation of the hospital's tax-exempt status, a third-party valuation of physician salaries is often recommended.

Unrelated business income tax. In the event a tax-exempt hospital lends funds to a for-profit captive to cover expenses, the loan payments and interest can constitute unrelated business income to the hospital. Hence, if there is repayment of amounts loaned, unrelated business income tax liability could exist.

Stark law. Under the Stark law, a physician is prohibited from referring to an entity that delivers designated health services, including inpatient and outpatient hospital services, if the physician has a financial relationship with the entity, unless an exception applies. In the case of a captive, a hospital can risk violating the Stark law if there is an unbroken chain of entities that have a financial relationship between them (i.e., each link in the chain has a financial relationship) and the physician's ultimate compensation takes into consideration the business generated by him or her for the hospital and the hospital has actual knowledge of the relationship. Hence, the infusion of funds either directly or indirectly into a captive that can be linked to referrals by the physicians back to the hospital can create liability under the Stark law. If a Stark violation exists, every referral made by the captive to the hospital and vice versa would be considered illegal.

Antikickback law. Under the antikickback law, whoever knowingly and willfully solicits, receives, or offers remuneration directly or indirectly, in cash or in kind, in return for referring an individual for a service for which payment may be made in whole or in part under a federal healthcare program is considered guilty of a felony. Although many hospitals would claim that the infusion of funds to the captive is "mission support," an antikickback law violation could occur if the funds given by the hospital to the captive are deemed to be used to generate referrals for the hospital. Thus, the infusion of funds indirectly or directly may create some exposure under the antikickback law for hospitals if there is evidence that the support given to the captive was to generate referrals.

Medical Foundations

Given the regulatory risks, hospitals may want to consider alternative practice models. Fortunately, with the advent of accountable care organizations (ACOs), the consolidation of healthcare providers, and the growth of integrated delivery systems, some states are recognizing the need to have hospitals and health systems own community-based physician practice groups. In fact, some states with the corporate practice of medicine prohibition have created medical foundation statutes allowing hospitals or health systems to own corporations providing physician services. In these states, medical foundations may be required to qualify for tax-exempt status or have community boards with physician representatives. If the medical foundation qualifies as a tax-exempt entity, the infusion of mission support payments from another tax-exempt entity potentially eliminates the risks associated with the tax-exempt rules as long as the payments to physicians are reasonable and do not result in private inurement.

As with a captive, the hospital or health system may create a board to maintain control over a medical foundation's operations. In states that require that the medical foundation board be composed of an equal number of physician employees and medical foundation owner employees, the board could consist of representatives from affiliated entities rather than the medical foundation's owner to avoid this requirement.

Accordingly, if the owner is the health system, the board may be composed of representatives from the health system's affiliated entities so the board does not need an equal number of physicians as the owner employees. Moreover, because the medical foundation may need to qualify for tax-exempt status, the number of physicians and insiders who can sit on the medical foundation's board will be limited.

To avoid violating either the Stark or antikickback laws, the medical foundation must also be careful to ensure that compensation for employed or contracted physicians is at fair-market value and does not take into account the volume of referrals made by the physicians. Presumably, if mission support does not result in unreasonable salaries to the physicians and the physicians are not obligated to refer patients to the hospital, implication of the Stark law and antikickback issues may be avoided.

Although the medical foundation model can be useful for hospitals or health systems that want to affiliate with community-based physicians, these organizations should confirm that state Medicaid agencies will pay community-based physicians for their professional services before creating the model. Because these physicians are indirectly employed by the hospital or health system, some Medicaid agencies may say the scenario would result in duplicate payment because Medicaid already reimburses the hospital for its employed physicians through its Medicaid cost report.

For this reason, the hospital or health system will need to establish that its cost reports will not claim any costs for the medical foundation. In particular, because a state may be suspicious of related-party transactions between the medical foundation and the affiliated hospital or health system, care must be taken to make sure all transactions are at arm's length.

Establishing a Medical Foundation

Hospitals and health systems can create one or more medical foundations depending on the level of integration they want to establish. The medical foundation model is particularly relevant for hospitals that are interested in establishing ACOs, in accordance with the Medicare Shared Savings Program or a private-payer ACO initiative, because medical foundations may be a useful tool to manage the coordination of care through employed and/or contracted physicians.

The most significant challenge in forming a medical foundation is obtaining meaningful buy-in from the participating physicians and avoiding an "us versus them" culture. Meeting this challenge requires a balance between giving the physicians a voice with respect to clinical operations and maintaining control over the medical foundation's business operations.

More important, an organization's success in establishing and implementing a medical foundation will depend on how well it manages costs and aligns participants' incentives. A particular concern is the growth of unnecessary, and often duplicative, administrative layers that result when bringing a hospital or health system and physician group together. To prevent costly administrative growth, a competent executive should run the operation and establish trust with physicians while promoting a culture of collaboration, quality, and efficiency.

A Growing Opportunity

The medical foundation model offers hospitals and health systems a potentially valuable opportunity to better integrate and collaborate with physician groups to improve the quality, efficiency, and coordination of care. The model may enable a hospital or health system struggling with insolvent captives to continue its relationship with the physician groups by avoiding many of the regulatory hurdles common in such arrangements.

Any hospital or health system considering the medical foundation model, however, must do so under its state's specific laws and legal standards. Although the corporate practice of medicine doctrine may be an impediment to the use of the medical foundation model in certain states, legislative remedies seem imperative in this era of healthcare reform—and they have been known to succeed in providing for explicit recognition of the model. ●

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