

Forming a Specialty IPA

By Jeremy N. Miller, J.D.

Independent practice associations (IPAs) have been a health care fixture for the past decade. The typical IPA is a professional corporation with a panel of participating primary care physicians and a broad range of specialists. Unlike an integrated medical group, IPA participating physicians maintain their separate medical practices, and use the IPA vehicle to pursue managed care contracts that they could not obtain on their own.

As part of the California health care delivery system's massive restructuring, a currently emerging organizational model is an IPA consisting of physicians in a single specialty, such as ophthalmology, orthopedics, oncology, cardiology, or psychiatry. Unlike the traditional IPA, the specialty IPA limits to a single specialty, rather than the full range of primary care and specialists services, the professional services it will contract to provide.

It remains to be seen whether specialty IPAs are an important new player in the health care delivery system or a temporary phenomenon. It is clear, however, that physicians considering the formation of a specialty, IPA need to proceed carefully. By following the steps outlined in this article, physicians should be able to increase the likelihood of a successful outcome.

WHY FORM A SPECIALTY IPA?

Physicians form specialty IPAs for a variety of reasons. The most common is to enhance their ability to obtain managed care contracts at the best possible rates. Physicians should realize, however, that in many markets, HMOs and self-insured employers are unwilling to contract directly with the specialty IPA. Rather, the specialty IPA's "customer" will be a "full-service" IPA or a multispecialty medical group. There are some possibilities for direct contracting with HMOs and employers, such as with the packaging of physician and hospital services for open-heart surgery.

In other cases, specialists might be compelled to organize in order to receive a subcapitation fee from a full-service IPA or multispecialty medical group that is seeking to reduce its own financial risk under a capitated contract by "carving out" specialist services. For example, many IPAs and medical groups do not consider themselves effective "gatekeepers" for such specialties as ophthalmology and orthopedics, and thus want to shift to the specialty IPA responsibility for utilization control and for providing the specialty services for the agreed-upon fee.

Additional reasons for forming a specialty IPA might include:

- ! hoped-for cost savings through joint managed care contract review, development and utilization of clinical protocol to improve quality and economic outcomes,

sharing staff such as a contract administrator, group purchasing, and improved medical information systems to track and control utilization

- ! increased access to capital
- ! expanded on-call coverage.

Finally, forming a specialty IPA might be an interim step or “get acquainted” measure prior to establishing a fully integrated, single-specialty medical group.

PUTTING TOGETHER A SPECIALTY IPA

Forming a specialty IPA is complex and requires careful handling from the start. The formation process involves four key steps: assembling the right planning team, assessing the market, resolving key organizational and operational issues, and forming the specialty IPA.

ASSEMBLING THE PLANNING TEAM

The specialist group should assemble a planning team at the very start of the process. Typically, the team should include some (if the proposed specialty IPA will be large) or all of the physicians, a marketing consultant familiar with the local managed care market, and an attorney who specializes in medical practice and health care issues. Physicians who hold more than one or two meetings on their own, without having benefit of the other professionals’ perspectives, could make such costly mistakes as pursuing an unmarketable project or inadvertently violating the antitrust laws by discussing their fees.

ASSESSING THE MARKET

Specialists must realize that carefully constructing a specialty IPA does not guarantee that managed care contracts will follow.

If they are starting an IPA because of their shrinking market share, physicians need to first understand the reasons for the decline. By combining forces in a specialty IPA, will a specialists’ group be able to offer a “product” better than they could as individuals and better than what is already available in the marketplace? Similarly, if the area’s full-service IPAs and multispecialty groups are already contracting with other specialist physicians, will they be willing to switch to different physicians?

On the other hand, if a full-service IPA or multi specialty medical group is supporting the proposed specialty IPA to subcapitate specialist services, the market is probably there for the new specialty group. The point is that specialists should make at least a preliminary market assessment for their services before spending significant time and money on the other steps to create a specialty IPA.

RESOLVING KEY STRUCTURAL ISSUES

Assuming market-assessment results are favorable, the next step is to identify, discuss, and resolve the key issues concerning the specialty IPA's organizational structure and operations. The following is intended only as a general guide to the various and complex issues:

Partnership or incorporation?

One of the first decisions is to determine the type of legal entity through which the specialty IPA will conduct its business. Theoretically, the two basic choices are a professional medical corporation and a general partnership.

As a practical matter the professional corporation model is the better choice in almost all cases. Among its advantages are that the corporation's owners (the physician shareholders) generally will not be personally liable for the group's professional liability obligations, debts, and other liabilities. Physician shareholders will always be liable for the consequences of their own professional actions, and the corporation will also be liable for its agents' acts. The other shareholders' personal assets, such as homes, bank accounts, and automobiles, will not be at risk.

In contrast, physicians in a general partnership are personally liable for all liabilities, debts, and obligations incurred in connection with partnership business. Even as a professional corporation, the specialty IPA should have its own professional liability insurance policy.

Heeding antitrust laws

Federal and California antitrust laws will significantly affect the specialty IPA's structure and operation. Because physicians are likely to be either actual or potential competitors with each other, the activities of the specialty IPA and the physicians will be subject to scrutiny for possible unreasonable restraint of trade.

Agreements among competitors could violate the antitrust laws if they involve price-fixing, division of markets, or a group boycott (all of which are deemed illegal whether or not there is actual harm to competition), unless the competitors' arrangement reflects a "legitimate joint venture" as first articulated in the 1982 U.S. Supreme Court decision in *Arizona V. Maricopa County Medical Society*. Furthermore, if the relevant market share represented by the specialty IPA's combined physician membership is too high, there is a risk that the IPA could be engaged in illegal market monopolization.

In light of the *Maricopa* decision, the question is how can a specialty IPA that wishes to conduct contract negotiations collectively for its physician members be structured so as to qualify as a "legitimate joint venture" for antitrust purposes? In general, the specialty IPA will need to have a substantial amount of "financial integration" (if the physician participants, that is, a way to pool capital and revenues so that the venture's participants share the specialty IPA's risk of loss. If the specialty IPA offers services to full-service IPAs and multispecialty medical groups on a capitated basis, these activities should represent joint venture-like integration among the physicians.

There is a separate question, however, regarding whether the specialty IPA will also be able to negotiate contracts on a noncapitated, fee-for-service basis. One possibility is to use the “messenger” approach, in which the specialty IPA acts as an intermediary in soliciting, but not negotiating, the price terms of payer fee-for-service offers, and then communicates the payer’s proposed contract terms, including price, to the specialty IPA’s physicians. Interested physicians then respond to the payer’s offer, usually through the specialty IPA. From an antitrust perspective, there is no agreement among the competing physicians on price terms. Specialty IPAs that use the “messenger” approach do negotiate some non-price terms of the payer-provider contract, such as utilization review procedures.

The second approach for dealing with fee-for-service contracts - and the one that, if available, provides the most marketable arrangement for the specialty IPA - would be for the IPA to negotiate and accept capitation payments and to also negotiate and obligate itself to provide physician services on a noncapitated basis. To do that, however, the physicians must establish financial integration among themselves in regard to such fee-for-service contracting. Among other things, this might require that the participating specialists transfer to the new specialty IPA all of their existing managed care business, and that all contracts for providing professional services be between the payer and the specialty IPA rather than with the individual physicians.

With respect to the monopolization potential, although it is unlikely to be a concern in an urban area, it can indeed be an issue in suburban, small-town, and rural areas. The monopolization inquiry asks: Are sufficient other specialists available to contract with payers not desiring to contract with or through the specialty IPA? Please note that under the federal antitrust guidelines issued on Sept. 15, the “safe harbor” for specialists in a joint venture from a challenge of monopolization is that the specialists’ market share not exceed 20 percent.

Structuring utilization review

The specialty IPA that will enter into managed care contracts on a capitated payment basis must resolve two issues: First, that the capitated contract’s key terms be acceptable and, second, that the specialists carefully monitor and control their utilization. Any contracts between the specialty IPA and a full-service IPA, multispecialty medical group, or other capitated payer must be carefully negotiated to try to limit the specialty IPA’s financial exposure. The agreement should clearly define what specialty services the IPA will be responsible for providing in exchange for the subcapitation fee. There should be “stop-loss” provisions and the ability to terminate the agreement early if necessary. Other important provisions include patient-authorization requirements, billing and collection procedures, and risk reserve pools.

With respect to utilization, a capitated selling can present an inherent conflict between individual physicians’ financial interests and the specialty IPA’s overall success (that is, the more procedures the physicians do, the more they bill the specialty IPA). Critical to the specialty IPA’s success will be the ability to determine which procedures are required for quality medical care and which are elective in nature. To address the problem (except in emergency cases, and perhaps initial consults), the specialty IPA’s utilization review committee should pre-approve any follow-up visit, test, procedure, or surgery. Initially, the committee might meet weekly to discuss follow-up visits,

tests, and procedures that require preapproval. Furthermore, the specialty IPA should develop clinical protocols or other strategies for work-up and treatment.

Physician compensation

Physician compensation is closely tied to the issue of utilization review and control. If the specialty IPA will be receiving fixed capitation payments, the physicians cannot bill the specialty IPA at their regular fee-for-service rates. Rather, in addition to agreeing upon a finite number of codes that the physicians can use to bill the specialty IPA for office visits and consultations, the physicians will need to develop a formula for billing the specialty IPA for testing, procedures, and surgery.

In general, the specialty IPA should underpay its physicians at first until it gets more experience working under a capitated-payment system. One approach is to set a very low rate, with a substantial amount withheld. Another approach is to use a “floating multiplier.” That is, at the end of the month, the physicians’ allowable charges are compared to the specialty IPA’s available funds. If total allowable charges exceed available funds by 20 percent, for example, then the multiplier used to determine allowable charges is reduced by 20 percent.

Management and control

If a professional corporation is formed, the physicians will have to address how the new entity will be controlled and by whom. Except for a few limited, albeit significant, decisions (such as election of directors, articles of incorporation amendments, sale of the business, or corporate dissolution), physicians in their capacity as shareholders do not control a professional corporation’s ongoing management and operation. In fact, if the shareholders manage the professional corporation’s affairs, they could lose the protection of the “corporate veil” and become personally liable for its debts and obligations. Rather, by law, a professional corporation’s business and affairs must be managed by, and all of its corporate powers exercised by or under the direction of, a board of directors.

Although the board of directors can delegate day-to-day management to its officers, a nonphysician administrator, or others, the board is ultimately responsible for their conduct. Thus, if the physicians want the specialty IPA’s control to be very democratic, they can create a board in which all physician-owners are directors. If this would be unwieldy, as might be the case with a group of 10 or more specialists, the board could be smaller. Furthermore, the board of directors can delegate specific functions to an executive committee and to other committees of still fewer physicians, as for utilization review.

Whatever the board’s size, the general rule is to take actions by a simple majority vote. To reduce the risk of majority “tyranny,” the physicians might want to require that certain decisions need “super majority” approval from two-thirds or even three-quarters of the directors. Such decisions might involve entering into capitated contracts, spending or borrowing money in excess of pre-determined limits, admitting or expelling a physician, and selling or dissolving the specialty IPA.

Retirement plans

The group should analyze how the new specialty IPA will affect physician members' existing, as well as any future, retirement plans. The problem arises if a physician is considered to be part of an affiliated service group (ASG) with the specialty IPA. The ASG rules-contained in Internal Revenue Code Section 414(m) and proposed Treasury Regulation Section 1.414(m)-provide, in general, that an ASG is considered a single employer for certain employee benefit purposes. This means that the Internal Revenue Service, in evaluating the qualified status of a physician's retirement plan, will look at the entire ASG and not just the individual physician's medical practice. Thus, the physician's retirement plan could be disqualified from certain tax advantages if contributions are not made for all of the ASG's eligible employees, (i.e., for the employees of all of the individual physicians' practices, and of the specialty IPA).

The IRS might disallow deductions for employer contributions, assess back taxes on plan earnings because of loss of the plan's tax-exempt status, and assess back taxes against employees for amounts that would have been included in gross income for each employer contribution.

Buy-sell issues

Physicians must discuss and agree upon the terms for a physician's possible withdrawal from the specialty IPA. Typically, the 'buy-sell' agreement between the shareholders and the specialty IPA will contain restrictions on the physicians' ability to sell their shares to a third party. Selling physicians will have to first give the specialty IPA or the other physician shareholders the opportunity to purchase their stock at the price offered by a third party or, perhaps, at a significantly lower price.

The specialty IPA should have the right or option to purchase a physician's shares under certain circumstances, such as if a physician were to terminate as a participating provider, die, become disabled, lose his or her medical license, or retire. In some circumstances, such as death, disability, or retirement, the departing physician might even be given the right to require the professional corporation to buy out his or her shares.

Generally, physicians should not be given a financial incentive to sell their shares back to the specialty IPA, because the remaining physicians would have to pay the buy-out price. In this regard, the buy-sell agreement will need to provide for how the buy-out price will be determined. There are a variety of possible valuation methods including fixed price, a price that is set each year, a price based upon the "book value" of the specialty IPA's assets, or a price determined by an appraisal.

Physicians also must agree upon the timing of the buy-out amount's payment. Unless the buy-out amount will be a relatively nominal sum, it probably should be paid out over a number of months or years.

Securities laws

The specialty IPA will have to comply with federal and California securities laws if shares of stock or other “securities” of the IPA will be offered to physicians. In most cases, an exemption should be available from federal “registration” and California “qualification” requirements. However, the anti-fraud provisions of the securities laws often require the preparation of a disclosure document describing the specialty IPA and the risks of becoming a shareholder and participating physician.

FORMING THE SPECIALTY IPA

The final step in the process is to create the specialty IPA. Typically, this involves:

- ! preparing corporate organizational documents, such as articles of incorporation and bylaws
- ! preparing physician participation agreements with the specialty IPA
- ! negotiating a subcapitation agreement with the full service IPA or multispecialty medical group
- ! possibly obtaining a group provider number
- ! obtaining liability insurance coverage for the specialty IPA
- ! contracting for necessary space and services
- ! preparing a buy-sell agreement obtaining new stationery and new telephone numbers
- ! establishing bank accounts
- ! obtaining a fictitious name permit
- ! and other details.

Caution, care, and thoroughness are essential to forming a specialty IPA. The entire process might take many months unless the specialists determine early on that the market is not ripe for them. Where market conditions are encouraging, a specialty IPA might well enhance many specialists’ practices.

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