FORMING AN INDEPENDENT PRACTICE ASSOCIATION

Issue

What legal issues does an IPA face during its formation?

Choice of Entity

In California there are two entity types to choose from in forming an independent practice association ("IPA"): a professional medical corporation, or a general partnership. The professional medical corporation is the better option because it (1) allows each physician in the IPA to be responsible solely for his/her own medical malpractice liability, whereas in a general partnership such liability is spread jointly and severally among the partners; and (2) the physician shareholders of the IPA will not be directly liable for the IPA’s debts and obligations, again as opposed to a general partnership.

The one benefit of a general partnership is that an IPA with more than 100 shareholders cannot be organized as an S-Corporation for Federal income tax purposes (S-Corporations pass through all income to the individual shareholders, thus avoiding the corporate tax), instead it must be taxed as corporation and pay corporate taxes. On balance, unless the IPA is likely to have more than 100 shareholders, the professional corporation remains the clear choice due to its liability protections. Also, see discussion below regarding non-physician participation in IPAs, which discusses entity choice in that context.

Avoiding Need for Knox-Keene Licensure

Under California Health and Safety Code section 1349, "It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan . . . ." This language has been interpreted by the Department of Managed Health Care ("DMHC") to restrict IPAs from entering into “global risk” arrangements with health care service plans unless the IPA has a Knox-Keene license. The corollary to this requirement is the implied exemption of IPAs that only accept provider risk from the necessity of obtaining a Knox-Keene license.

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1 Overview of Risk-Sharing Arrangements, Department of Managed Health Care, Financial Solvency Standards Board, p. 2 (January 29, 2002), https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/Meetings/a020129_info.pdf; see also CALIFORNIA PHYSICIAN’S LEGAL HANDBOOK, 2014 Ed., Vol. 3, Ch. 22, p. 50 (“the DMHC currently will not allow a medical group to assume global risk . . . unless it obtains a Knox-Keene Act license with restrictions . . . ”).
While no statutory definition of global risk exists, the DMHC’s Financial Solvency Standards Board issued guidance in January 2002, which the DMHC continues to follow. The main feature of global risk is acceptance of risk for both professional services and institutional services, e.g., services provided by a hospital, skilled nursing facility, home health care agency, ambulance, pharmacy, etc.\(^2\)

Accordingly, an IPA that does not desire to obtain a Knox-Keene license must not accept institutional risk; rather the IPA must only accept risk related to the provision of professional services.

**Non-physician Participation in IPAs**

Non-physician participation in an IPA is a tricky issue. First, if the IPA is organized as a professional corporation, then only individuals maintaining the following types of licenses may own an interest therein: (1) physicians, (2) psychologists, (3) registered nurses, (4) optometrists, (5) marriage and family therapists, (6) clinical social workers, (7) physician assistants, (8) chiropractors, (9) acupuncturists, (10) naturopathic doctors, (11) podiatrists, and (12) physical therapists.

If an IPA is formed as a partnership, there may be some room for argument that non-physicians could be partners. However, the State’s Corporate Practice of Medicine (“CPM”) doctrine makes this a risky move. The California Medical Board lists the following as indicia of a CPM violation: (1) determining what diagnostic tests are appropriate for a particular condition, (2) determining the need for referrals to or consultation with another physician or specialist, (3) responsibility for the ultimate overall care of a patient, and (4) setting the parameters of physician contracting with third party payers. Each of these factors is arguably present in an IPA’s dealings with its contracted physicians. Accordingly, an IPA with non-physician ownership may violate the CPM.

A safer alternative would be to retain the professional corporation organization, and to have non-physicians participate through ownership and operation of a management services organization that provides administrative and managerial services to the IPA.

**Antitrust Concerns**

The single most important legal issue to consider in forming an IPA is ensuring the IPA’s structure does not violate Federal antitrust laws. The U.S. Department of Justice and the Federal Trade Commission have produced detailed guidance on this issue. To avoid antitrust concerns altogether, the IPA can be organized to fit within one of two antitrust Safety Zones.

The First Safety Zone requires an IPA to (1) be exclusive (see below for a discussion of indicia of exclusivity), (2) share substantial financial risk among its physician participants.

\(^2\) Overview of Risk-Sharing Arrangements, supra n. 1, at p. 5.
(see below for a discussion of indicia of substantial financial risk), and (3) include 20% or less of the physicians in each physician specialty who practice in the relevant geographic market.\(^3\)

The Second Safety Zone requires an IPA to (1) be *nonexclusive*, (2) share substantial financial risk among its physician participants, and (3) include 30% or less of the physicians in each physician specialty who practice in the relevant geographic market.\(^4\)

In an exclusive IPA the IPA’s physician participants are restricted in their ability to, or in practice do not, individually contract or affiliate with other health plans or IPAs.\(^5\) An IPA is likely non-exclusive if the IPA’s physician participants (1) actually individually participate in or contract with other health plans or IPAs, (2) earn substantial revenue from other health plans or IPAs, (3) do not significantly “de-participate” in other health plans and IPAs, and (4) do not coordinate regarding pricing or other participation terms in other health plans or networks.\(^6\)

Examples of IPA’s physician participants sharing substantial financial risk include: (1) an agreement by the IPA to provide their services to a health plan at a capitated rate; (2) an agreement by the IPA to provide designated classes of services for a health plan for a predetermined percentage of the health plan’s premium; and (3) use by the IPA of significant financial incentives to contain costs, such as (a) withholding a substantial amount of compensation from the physicians and then distributing it based upon meeting cost-containment goals of the IPA as a whole, or (b) establishing overall cost or utilization targets for the IPA as a whole that lead either to bonuses or penalties.\(^7\)

Even if an IPA does not fit within one of the above Safety Zones, e.g., if an IPA has more than the allowable percentages of a physician specialty in a given geographic market, the IPA is not necessarily illegal, rather its antitrust concerns are evaluated under the rule of reason, so long as the IPA is likely to (1) produce significant efficiencies that benefit consumers, and (2) any price agreements by the IPA are reasonably necessary to realize those efficiencies.\(^8\) As a practical matter, an IPA whose physician participants share substantial financial risk will be considered to meet the above criteria, and thus may be analyzed under the rule of reason.\(^9\) Alternatively, if the IPA has sufficient clinical integration, as evidenced by establishing utilization mechanisms, selectively choosing physician participants in the IPA, and the investment of significant financial and human capital, it can also be analyzed under the rule of reason, even if it lack substantial financial risk among its participants.\(^10\)

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\(^4\) Id., at p. 65.

\(^5\) Id., at p. 64.

\(^6\) Id., at p. 66-67.

\(^7\) Id., at 68-69.

\(^8\) Id., at 71-72.

\(^9\) Id., at 72.

\(^10\) Id., at 72-73.
The rule of reason has four steps. First, the relevant market must be defined. The market is defined based upon (1) the types of services the IPA will provide, and (2) the geographic reach of the IPA.\footnote{Id., at 76.}

The second step is to evaluate the competitive effects of the IPA. The two key areas of concern are whether (1) whether the IPA could raise prices for health plans above a competitive level, and (2) whether the IPA will impede the formation or operation of other plans.\footnote{Id., at 77.} To put it another way, it is good for the IPA to have successful competitors.

For example, the Department of Justice will heavily consider whether the percentage of certain specialists in an IPA is so high that the IPA will be able to significantly raise prices and, by boycotting other health plans and IPAs, limit the availability of such specialty services in the market.\footnote{Id.} Accordingly, an IPA should not seek to be a monopoly in any specialty, as this will likely eventually lead to antitrust violations.

Further, the Department of Justice will also consider whether members of the IPA have divergent interests,\footnote{Id.} such as whether they compete outside of the IPA for other health plan, IPA, or private pay business; or where only a small group of physicians participating in the IPA own interests in the IPA, and therefore have an incentive to control the costs of participating non-owner physicians in the IPA,\footnote{Id., at 77-78.} such cost control is a good indicia of positive competitive effects.

Finally, an IPA can lessen anticompetitive effects by ensuring the physician participants do not discuss/share or agree on prices they charge outside the IPA.\footnote{Id., at 79.} Such sharing can occur when the IPA is formed and uses participating physician fee data to build its initial fee schedule (and as the IPA annually updates the fee schedule). To avoid antitrust concerns, the IPA should use an outside agent to collect and analyze physician participants’ fee data for use in creating the IPA’s fee schedule.\footnote{Id.} Also, before the IPA is formed the physicians should not in any way discuss fees or other terms of participation, or participate in a boycott of any health plan or IPA, even in the context of discussing a future yet-to-be-formed IPA’s fees and other required payer terms, as this qualifies as per se price fixing and is an illegal restraint on trade under the Sherman Act.\footnote{See In the Matter of Obstetrics and Gynecology Medical Corporation of Napa Valley, et al., Consent Order, etc., In Regard to Alleged Violation of Section 5 of the Federal Trade Commission Act, Docket C-4048, File No. 0110153 (May 14, 2002)(hereafter “Napa Valley”).}

The third step is to assess procompetitive efficiencies created by the IPA. Again, sharing of substantial financial risk or substantial clinical integration are the best indicators of procompetitive efficiencies.\footnote{Id., at 80.} The Department of Justice will also consider
evidence of substantial competition facing the network, improved cost controls, improved case management and quality assurance, economies of scale, and reduced administrative and transaction costs.  

The final step requires an analysis of any collateral agreements the IPA’s members may have. Basically, the IPA’s participants absolutely cannot agree on or discuss prices and other contractual terms they will accept outside of the IPA, or agree to boycott other health plans or IPAs. Contractual terms in the IPA’s operating agreement and shareholder agreement should require participating physicians to refrain from sharing or agreeing upon such information and to refrain from boycotts.

To summarize, to avoid antitrust concerns an IPA should: (1) ensure that its members share substantial financial risk, likely through agreeing with payers to accept capitated payments and implementing withholds that pay out upon meeting certain utilization and efficiency goals; (2) ensure clinical integration by establishing utilization review (see below for a further discussion) and quality assurance programs, selectively choosing physician participants, and investing significant financial and human capital in tracking and operating the utilization review and quality assurance programs; (3) avoid growing to monopoly or near-monopoly size, while endless growth is tempting if the IPA gains more than 50% share in any specialty within its relevant geographic markets it will likely begin to attract lawsuits from payors and other physicians that will lead to large legal bills and the potential for the IPA to be broken up; and (4) require physician participants to refrain from agreeing on or discussing prices and other contractual terms they will accept outside of the IPA, or agreeing to boycott other health plans or IPAs.

**Payor Contracting**

When entering into payer contracts with HMOs, other IPAs, and self-insured employers, the IPA should pay special attention to the following issues. First, the IPA must ensure that the definition of covered services is clearly and as narrowly defined as possible, e.g., a list of covered procedures is the best choice, rather than vague descriptions such as “all medically necessary services.”

Second, the agreement should contain a “stop-loss” provision if possible, which will allow the IPA to stop seeing new patients once a certain level of losses has been reached (in addition to this provision, the IPA should purchase stop-loss insurance).

Third, the agreement should clearly define patient authorization requirements to ensure that the IPA only treats patients it can be reimbursed for. Under California law, procedures for the authorization and denial or care must be submitted, reviewed, and approved by the DMHC, and must be disclosed to patients and the public. An IPA should ensure the procedures it agrees to with payors are medically appropriate and submitted to and approved by DMHC.

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20 Id., at 80-81.
21 Id., at 81.
22 Id., at 81; see also Napa Valley at 798-800.
23 California Health & Safety Code § 1363.5(a); California Insurance Code §10123.135(f).
Fourth, specific and fair utilization review procedures must be agreed upon to ensure that the IPA does not lose out on reimbursements. Under California law, utilization review must be based on sound clinical principles, such that they are (1) developed actively by physicians, (2) consistent with sound clinical principles, and (3) be evaluated and, if necessary, updated annually. The procedures must also be submitted, reviewed, and approved by the DMHC. An IPA should ensure the procedures it agrees to with payors are based on sound clinical principles and submitted to and approved by DMHC.

Finally, risk reserve pools should be established whereby a percentage of the capitation payments received by the IPA are invested in liquid assets, e.g., cash and readily marketable securities, to cover unforeseen losses. At the end of each fiscal year any amounts left in the risk reserve pool are then paid out to the IPA.

**DMHC Regulations and Reporting Requirements**

DMHC regulations require plans contracting with IPAs to include contractual terms requiring the IPA to meet five criteria and to make quarterly and annual reports regarding such criteria to DHMC. The five criteria are: (1) the IPA must meet the timeframes established by California Health & Safety Code § 1371 for reimbursement, payment or denial of claims; (2) the IPA must calculate its incurred but not reported (“IBNR”) liability on a monthly basis; (3) the IPA must maintain positive tangible net equity (“TNE”); (4) the IPA must maintain positive working capital, i.e., excess of current assets over current liabilities; and (5) maintain a cash-to-claims ration of at least 0.75.

On a quarterly basis, the IPA must submit a report to the DMHC detailing its compliance with the above criteria, and, if the IPA has at least 10,000 covered lives, the report must also include a “financial survey report” consisting of the IPA’s balance sheet, income statement, and cash flow statement. All IPA accounting must be done on an accrual basis, or the IPA is deemed to have failed to maintain positive TNE and cash flows.

With regards to criterion 1, the IPA must calculate and submit a statement as to what percentage of claims were timely reimbursed, contested, or denied in accordance with California Health & Safety Code § 1371. If less than 95% are in accord with California

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24 California Health & Safety Code § 1363.5(b); California Insurance Code §10123.135(f).
25 California Health & Safety Code § 1367.01(b); California Insurance Code § 10123.135(b).
26 California Health & Safety Code § 13754.4.
31 28 CCR § 1300.75.4.2(a)(2).
32 28 CCR § 1300.75.4.2(b)(1)(A); 28 CCR § 1300.75.4.2(b)(2)(A).
33 28 CCR § 1300.75.4.2(b)(1)(C).
34 28 CCR § 1300.75.4.2(b)(1)(B).
Health & Safety Code § 1371, then the IPA must also submit a statement explaining why this is the case and the steps it is taking to fix the issue.\textsuperscript{35}

Under criterion 2, the IPA must submit a statement confirming it has calculated and documented its IBNR liability on a monthly basis, and must use such calculations when creating its financial survey report.\textsuperscript{36} The IBNR liability must be calculated either by performing a lag study or an actuarial study in compliance with the requirements of 28 California Code of Regulations § 1300.77.2.\textsuperscript{37} If the IPA fails to meet this criterion it is deemed to have failed to maintain positive TNE and cash flows.\textsuperscript{38}

Turning to criteria 3 and 4, the IPA must submit a statement as to whether it has maintained positive TNE and cash flow during the entire preceding quarter, calculated in a manner consistent with generally accepted accounting principles (“GAAP”).\textsuperscript{39} If such positive TNE and cash flows were not maintained then the statement must describe in detail the nature and reasons for the deficiency, and what corrective actions were taken and the result of such corrective actions.\textsuperscript{40}

TNE is defined as net equity (net equity is total assets over total liabilities) reduced by the value of intangible assets, “by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due; long term prepayments of deferred charges, and nonreturnable deposits.”\textsuperscript{41}

With respect to criterion 5, IPA must submit a statement that its cash to claims ratio met or exceeded 0.75 during the entire preceding quarter.\textsuperscript{42} Cash to claims ratio is defined as “an organization’s cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within 60 days divided by the organization’s unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability.”\textsuperscript{43}

Also, on an annual basis the IPA must submit a detailed a voluminous annual report, including the following information: (1) an annual financial survey report, i.e., the IPA’s annual balance sheet, income statement, and cash flow statement; (2) the opinion of a certified public accountant that the IPA’s annual financial survey report was prepared in accordance with GAAP, and fairly present, in all material respects, the IPA’s financial

\textsuperscript{35} Id.
\textsuperscript{36} 28 CCR § 1300.75.4.2(b)(1)(C).
\textsuperscript{37} Id.
\textsuperscript{38} Id.
\textsuperscript{39} 28 CCR § 1300.75.4.2(b)(1)(D).
\textsuperscript{40} Id.
\textsuperscript{41} 28 CCR § 1300.76(e).
\textsuperscript{42} 28 CCR § 1300.75.4.2(b)(1)(E).
\textsuperscript{43} 28 CCR § 1300.75.4(f).
condition; (3) a statement as to whether the IPA has estimated and documented its IBNR liability (again failure to do so is deemed failure to maintain positive TNE and cash flow); (4) a statement as to whether the IPA has maintained positive TNE and cash flow, and if not a statement explaining why, what corrective actions were taken, and the results of such corrective action; (5) a statement as to whether the IPA has maintained a minimum 0.75 cash to claims ratio, calculated in accordance with GAAP; and (6) a statement regarding whether IPA has stop-loss coverage or reinsurance. 44 Along with the above report, the IPA must submit an additional report containing certain specified information about the IPA, such as contact person, organization type, identity of its contracted payers, a matrix listing its services, etc. 45

Any significant change in an IPA’s finances that materially alters its financial situation or threatens solvency must be reported to DHMC within five business days, 46 and if an IPA fails to meet the criteria or to provide required reports discussed above, it will be required to enter into and comply with a DHMC proposed corrective action plan (“CAP”). 47 Failure to adhere to the CAP can lead to the closure of the IPA.

**Retirement Plan Issues**

The IPA should hire an expert in retirement plan requirements to ensure that its formation and structure will not lead it to be considered an affiliated service group (an “ASG”) under Federal law. If the IPA is considered an ASG, then its retirement plan contributions are only exempt if contributions are made for all eligible employees, which means all eligible employees of *every independent practice* in the IPA would need to receive contributions or everyone’s contributions would *not* be exempt. 48 An IPA may be considered an ASG if the individual physician practices perform a significant portion of their services through the IPA and 10% of more of the interests in the individual physician practices are held by highly compensated employees of the IPA. 49 However, many IPAs are not considered ASGs. Ultimately, as mentioned above, an expert on retirement plan requirements should advise the IPA on these issues.

**Buy-Sell Clauses**

The IPA’s shareholder agreements should contain buy-sell clauses restricting IPA owners’ ability to sell their interests. The best method is to grant the IPA a right of first refusal. Further, a valuation method should be agreed upon in advance, and the buyout payment should be structured over several years to lessen financial impact.

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44 28 CCR § 1300.75.4.2(c).
45 28 CCR § 1300.75.4.2(d).
46 28 CCR § 1300.75.4.2(f).
47 28 CCR § 1300.75.4.8.