

## MANAGED CARE

# Do IPAs have a future?

*Healthcare observers say the model must be reinvented before it will fly*

BY ELIZABETH THOMPSON BECKLEY

Recent years have been bleak for many independent practice associations. California alone has witnessed hundreds of IPA collapses. One trade association, the National IPA Coalition, folded last October, and attendance at another's national meeting in March was eerily sparse.

Concrete national figures are elusive, but Albert Holloway, president and CEO of the remaining trade group, The IPA Association of America, estimates the number of IPAs has fallen from around 3,500 to about 2,250 today.

Industry observers and insiders alike say IPA survivors are hunkering down to examine their business models. Those who reinvent themselves may yet make the model soar.

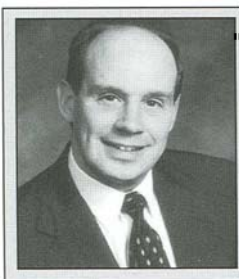
"I don't think IPAs should be taking risk," says Frank Stevens, a healthcare director in the Los Angeles office of Peterson Consulting.

"We went through a period when doctors and hospitals thought if you weren't willing to take risk, you weren't going to be part of the ballgame. They saw HMOs making all this money, but what they weren't seeing was the physicians getting paid 20 cents for 24-cent costs. That's what is putting (IPAs) out of business."

Stevens gained his perspective as the conservator retained by the California Department of Managed Health Care for two troubled HMOs and the bankruptcy of Chaudhuri Medical Corp., part of the MedPartners and KPC Medical Management lineage.

Taking a cue from successful medical groups, IPAs are pushing back against health plans and saying no to untenable risk and unreasonable contracts. Some IPAs, learning from physicians in integrated systems, are building stronger relationships with payers and hospitals, branding themselves with quality initiatives and clinical standards and investing in technology systems they couldn't afford on their own.

**TRADING CAPITATION FOR 'EXPENSE TARGETS**  
The 2,300 physicians of Taconic IPA, based in Fishkill, N.Y., are spread across eight counties and represent a model that both rejects risk and works closely with its plan.



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*A. John Blair III, M.D.*

More than a year ago, Taconic decided to move away from capitation, instead using a similar reimbursement figure called a "medical expense target." If costs stay within the target, Taconic shares revenues with its exclusive contracted payer, Schenectady, N.Y.-based MVP Healthcare. If expenses exceed the target, the payer bears the risk.

To make that happen the IPA turned final authority of all medical management over to MVP, says Taconic Chairman and CEO A. John Blair III, M.D. While the doctors cannot veto MVP's utilization review policy, they are very much involved with analysis and development of that policy, Blair says.

Policy is the IPA's secondary function, however.

"What we are contracted to do is provide a comprehensive, stable, compliant, high-quality network of physicians that advocate this plan," he says.

Some IPA administrators and consultants recommend diversification of payers, but that is impossible for Taconic due to the regional market dominance of MVP whose members constitute 10% to 80% of anyone physician's panel. Consequently, the IPA contract is strong

enough to keep the doctors in line. All Taconic physicians are paid equally, and the IPA bylaws are designed to dissuade them from using higher contract offers from other payers as leverage for special treatment.

"If the doctors don't have this payer, they can't practice in this area," Blair says. "If you leave the IPA, you can't come back for three years."

With that stick comes a carrot, and Blair says Taconic is building the technological infrastructure with help from MVP and local hospitals and labs to reduce errors and improve quality. The goal is to financially reward those physicians who meet quality measures.

"Success has to do with governance, administrative leadership, capital and incentives," Blair says. "You have to have payers involved in that. Pulling it off is a Herculean task. I don't know if we or others can do it, but is so, that is where success lies."

### BEARING RISK COULD BRING ON REGULATION

IPAs that continue to bear risk must be regulated like HMOs and insurance companies, insists Stevens of Peterson Consulting.

Regulation efforts in New York and California are proceeding slowly, with resistance coming from groups struggling to maintain required reserves on thin margins and concerned about the effect open books will have on payer negotiations.

If IPAs must take risk, it should come in the form of partial capitation for professional services only, says Beverly Sepulveda, president of health care consulting company SynerImages, based in Houston.

Sepulveda also is an advocate of capitation for disease management with established clinical guidelines. Diabetes and cardiovascular disease require multi-disciplinary, coordinated care and physician solidarity, she says.