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Rural IPA Formation: Nothing Like What the City Slickers Do

BECAUSE OF OUR SUCCESS OVER THE PAST 21 years in Mesa County, Colo., with a non-competitive, nearly all-inclusive IPA, we receive many requests, usually from small unorganized medical communities, for information on how to organize. Most areas seem to be under pressure from either hospitals or third parties to start signing something.

Our experience suggests that IPA formation and management is quite different in small isolated communities than in large metropolitan areas. When competition between physician groups is not realistic, all the rules change. Some changes make things easier; some make it harder.

Mesa County Physicians IPA includes 90 percent of the practitioners in our area. In 1993, we began an HMO that now handles 45 percent of the private business, 60 percent of Medicare and 80 percent of Medicaid. I've described the organizations previously in *Family Practice Management* (see "Rural Managed Care: A 20-Year Road to Success," October 1993, page 79, and "Medicaid Miracle in the Mountains," February 1994, page 45).

The first request from a medical community curious about organizing is invariably to see our articles of incorporation and our by-laws. We are always happy to oblige, but most of that information is useless, though necessary, legal boilerplate that any lawyer can provide. Some things, however, are critical.

Primary care representation

The IPA board must be structured so that primary care physicians (PCPs) have at least an equal voice with non-PCPs. Any organization controlled by non-primary-care specialists will be considered suspect by third parties, but that is not the biggest issue. To survive and thrive in managed care, the PCPs in your organization must be treated fairly relative to other specialists. Our early experience was that PCPs have been much more willing to take leadership positions than referral specialists. Because so many delicate and controversial decisions must be made, physicians who are dependent upon referral business feel very vulnerable in leadership posts.

If you do not have strong PCP leadership in your medical community, you need to begin developing it. In rural areas, most PCPs are too busy to devote the necessary time, so your first step may be to make realistic arrangements to compensate

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them for lost practice time as they take on administrative work.

Another reason for an equal distribution of PCP and non-PCP votes on your board is that you must function by consensus or near-consensus. Unlike big-city organizations where you can drop those unreasonable orthopedists and readily find some more, we in the hinterland are basically stuck with each other. While cumbersome at times, the need for true collegiality has prompted remarkable concessions from both PCPs and referral specialists — concessions that would require bloodletting in the big city.

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Money

You will need financing for your IPA. If you ask your physician leaders to do their job in their spare time and without paid staff, you will get just what you pay for. In the big cities, IPAs take some money out of physicians' fees or assess physicians for operating funds. But remember, this funding concept was established where physicians were afraid of losing business. In our area, most of us would like to lose some business.

In Mesa County, we insist on an access fee from the insurance companies we deal with. If they won't agree to pay, then we invite them to try negotiating with 150 individual physicians, many of whom don't want more business. Third parties soon realize that the access fee actually saves them money and provides them with a comprehensive panel of providers. How much is the access fee? We cover all our expenses and nothing more. We use these funds to pay all physicians for all time spent performing any function requested for the IPA.

The antitrust attitude

Antitrust issues are problematic. Lawyers get squeamish. You have to be willing at least to talk with all players, but you cannot be collectively greedy. We have done several benevolent medical projects for the community to make our intentions perfectly clear. We have the advantage of working with one large HMO and thereby sharing risk. But our lawyers are still uncomfortable when we boast that 90 percent of the county's practicing physicians are members. Our collective feeling is that the benefits of organizing — benefits for our patients and their medical future — far outweigh the risks. Remember that anyone proposing antitrust action in a small rural area is proposing to financially destroy his referral base — or the PCPs he needs to make his managed care plans succeed. Regardless, this area desperately awaits legislative relief, and we continue to run everything we do and everything we print by two antitrust lawyers.

Selectivity — within reason

The issue of which doctors to include in the IPA is sometimes problematic. You must have a core group of PCPs, preferably most PCPs, solidly behind the project. Ideally, the PCPs would *be* the IPA and subcontract with other specialists. Under that scenario, decisions are easy, but, in our less-than-ideal world, implementation may be tougher. Most referral specialists become so paranoid when PCPs organize that you probably would be wiser to include them somehow in the original plans. You will have to work with them either way, so give

them enough representation to maintain communication without impeding change unduly. In our area, three specialty groups opted to stay out, but we work well with them.

Don't permit any obviously substandard practitioners to be part of your IPA. They are hard to deal with later. Beyond that, you probably need to offer some sort of membership to every physician in a rural area. But remember the control issues. If the board is not balanced, you will struggle.

Quality

You must control medical standards review in your community. Our Medical Practice Review Committee is selected by our IPA, and no one else makes quality decisions. The hospital quality review committees are composed of peers; we have to be certain that the out-patient committees are as well. Do not allow third parties to provide medical quality review. We offer credentialing and review services to third parties for a fee. Physicians and only physicians decide the standard of care in Mesa County.

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If you have these issues in hand, the balance of the articles of incorporation and the by-laws are routine and of minor significance. The rules are naturally different in rural areas because the driving forces at the provider level are totally different. Be sure you don't give up your role in deciding standards of care just because they have given it up in the big city. This is definitely one way in which being isolated and rural is a big benefit. FPM

Editor's note: For other perspectives on IPA formation, see "The Building Blocks of Successful IPAs," page 35.