

PEN's CALIFORNIA OPTOMETRIC IPA PROJECT: Frequently Asked Questions

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Q1. What do I get for my contribution to Phase Two of PEN's California optometric IPA project?

- A. You are being asked to contribute to a fund that will be used to pay the expenses of Phase Two of PEN's medical IPA project, as described in the presentation, which are estimated to total \$175,000. These expenses include:
- \$20-\$25,000 in attorneys' fees to provide all the advice, documentation, and filings necessary to create the IPA.
 - \$75-100,000 in managed care consulting fees to test potential market models; identify and select partners and affiliates; and produce a business plan.
 - \$50,000 for associated management fees and administrative costs.

You are *not* being asked to invest or become a shareholder in the IPA itself. If sufficient funds are raised to complete Phase Two, capitalization of the IPA to begin operations will be the next challenge.

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Q2. What assurances do I have that my money will be spent as advertised?

- A. Your contribution and all others will be deposited into a segregated account managed by PEN, which will monitor and account independently for all activities billed and expenses paid. As a contributor, you will be entitled to know how and when any monies are spent.

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Q3. What happens to my contribution if we don't raise enough to complete Phase Two?

- A. If the profession is unwilling to contribute enough to defray its cost by mid-summer, Phase Two will not go forward. All contributions received for this purpose will be returned on a *pro rata* basis, according to the size of each, after adjustment for any expenses incurred during the solicitation period.

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Q4. What happens if we collect more than we need for Phase Two?

- A. If at any point before July 1 we've collected enough to cover the costs of Phase Two, you'll be notified here. PEN will return a portion of your contribution, which will be reduced pro rata in proportion to all contributions versus expenses.

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Q5. Who's doing the legal and managed care consulting work for me?

- A. The attorneys recommended to and hired by PEN to complete Phase One's investigation of legal options are [Cathy Deubel Salenko](#), Esq., Partner, and [Gary F. Loveridge](#), Esq., of Counsel, of [Best, Best and Krieger LLP](#) of Sacramento. Our managed care consultants who prepared the initial market analysis and report and recommendations for Phase Two are [Karen F. Taranto](#) and [Russell D. Foster](#), Principals in [pmpm® Consulting Group, Inc.](#) (Click on any of the names to learn more about the firms and individuals.)

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Q6. What are the steps required to create the IPA'S legal structure, and how long will they take?

- A. Our attorneys estimate that they can complete, register, and file all necessary documents—Articles of Incorporation, Bylaws, charter, and other initial compliance documents—to meet all California statutory and regulatory requirements for doing business in approximately 30 days, after consultation with potential initial incorporators about the new corporation's goals and objectives.

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Q7. What can I expect the IPA's business plan to look like, after four months, on October 1?

- A. The final business plan itself will reflect the results of completion of the following tasks performed by the managed care consultants over that period:
- Preparing a Strength/Weaknesses/Opportunities/Threats (SWOT) analysis;
 - Defining and testing potential market and business model options;
 - Confirming ultimate organizational and management structures and product lines;
 - Defining all potential preferred demonstration sites and other potential HMO, IPA, and other institutional partners;
 - Selecting and prioritizing preferred demonstration sites and partners; and
 - Developing a budget.

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Q8. What's in it for PEN?

- A. PEN committed itself fully to complete Phase One of its IPA project. PEN has also committed itself to offering an expanded credentialing service, either independently for its members or as a management service to the network. Whether the IPA would use PEN's credentialing or other management services, or those of another contractor, would be decided by the IPA's Board of Directors and management.

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Q9. I'm ready to contribute to help complete Phase Two. How do I go about it?

- A. It's simple—just go to PEN's dedicated project page, where you can donate online using your PayPal account or credit card or get the information necessary to mail in a check. (If you still have questions or need more information about the project, it's available from that page, as well.) Click [here](#).

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Q10. What is an "Accountable Care Organization (ACO)?"

- A. An "Accountable Care Organization" is a "blended" physician/hospital organization authorized by the federal reform law to achieve savings in Medicare and Medicaid by preventing undesirable patient outcomes. Optometrists could play a strong role both in the diagnosis and management of chronic systemic diseases and conditions and the detection and prompt referral of non-systemic ones in at-risk patients.

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Q11. Doesn't the federal reform law exclude optometrists from participation in ACOs?

- A. It's true that, in the amendments made by the ACA to the Social Security Act, optometrists are not affirmatively defined as a class of health care provider that is authorized to create and participate in ACOs. It's also true that draft regulations implementing those provisions released by the federal Department of Health and Human Services state that types of providers other than those mentioned specifically in the Act can participate in ACOs. Revisions to the draft regulations are anticipated, which may make a change to the ACO provider types.

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Q12. How might an optometric IPA fit into an ACO or Patient-Centered Medical Homes?

- A. The overall goal of ACOs and Patient-Centered Medical Homes is the same: to provide integrated and coordinated care to achieve savings by providing care more efficiently and improving patient compliance and outcomes—such as reducing hospital admissions and readmissions. Integrating and focusing information and care delivery resources on finding and managing at-risk and high-risk patients is the methodology for both. We believe a strong argument can be made that Doctors of Optometry are an overlooked and underutilized primary care resource, based on the following points:
- Over the next half-decade, California faces both shortages in available primary care physicians and physician extenders and a significantly higher number of residents with health insurance coverage.
 - Besides being "primary eye care specialists" trained to diagnose, treat, and refer diseases and conditions specific to the eye and its adjuncts—such as glaucoma—optometrists are

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capable of detecting a high number of high-risk, non-systemic diseases and conditions—such as diabetes, hypertension, and vascular diseases—by taking detailed patient histories, performing comprehensive eye exams, and taking intraocular images.

- Over 7,000 optometrists practicing in both urban centers and less-populated areas, who are more available and accessible to screen and refer at-risk patients, represent a potential primary care asset too valuable to ignore.

That argument would be made to institutions that could sub-capitate care to ODs—including hospitals; medical groups, foundations, and IPAs; and other allied providers who join together in ACOs or participate in Patient-Centered Medical Homes—both to diagnose, treat, and manage systemic diseases and conditions and to detect and refer appropriately non-systemic diseases and conditions, especially among patients with chronic conditions.

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Q13. Medical eye care services are not a large part of my practice revenue. Why should I invest in an “integrated care” IPA?

- A. That's a good question, if you assume that the current, refraction-heavy, fee-for-service model—which is essentially carved out of managed care—should and will remain the service delivery model for the profession. Managed medical care has been a fact of life in California for decades. Broad federal health care reforms aimed at reducing the cost of both public and private coverage, and their accelerated implementation here, suggest that the days of both the fee-for-service model and excluding vision care generally from shared risk may be numbered.

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Q14. Given the recession and uncertainty in implementing federal reform and state scope laws, is now a good time to start an optometric managed care network?

- A. Several factors suggest that the timing will never be better for the profession to organize to become and remain competitive in California's managed care market:
- As a matter of public policy, if deficit spending by federal and state governments is to be controlled, the cost of health care as a percentage of Gross Domestic Product must be reduced, and dramatically, given the aging of our population who consume benefits and the corresponding decline in the employed workforce who pay for them.
 - The Patient Protection and Affordable Care Act (ACA), enacted last year, combines incentives and penalties that take full effect in less than three years to rein in Medicare and Medicaid costs. What they add up to is that providers who can demonstrate that, working together, they reduce costs through efficient utilization and improved outcomes will be rewarded, and those who can't will be punished. Incentives are strongly weighted toward innovation and prevention.
 - California has already received federal approval to migrate Medi-Cal managed care from a dozen to all 58 counties in the state, and is implementing plans to capitalize on federal incentives to expand Medi-Cal coverage. Based on current projections, by the end of this decade one in five Californians will be insured by Medi-Cal.
 - Assuming they pass legal muster—and it's worth remembering that both Medicare and Medicaid faced similar, unsuccessful challenges after enactment—ACA's creation of state health benefit exchanges and imposition of mandates on private health insurers, employers, and individuals will significantly change how *all* health benefits are designed, marketed, paid for, and delivered, in a relatively short period of time.

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- The ACA defines pediatric vision and hearing as “essential”—and therefore mandatory—health benefits, subject to additional regulatory definition.
- Due to expansions of scope of practice in the last five years, California Doctors of Optometry are better positioned to become primary care and prevention assets in integrated care delivery, especially for older and high risk patients with undetected but manageable chronic conditions.

In short, the combined effect of these factors is to create both opportunity and risk for the profession. The opportunity is to capitalize on broad institutional changes to win a seat at the integrated, managed health care services table. The risk is to become an outlier as the fee-for-service delivery model is replaced by capitation and other forms of assumed financial risk.

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Q15. Will organized medicine's lawsuit, challenging the State Board of Optometry's glaucoma certification regulations, affect credentialing and the IPA's chances?

- A. So far, they've already lost an important battle in their declared war. It remains to be seen whether they'll continue to fight on appeal.

The combined California Medical Association/California Academy of Eye Physicians and Surgeons complaint was filed on January 10 and the State Board was served February 23. The Attorney General filed a demurrer in response, asking that the complaint be dismissed without leave to amend because it was, in essence, legally insufficient to warrant the relief requested. The demurrer motion was heard before the Hon. Peter J. Busch in San Francisco Superior Court on Monday, May 2. At the conclusion of oral argument the Judge sustained the demurrer, without leave to amend, on two grounds:

- The Board acted within its rulemaking authority under California Business & Professions Code Section 3025 in promulgating the regulations, and no abuse of discretion was shown in the complaint; and
- Neither CAEPS nor CMA demonstrated sufficient standing to bring the action.

Because the demurrer was sustained without leave to amend, the present case at trial is effectively ended. The Attorney General prepared a draft "Notice of Entry of Judgment/Order," which was reviewed by the plaintiffs and submitted to the Court for signature and entry. CMA and CAEPS will have until mid-July to file an appeal from the final order of judgment. So, we'll know by mid-August whether the battle will continue.

Regardless of when and how any appeal plays out, uncertified ODs will have a much larger pool of certified ODs with whom to affiliate to co-manage, or to whom to refer, primary open-angle glaucoma suspects for treatment.

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Q16. How certain are you that a medical eye care IPA for optometrists can be successful?

- A. The only two things in life that are certain are—well, you know. PEN's Advisory Board has taken a deliberate approach to this project; they discussed it for over a year before agreeing to commit any funds to it. Further, we decided first to investigate thoroughly the feasibility of getting into managed care in today's ever-changing environment. We've learned that, as discussed elsewhere, California's managed care market is mature, sophisticated, and very competitive, and our profession has a lot of ground to make up. A significant number of medical and other professional IPAs have failed, we believe, because they've underestimated the capital, time, and effort required to become successful, and we're determined not to make that mistake. This

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project will be a marathon, not a sprint; without a strong commitment from our profession, it surely won't succeed.

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Q17. What is an “Independent Practice Association (IPA)?”

- A. A good working definition of an “Independent Practice Association (IPA)” is a group of providers, typically MDs, who organize into a corporation which contracts with HMOs. In IPAs, these providers retain their traditional practice autonomy, while integrating themselves into self-directed groups that solve group problems and exert political influence within the managed care system.

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Q18. How is an IPA different from a health or vision plan?

- A. Basically, a health or vision plan contracts with employers, other groups, or individuals to provide covered health care benefits, while an IPA is an organization of health care providers (e.g., medical group or foundation) who contract with HMOs and other health insurers to provide the necessary services to fulfill those benefit contracts. California is one of a handful of states that protects the independent exercise of medical and optometric judgment by prohibiting economically-interested entities—like health plans or optical companies—from employing MDs and ODs directly. The Knox-Keene Health Care Service Plan Act of 1975 reflects this policy by requiring that covered plans' services be provided only by licensed health care providers.

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Q19. Why couldn't an optometric IPA be a nonprofit corporation, like VSP?

- A. As noted in the answers to [Question 18](#) and [Question 20](#), state laws governing health care plans and licensed health care professionals require health care services to be provided only by licensed professionals who, if they wish to incorporate, must follow specific provisions applicable to their profession. Another consideration is that, to satisfy federal and state antitrust requirements, an optometric IPA would have to demonstrate that it is either “financially” or “clinically” integrated to avoid possible anticompetitive behavior. Generally, the former standard is more realistic, and one of its hallmarks is that its practitioners agree to bear financial risk for the services they provide. (See [Question 48](#).)

As for profits and losses, how corporate shareholders agree to share in or dispose of them is up to them, subject to applicable laws and regulations. VSP was formed as an entity that at the time qualified for tax-exempt status under the federal Internal Revenue Code; it lost that status in litigation that ended in 2009.

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Q20. Why does the IPA have to be an optometric corporation? Why can't it be a Limited Liability Corporation (LLC)?

- A. Under California law, individuals licensed to provide certain types of professional services are required to form Professional Corporations under the terms of the Moscone-Knox Professional Corporations Act. The Act covers accountants; architects; attorneys; shorthand court reporters; and 15 categories of licensed health care providers, including optometrists. The reason? As a matter of public policy, these licensees are not permitted to shield themselves from liability for professional malpractice, but otherwise are entitled to enjoy the legal and tax advantages of incorporation; therefore, they have their own statute and rules to follow. There are also specific requirements for optometric corporations set forth in the Optometric Practice Act, our licensing law, which also must be met.

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Q21. Can both ODs and MDs be involved in an optometric corporation?

- A. Yes—the Moscone Knox Professional Corporations Act permits physicians and surgeons, podiatrists, and five other types of licensed professionals to participate in optometric corporations, subject to additional requirements in the Optometric Practice Act. Generally speaking, the majority interest in the corporation would have to be held by licensed optometrists. (See also [Question 20](#).)

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Q22. Will the IPA be operated as a for-profit entity?

- A. The IPA would be organized around the principle of accepting risk of profit or loss, for two reasons: to be competitive in the market (see [Question 48](#)) and to comply with federal and state antitrust laws (see [Question 19](#)). As for profits and losses, how corporate shareholders agree to share in or dispose of them is up to them, subject to applicable laws and regulations; presumably, the central goal of the corporation would be achieve the maximum possible benefit for its shareholders in California's competitive managed health care market.

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Q23. What are the advantages to having either a statewide IPA with regional practice committees, or three or more regional IPAs governed by a single board?

- A. California is nothing if not the most diverse state in the nation—geographically, demographically, ethnically, and in distribution of resources. These factors combine to make the state a collection of markets, each with unique characteristics. Our research tells us that an IPA must be structured to both reflect and capitalize on these differences.

Existing IPAs—especially newer ones—tend to be regional in focus; another detectable trend is that licensed health plans are shifting focus, through marketing if not formal structure, to local markets. Taking into account the number of us in practice and these factors, we believe the two structural models outlined in the presentation achieve the necessary balance. What remains to be decided is how much autonomy regional IPAs should have to manage needs and services in their markets.

Put another way, the question becomes: how many independent risk bearing organizations and risk pools should there be?

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Q24. Must the IPA have a credentialed panel of practitioners before contracts can be negotiated?

- A. Yes. The strongest incentive for a for-profit health or vision plan (and almost all of them are) to enter into service contracts is the existence of a network of providers prepared to agree to provide their services in a manner that will make plan member benefit utilization and cost predictable. This is especially true now that most plans cannot spend more than 15 or 20 percent of total premium on nonmedical costs without penalty.

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Q25. Is PEN going to offer a credentialing service? What if the IPA doesn't go forward?

- A. PEN already offers a credentialing service to its members, priced on a per-application basis. In Phase One, PEN staff and consultants evaluated several existing credentialing services, including the one in use in SUNY's University Eye Care Network. PEN is considering offering a credentialing service both to the IPA as a management service and to the profession at large.

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Q26. How large would the IPA's network have to be to compete in the market?

- A. The short answer is, large enough to assure that a sufficient number of providers are available to provide contracted-for benefits to plan members in the market served, but not so large as to dilute the ability of providers to be willing to offer those services. Finding that balance is key, but there is no magic number.

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Q27. When does the IPA expect to be awarded its first contract?

- A. Our experts in this market tell us: "Two years later than you think." In all seriousness, the answer really depends on the thought, effort, sweat, and equity that are invested in research; structure; a business plan; and capital before contracts are drafted and formal negotiations begin. Phase Two will fill out the details of how big a job that is. Our consultants tell us it's reasonable to expect to be under contract initially 18-24 months from the conclusion of Phase Two.

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Q28. What types of health or vision care contracts is the IPA going after first?

- A. We won't have the answer to that question until the three contracting models have been tested in likely markets and built into the IPA's business plan. (See [Question 29](#).)

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Q29. Which is the best short-term contracting option for the IPA: directly with health plans, with other IPAs, or with public and private entities for managed care demonstration projects?

- A. There are a number of environmental factors at work that are shaping the likely answer to this question, chief among them the requirements imposed by the federal Affordable Care Act and California's plans to implement them. (See [Question 14](#).) As the presentation points out, each has its advantages and disadvantages, depending largely on who the potential contractor is and in what market. The answer also depends on the desired services to be offered under contract—that is, whether the emphasis is on refractive services; comprehensive specialty eye care; integrated "primary-specialty" care; or a combination of all three.

Because the burden will fall on us to demonstrate potential savings and efficiencies to win contracts, it's most realistic to focus on smaller-scale projects which can produce the data and outcomes that meet that burden, in carefully selected markets. For the same reasons, it would make sense to focus on programs like Medicare, where optometrists' accessibility by at-risk patients and their ability to detect both systemic and non-systemic high-risk and chronic conditions could produce savings through improved outcomes.

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Q30. What percentage of its annual operating budget could the IPA expect to spend on managed services unrelated to payment for eye care, such as claims and capitation processing and provider activities?

- A. It's hard to give a hard number or percentage, since a lot of capital is front-loaded into startup costs. Our consultants tell us that general administrative costs are highly variable initially but tend to decline as enrollment increases and economies of scale can be achieved. They've told us that in similar, established organizations the average is 10-12%, in a general range of 16% to 9%. Their business plan will include estimates of administrative costs based on estimated volume and numbers of covered lives.

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Q31. How much of an IPA's budget would have to be reserved for legal and regulatory compliance activities?

- A. Less than a full-service Knox Keene plan, but more than doing nothing. Seriously: after the IPA is formed, the business plan adopted, and sufficient capital acquired to begin operations, we'll have a much better idea of what routine costs of compliance will be. (Those of you who've opened a new practice, expanded an existing one, or acquired substantial capital assets know that the cost of doing business anywhere in California is substantial.)

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Q32. How long will it take for the IPA to reach a break-even point?

- A. We couldn't begin to speculate—and to do so would be irresponsible, anyway. You can expect the business plan to provide a general forecast for profitability dependent on how ambitious the IPA's Board and management want to be up front.

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Q33. Will I be required to join the IPA? What if I don't?

- A. You will be required to join the IPA if it's your wish to be paid for services provided pursuant to the terms of the contracts it negotiates. It's your choice; you are always free to negotiate most favorable payment terms with individual payers on your own.

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Q34. If I join the IPA, will I be required to accept all contracts and rates of reimbursement negotiated by the IPA?

- A. Yes. As an aside, the legal concept of "any willing provider" is widely misunderstood in our profession. Our Knox-Keene Act has contained an antidiscrimination provision for some time, and every regulated plan will tell you that they are "open panel." To join their provider network, your end of the deal is that you must agree by contract to their terms, including covered services and rates of reimbursement—whether you think they're fair or not. "Strength in numbers" is the theory behind joining together to negotiate those terms from a position of scale.

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Q35. What if the IPA negotiates a Medi-Cal contract for medical eye services and I don't accept Medi-Cal patients? Will I be required to do so?

- A. Yes. (See [Question 14](#).)

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Q36. In seeking sub-capitation contracts with ACOs, foundations, or medical groups/IPAs, wouldn't optometric IPA members be in competing with ophthalmologists as "specialists" for non-surgical medical eye care services?

- A. Potentially, yes. The trick will be to demonstrate that those non-surgical services can be provided more efficiently and produce equal to better patient outcomes, be it cooperatively or in competition. The other elements at work will be the ability to demonstrate that optometrists—
- Can function as key players on the primary care team through both comprehensive eye exams and patient screening,

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- Are more accessible than surgical subspecialists and even primary care physicians who are not as skilled at detecting systemic diseases and conditions; and
- Are an underutilized asset in detection of and referral for non-systemic diseases and conditions in at-risk patients.

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Q37. Is it possible to seek capital to form the IPA from outside the profession? If so, how would that work?

- A. Yes, so long as all the legal niceties are observed. As an optometric corporation, the IPA would be bound by both incorporation and securities laws, depending on how its founders intend to acquire shareholders. Apart from that it would be possible for the IPA to organize itself, such as by creating an affiliated foundation, to apply to public and private entities for grants to participate in selected, advantageous demonstration programs.

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Q38. Is California's health care market that much different from other states?

- A. California has the largest sub-national health care market in the world. The amount of money the State of California spends on health care alone is greater than the total budgets of 40 other states. Managing health care costs by controlling utilization has been a fact of life in California since 1945, when Henry Kaiser created a benefit management system for his factory workers.

The Knox-Keene Act, which regulates all health care service plans doing business in the state, has been on the books since 1975. The Department of Managed Health Care was created in 2000 and "risk-bearing organizations"—medical groups, foundations, and IPAs—have been regulated by DMHC since 2005.

On the public side, apart from Medi-Cal the State of California has operated a coverage pool for high-risk individuals and families otherwise unqualified for public programs and unable to find private market coverage since 1991. Managed care programs are already in place in 12 of California's more populous counties, and the Department of Health Care Services will be expanding those programs to all 58 counties over the next five years, pursuant to their latest, federally-approved program waiver. California is the first state to have authorized and established a state-level Health Benefits Exchange and Board to implement the requirements of the federal Affordable Care Act.

A concise breakdown of insured and uninsured lives in California, including the former's distribution among public and private for-profit and non-profit plans, can be found [here](#).

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Q39. What does the phrase "Knox-Keene plan" mean, exactly?

- A. A "Knox-Keene plan" is either a full-service, "health care benefits plan" or a "specialized health care benefits plan," as defined by and regulated under the Knox-Keene Health Care Service Plan Act of 1975, which is administered and enforced by the California Department of Managed Health Care.

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Q40. Are there differences between a Knox-Keene health and a vision plan? Are they regulated differently?

- A. They differ in that a health plan is defined as full-service and a vision plan is “specialized,” meaning that the schedules of benefits they offer are different. That’s the biggest difference; in essence, they’re regulated in the same way.

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Q41. What’s the difference between “financial integration” and “clinical integration,” and why is it important?

- A. Our attorneys have opined that, under federal and California antitrust laws, attempts by IPAs to contract on behalf of their members will be viewed as *per se* illegal price fixing agreements, unless they are permitted to do so because the IPA is either “financially” or “clinically integrated.”

IPAs which contract with managed care organizations on a capitated basis to provide professional services to HMO members are viewed as financially integrated, for antitrust purposes, because the IPA and its owners are deemed to be at risk for the delivery of the required care. IPAs not accepting risk—for example, contracting on its members’ behalf with Preferred Provider Organizations on a fee-for-service basis—have generally been viewed by regulators as engaged in illegal price-fixing; their members are deemed competitors because they are not bound by shared risk.

A few IPAs have been permitted to contract with PPOs on behalf of their members on a fee-for-service basis, after they were able to prove to the regulators that utilization and quality processes they applied to their HMO patients were applied equally to their PPO patients. The antitrust regulators determined that benefits arising out of their “clinical integration” activities outweighed the anti-competitive aspects of their arrangements. (Usually clinical integration includes such things as common electronic health records (“EHR”); common quality and utilization policies and protocols; seamless inter-group referral processes; etc.) It is anticipated that participants in an ACO will be deemed to be clinically integrated for antitrust purposes.

Thus, it is rarer for IPAs not accepting contract risk to meet the “clinical integration” antitrust test because it is more difficult to demonstrate.

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Q42. Why can’t there be a nonprofit Management Services Organization in California, like SUNY Optometry’s University Eye Care Network in New York?

- A. The short answer is, because California and New York regulate both health plans and professions differently. New York’s scheme for regulating health maintenance and management services organizations is such that SUNY-UECN was able to organize itself as a nonprofit MSO, contracting to provide health services through its members without accepting financial risk for them, allowing it to obtain necessary exemptions from three separate regulators to operate outside that system. Our attorneys found that two features in California law make that impossible to do here: the prohibition on the corporate practice of medicine and optometry, and the requirement that all non-provider entities offering health insurance benefits under contract be licensed as health plans and that all provider entities be regulated as Risk Bearing Organizations (RBOs).

As it is, the IPA would have to either create or contract for management services—e.g., credentialing of member providers; network development and maintenance; claims adjudication; utilization review; peer review; development of clinical standards and guidelines; provider relations; provider education; and provider services—necessary to assure compliance with all legal and regulatory requirements.

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Q43. I want to review and share your online presentations about the Medical Eye Care IPA project. How do I do that?

- A. You can find direct links to our online presentations and other pertinent information about the IPA project page on PEN's web site—just click [here](#).

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Q44. What roles can California's schools of optometry, their leaders, and faculty play in a California IPA?

- A. In our conversations with the founders and current administrators of the University Eye Care Network at the State University of New York's College of Optometry, it became obvious that the fact that the Network and the great majority of its members were affiliated with the College was a major selling point for health maintenance organizations, for four principal reasons:

- College officials were among the Network's original incorporators and officers and the Network itself is maintained by College staff;
- The vast majority of the Network's providers were under the College's control and were required to abide by terms and conditions imposed by the College on the provision of services;
- All providers were governed by the standards of practice and clinical protocols for service provision maintained by the College; and
- The College had certain native resources, such as affiliated hospitals and clinics and associated faculty, that assured that services would be provided uniformly and efficiently.

California's three schools of optometry could bring many of the same assets to an optometric IPA here. Their leadership and involvement would have strong appeal to potential contractors for the same reasons. Use of their peer and alumni/alumna networks would be of great help in the recruitment, credentialing, maintenance, and education of participating network optometrists. Their collaboration in the development of clinical standards and practice protocols, and the use of their resources to assist in claims and peer review, would also be valuable. Usual and demonstration patient intake screening and care provided in their clinics and in affiliated institutions could provide the laboratories and the outcomes data required to demonstrate the optometrist's utility as a "primary care specialist."

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Q45. What is a "Risk Bearing Organization (RBO)?"

- A. A "Risk-Bearing Organization (RBO)" is defined by law as a medical IPA, group, foundation, or other physician organized and controlled entity that accepts financial risk for the delivery of health care services pursuant to contract. They are overseen and regulated by the Department of Managed Health Care to assure that contracted-for services are not jeopardized by inefficiency or insolvency.

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Q46. Are RBOs treated differently from Knox-Keene plans?

- A. They are not Knox-Keene health plans, per se, but are nonetheless required to meet quarterly or annual audit, reporting, and compliance requirements, depending on each entity's degree of accepted financial risk. Currently, there are over 250 regulated RBOs doing business in California, compared with 108 licensed health plans.

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Q47. Doesn't the RBO law apply only to medical groups, foundations, and other MD-organized entities?

- A. Technically, that's true. We've concluded that to create a risk-bearing optometric IPA to compete for health care business and claim that it is exempt from regulation based on a single definition is very likely a self-defeating strategy, in the long run.

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Q48. Why is it necessary for a California optometric network to accept financial risk to be competitive?

- A. Our survey tells us that accepting financial risk for the provision of provider services is the overwhelming rule in California's mature and highly competitive market; indeed, it is difficult to find exceptions that are competitive.

Full-service and specialized health care plans operating in California have little interest in contracting with primary or specialty provider entities which don't capitate their rates, because they cannot assure that utilization will be predictable or manageable.

The federal Affordable Care Act has curtailed or eliminated a significant number of methods health plans have employed to control utilization in the past and also imposed new benefit, coverage, and management requirements that will affect their innate ability to manage both medical and nonmedical services and charges. These developments will make them more receptive to potential contractors who can demonstrate the ability to improve provider efficiency and patient outcomes, but we don't believe they'll show much interest in IPAs that don't back up their promises by accepting the financial risk for their failure to deliver.

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