Independent Practice Association Physician Groups In California

Do physicians fare better under physician-run managed care organizations? New data from California.

by Kevin Grumbach, Janet Coffman, Karen Vranizan, Noelle Blick, and Edward H. O’Neil

ABSTRACT: We surveyed independent practice association (IPA) physician groups in California about their approaches to staffing, physician payment, and governance. Most IPAs desired more primary care physicians but not more specialists. Capitation was the major mode of remuneration for primary care physicians in 77 percent of IPAs, and for specialists in 30 percent of IPAs. Most IPAs also used financial incentives related to use of referral or ancillary services. Boards of directors were dominated by physicians, but governance tended to be centralized rather than highly democratic. We found that IPAs mirror many of the broader trends in physician staffing and physician payment that exist in managed care organizations.

American physicians are increasingly organizing themselves into larger practice structures. One popular type of practice organization is the independent practice association (IPA). An IPA consists of a network of physicians who agree to participate in an association to contract with health maintenance organizations (HMOs) and other managed care plans. Although physicians maintain ownership of their practices and administer their own offices, the IPA serves as a corporate structure for negotiating and administering HMO contracts for its physician members.

The IPA physician group has become a prominent organizational structure in western states, especially in California. In other regions most HMOs contract directly with individual physicians in what have been referred to as “two-tier” managed care structures. In such systems HMOs deal directly with individual physicians, and pay...
ments pass from the HMO to the individual physician or small office-based group practice. In contrast, IPAs in states such as California represent a “three-tier” form of managed care. Rather than contracting directly with different HMOs, physicians in office-based practice participate in one or more IPAs, and the IPA—rather than the individual physician—relates to HMOs and other managed care plans. Both practicing physicians and HMOs retain corporate independence from the IPA. In its role as a contractual intermediary, the IPA accepts capitation payments from HMOs and distributes these revenues to participating physicians. The IPA does not actually own physician practices or employ physicians, nor does the IPA act as an insurance plan or a subsidiary of an insurance plan and market itself directly to health plan purchasers.

Most HMOs in California prefer to use three-tier models and contract with IPAs or other types of large physician organizations rather than with individual physicians. A 1996 survey of office-based primary care physicians in the state found that three-quarters participated in at least one IPA.4

The term IPA is unfortunately victim to the confusing nomenclature of managed care. The term is most correctly used (and is used in this paper) to refer to the type of physician organization, described above, that acts as an intermediary between managed care plans and individual office-based physicians. Some HMOs themselves, however, are often described as IPA-type plans, in an attempt to distinguish HMOs that contract with individual physicians or multiple physician networks from group- and staff-model HMOs that contract with a single group (such as the Kaiser health plan and the Permanente Medical Group) or employ their own physician staff (such as Group Health Cooperative of Puget Sound). The term IPA when applied to HMOs, rather than to physician groups, tends to be used as a generic label for any HMO that is not a classic, vertically integrated system. We use the term IPA with a more specific intent to indicate a particular type of physician organization that occupies the middle tier between HMOs and office-based physicians in three-tier managed care structures.

IPAs initially did little more than act as brokers between independent physicians and HMOs. However, California HMOs are increasingly transferring financial risk to IPAs under capitated contracts that make the IPA liable for a large portion of the costs of care for patients enrolled in the practices of participating physicians. As IPAs have begun to assume more financial risk, they have become more involved in managing the clinical practices of participating physicians. Some observers have suggested that “MD managed care” in organizations such as IPAs will be more responsive to physicians’
interests than “MBA managed care” that is under the control of insurance corporations. These observers have argued that three-tier structures allow a more formal role for physician self-governance and management through organizations such as IPAs, rather than having individual physicians answer directly to HMO administrators.

Little is known, however, about the actual workings of IPAs. The few studies that have been published indicate that IPAs may differ little from other forms of managed care organizations in their approach to utilization management. For example, similar to the approach of most managed care plans, IPAs tend to rely on practice audits to detect excessive use of costly services rather than to detect underuse of appropriate care. Much less is known about other features of IPAs, such as their approach to staffing, physician payment and incentives, and governance. In this DataWatch we report the results of a survey of California IPAs that provides a more comprehensive characterization of these physician organizations.

Methods

We surveyed all IPAs in California in 1996 that were members of the IPA Association of California (IPAAC, subsequently renamed the National IPA Coalition). Criteria for IPAAC membership are that the organization is physician led, actively participating in managed care, and accepting (or seeking to accept) risk-bearing contracts with health plans.

A self-administered questionnaire was mailed to the executive director of each IPA. The survey was performed in conjunction with a periodic survey performed by IPAAC to elicit information for their membership directory. In addition to a general questionnaire that asked about IPA size and related items for use in the membership directory, IPAs received a supplemental questionnaire asking more detailed questions about several IPA characteristics. IPAs were informed that all responses to the supplemental questionnaire would be considered confidential and that no data from this questionnaire would be released in a manner that identified individual IPAs. Because of the small sample size and exploratory nature of the study, analysis of results was limited to descriptive tabulations.

Results

Ninety-eight IPAs, constituting 87 percent of IPAAC members in 1996, returned completed membership directory surveys. Of these, fifty-three IPAs also returned supplemental study surveys. Respondents to the study survey had an average of 500 physicians in their network and nearly 40,000 capitated enrollees and had an average of nine commercial managed care contracts (Exhibit 1). IPAs averaged
two specialists for every primary care physician in their network, a ratio similar to the overall specialty distribution of physicians in the state. Compared with IPAs that completed membership, but not study, surveys, IPAs that completed study surveys had somewhat larger numbers of physicians and capitated patients.

**Staffing and contracting.** The following results are based on the fifty-three IPAs that completed supplemental study questionnaires. All fifty-three IPAs included physicians in each of the three generalist fields in their panels of physicians listed as primary care providers for IPA enrollees (Exhibit 2). The majority of IPAs also listed physicians in other specialties as primary care providers, with obstetrician-gynecologists (OB-GYNs) being included most frequently. (California state law requires that managed care organizations offer OB-GYNs the opportunity to qualify as primary care providers.) Of the IPAs that listed nongeneralist physicians as primary care providers, 77 percent stated that the IPA had “formal, objective criteria” for credentialing specialists as primary care providers. With only one exception, IPAs were directly involved in developing these credentialing criteria, in some cases with the collaboration of HMO plans. Only 15 percent of IPAs included non-physician providers such as nurse practitioners in their lists of primary care providers distributed to IPA enrollees.

Forty percent of IPAs exercised exclusive contracting for at least a portion of their physician membership. Under exclusive contracts, physicians agree not to participate in other IPAs. However, only 11 percent of IPAs indicated that exclusive contracts were required for all new IPA physician members. When considering adding new physicians to the IPA, most IPAs required board certification, and

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**EXHIBIT 1**

**Characteristics Of Independent Practice Associations (IPAs) In California, 1996**

<table>
<thead>
<tr>
<th></th>
<th>Survey respondents</th>
<th>Total sample&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>53</td>
<td>98</td>
</tr>
<tr>
<td>Years in operation (mean)</td>
<td>7.6 (7.6)</td>
<td>8.7 (6.6)</td>
</tr>
<tr>
<td>Number of physicians (mean)</td>
<td>500 (654)</td>
<td>419 (514)</td>
</tr>
<tr>
<td>Primary care</td>
<td>147 (180)</td>
<td>123 (146)</td>
</tr>
<tr>
<td>Specialty</td>
<td>353 (484)</td>
<td>296 (378)</td>
</tr>
<tr>
<td>Primary care-to-specialty ratio</td>
<td>1:2.0</td>
<td>1:2.2</td>
</tr>
<tr>
<td>Capitated enrollees (mean)</td>
<td>38,964 (48,587)</td>
<td>35,902 (42,459)</td>
</tr>
<tr>
<td>Commercial</td>
<td>32,192 (42,954)</td>
<td>29,762 (36,912)</td>
</tr>
<tr>
<td>Medicare</td>
<td>4,438 (6,588)</td>
<td>4,183 (5,866)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2,334 (8,974)</td>
<td>1,957 (7,500)</td>
</tr>
<tr>
<td>Commercial managed care contracts (mean)</td>
<td>9.4 (6.6)</td>
<td>9.0 (6.2)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Total sample includes all IPA members providing information to the IPA Association of California (IPAAC) on basic IPA characteristics for the IPAAC membership directory. The fifty-three survey respondents are a subset of the ninety-eight total IPAs. Numbers in parentheses are standard deviations.

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**SOURCE:** Authors’ survey of IPA Association of California members, 1996.
almost all insisted on hospital admitting privileges (Exhibit 2).

There was a noticeable difference between the desire of IPAs to recruit generalist and specialist physicians. Almost half of the IPAs (44 percent) stated that they would like to recruit many more primary care physicians, while only 4 percent wanted to recruit many more specialists. More than half (52 percent) indicated that they desired no more specialist physicians whatsoever, while only 14 percent desired no more primary care physicians. However, roughly the same percentage of IPAs desired somewhat more primary care and specialist physicians (42 percent and 44 percent, respectively).

Approximately half of the IPAs reported that they had terminated a contract with a physician in the past year. The most commonly cited reasons for termination were related to concerns about quality of care, although more than one-quarter of IPAs mentioned concerns about a physician’s “excessively costly practice pattern” as a reason contributing to a contract termination (Exhibit 3).

**Physician payment and incentives.** In terms of physician remuneration, the majority of payments to primary care physicians were in the form of capitation payment (Exhibit 4). In contrast, capitation payments represented a much smaller share of payments to specialists in most IPAs. Only 30 percent of IPAs used capitation for the majority of their payments to specialists.\(^9\)

Physicians were at financial risk in 87 percent of IPAs for use of at least some type of referral or nonphysician service, either through
inclusion in their capitated payments or through other bonus and withholding incentives (Exhibit 5). Among IPAs that included incentives for primary care physicians indexed to use of services, the types of services factored into these incentives included physician specialty care (61 percent of IPAs), laboratory and radiology services (61 percent), outpatient prescription drugs (48 percent), inpatient hospital care (68 percent), and ancillary care such as physical and occupational therapy (57 percent). IPAs that relied more heavily on capitation as a mode of paying primary care physicians were more likely to hold their primary care physicians at risk for these types of services. For example, 85 percent of IPAs that relied on capitation for the majority of payments to primary care physicians used incentives related to hospital care, compared with 48 percent of IPAs that relied less heavily on capitation \( (p = .002) \).

We asked IPAs about additional aspects of the methods they used for distributing bonus funds to physicians from risk pools

### EXHIBIT 3
Reasons For California Independent Practice Associations (IPAs) To Terminate Contracts With Physicians, 1996

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent citing reason applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns with quality of care</td>
<td>64%</td>
</tr>
<tr>
<td>Concerns with patient satisfaction</td>
<td>55</td>
</tr>
<tr>
<td>Formal disciplinary action</td>
<td>55</td>
</tr>
<tr>
<td>Conflicts over IPA policies</td>
<td>41</td>
</tr>
<tr>
<td>Excessively costly practice</td>
<td>27</td>
</tr>
<tr>
<td>Incidence of malpractice claims</td>
<td>18</td>
</tr>
<tr>
<td>Inadequate demand for all physicians in specialty</td>
<td>14</td>
</tr>
<tr>
<td>Inadequate demand for individual physician</td>
<td>9</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ survey of IPA Association of California members, 1996.

**NOTE:** Includes only the twenty-one IPAs that reported terminating one or more physician contracts.

### EXHIBIT 4
Use Of Capitation Payment By California Independent Practice Associations (IPAs), 1996

<table>
<thead>
<tr>
<th>Percent of IPAs</th>
<th>0-10%</th>
<th>11-50%</th>
<th>51-90%</th>
<th>91-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>37</td>
<td>6</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Specialty</td>
<td>40</td>
<td>30</td>
<td>44</td>
<td>2</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ survey of IPA Association of California members, 1996.
related to use of referral and other types of services. The majority indicated that distribution of funds was based on overall IPA performance, although 27 percent of IPAs indicated that the performance of individual physicians or small office groups was also factored into these incentive formulae (Exhibit 5). Approximately half of IPAs also reported using financial incentives related to quality of care and patient satisfaction, with fewer IPAs adjusting payments on the basis of exclusivity or duration of IPA membership.

**Governance.** Practicing physicians filled almost all of the positions on IPAs’ boards of directors (83 percent). Although specialists outnumbered primary care physicians in IPAs two to one, primary care physicians constituted a majority of the members of boards in 62 percent of IPAs. Almost all IPAs (90 percent) empowered the current board to nominate new members of the board, while far fewer allowed member physicians to directly nominate themselves or their colleagues to the board (35 percent and 54 percent, respectively). A minority of IPAs based board elections on a vote of the total IPA physician membership (43 percent) or allowed the general membership to vote to recall a board member (39 percent).

We also asked IPAs about their origins and future plans. Almost half of the IPAs reported that their association was started in partnership with a hospital. Regarding their future plans, one-third of the IPAs stated that it is “very likely” or “almost certain” that they would bypass health insurance plans and obtain direct contracts with employers or employer groups in the next five years.

**Discussion**

**Staffing patterns.** Our findings shed light on many dimensions of IPAs that have not previously been systematically studied. On many
features, IPAs appear to manage their physician networks and physician practices in a manner that resembles the approaches used by HMOs that contract directly with physicians or that employ their own physicians. Similar to staffing patterns found in large vertically integrated HMOs, IPAs appear to have reached the saturation point in their complement of specialist physicians. Half of IPAs stated that they did not desire any more specialist physicians for their networks. In contrast, most IPAs expressed interest in recruiting more primary care physicians. These findings add to the growing evidence that practice opportunities for new specialists in regions with high degrees of managed care market penetration may be limited. The overall supply of practicing physicians per capita, as well as the ratio of specialists to generalists, is comparable in California to that of the United States as a whole. This suggests that our findings on interest in physician recruitment among California IPAs is not attributable to an atypical pattern of physician supply.

Our results also suggest that board certification may be taking on growing importance as a criterion for physician participation in managed care organizations. An HMO survey conducted in 1994 found that while almost all group- and staff-model HMOs required board certification, only about half of HMOs that contracted with individual physicians or physician networks required it. In contrast, three-quarters of IPAs in our survey required board certification for new physician members.

Anecdotal reports about managed care’s “fallout” for practice opportunities in California have tended to focus on accounts of involuntary terminations of physicians by HMOs and physician groups, including IPAs. Bills introduced in the California legislature in 1997 addressed issues related to physician contracting, including proposals to require that terminations be based on “just cause.” Managed care advocates have defended selective contracting as a means of choosing higher-quality physicians for networks. IPAs in our survey also highlighted quality concerns as their main reason for failing to renew physician contracts, although some did acknowledge that a costly practice style was also a consideration. Despite their expressed lack of interest in recruiting more specialists, IPAs rarely cited inadequate demand for services from a particular specialty or individual physician as a reason to terminate a contract. These findings suggest that IPAs’ concerns about specialist oversupply may have a greater influence on their decisions to deny a new contract than in decisions to terminate an existing contract.

We found that many IPAs allowed some physicians in nongeneralist fields to participate as primary care providers. Not surprisingly, in view of existing state legislation, OB-GYNs were the specialists
most likely to be included by IPAs as primary care providers. Most IPAs that allowed specialists to serve as primary care providers stated that they had formal criteria for credentialing these physicians as primary care providers. We did not query IPAs about their specific criteria; however, we consider it likely that these criteria are not uniform across IPAs and represent a decentralized and highly variable approach to regulating scope of practice. Far fewer IPAs listed nonphysicians as primary care providers. However, the fact that 15 percent of IPAs explicitly included nurse practitioners or physician assistants as primary care providers may be interpreted as an indication that some physician-run organizations are amenable to having nonphysician providers play a prominent role in their practice group. Also, our survey only inquired about practitioners specifically mentioned in lists of primary care providers given to plan enrollees; many physicians’ offices in these IPAs may include nurse practitioners, nurse-midwives, and physician assistants as staff but not formally list these practitioners as primary care providers.

**Physician payment patterns.** Similar to patterns reported for HMO payments to physicians, capitation was the primary mode used by IPAs to remunerate primary care physicians. Far fewer IPAs relied on capitation as the predominant mode of paying specialists, although many IPAs may be shifting to capitated specialist payment in the coming years. Considerable controversy exists about the propriety of financial incentives over and above base capitation payments. Critics of these incentives have particularly admonished managed care organizations about incentives that are indexed to individual physician performance in restraining the use of referrals and other ancillary services. We found that most IPAs made some use of incentives related to use of referral or ancillary services, although a minority based these incentives on an individual physician’s practice pattern. Many IPAs also appeared to be incorporating bonus structures that included incentives related to quality of care or patient satisfaction as well as to costs of care.

**Governance.** Considerable debate also has centered on governance of physician-run practice organizations. Some physician advocates have argued that IPAs and other practice groups are becoming autocratic organizations that make decisions with little input from rank-and-file physician members, which taints one of the potential virtues of IPAs as physician-responsive, democratic organizations. Some managed care consultants have countered that a centralized governance structure insulated from the membership is necessary for making the “tough” and definitive decisions required by a competitive market. The IPAs we studied had boards of directors that
were dominated by physicians, including a majority of primary care physicians. However, the IPAs tended to have relatively centralized and insulated governance, with most boards nominating their successors, a minority of IPAs subjecting board elections to a vote of the full membership, and a minority having mechanisms for members to recall board members.

**California as trendsetter.** Our survey is limited by its focus on only one state and by its sample size. However, California has been regarded as a trendsetter for many managed care phenomena, and results from our California sample may well be indicative of important trends in the wider IPA market. Respondents to our survey also tended to have more patient enrollees and member physicians than nonresponders did. Therefore, although 53 percent of IPAs responded, they represent considerably more than a 53 percent share of the patients and physicians involved in IPAs in California.

Our study suggests that IPAs mirror many of the broader trends in physician staffing and approaches to payment and incentives developing among HMOs and other managed care organizations. Although physicians govern IPAs, governance structures may not promote a high degree of democratic control by the physician members of IPAs. It remains to be determined whether physicians and the patients they care for fare differently under “MD managed care” than they do under “MBA managed care.” The imperatives of a highly competitive, market-driven system may count more than distinctions in professional degrees in influencing organizational behavior.

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**NOTES**


7. J. Coffman et al., California Needs Better Medicine (San Francisco: California Primary Care Consortium and the Center for the Health Professions, University of California, San Francisco, 1997).


9. It is important to note that IPAs may themselves receive revenues in fee-for-service and other noncapitated forms from managed care plans such as preferred provider organizations (PPOs) and therefore may in turn maintain fee-for-service payments to participating physicians for patients enrolled in PPOs. Some IPAs also may pay physicians using fee-for-service methods, at least in part, even when the IPA receives capitated payments from an HMO. See Bodenheimer and Grumbach, “Reimbursing Physicians and Hospitals.”


16. Our 1996 survey of primary care physicians in California also found that “too many physicians” was cited more often by physicians as a reason for experiencing a contract denial than a contract termination. See Bindman et al., “The Selection and Exclusion of Primary Care Physicians.”
