Healthcare ∎ (∎∎∎∎) ∎∎∎–∎∎∎

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/hjdsi

Independent practice associations: Advantages and disadvantages of an alternative form of physician practice organization

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ARTICLE INFO

Article history:
Received 25 November 2015
Received in revised form
12 August 2016
Accepted 22 August 2016

ABSTRACT

Background: Value-based purchasing (VBP) favors provider organizations large enough to accept financial risk and develop care management infrastructure. Independent Practice Associations (IPAs) are a potential alternative for physicians to becoming employed by a hospital or large medical group. But little is known about IPAs.

Methods: We selected four IPAs that vary in location, structure, and strategy, and conducted interviews with their president and medical director, as well as with a hospital executive and health plan executive familiar with that IPA.

Results: The IPAs studied vary in size and sophistication, but overall are performing well and are highly regarded by hospital and health plan executives. IPAs can grow rapidly without the cost of purchasing and operating physician practices and make it possible for physicians to remain independent in their own practices while providing the scale and care management infrastructure to make it possible to succeed in VBP. However, it can be difficult for IPAs to gain cooperation from hundreds to thousands of independent physicians, and the need for capital for growth and care management infrastructure is increasing as VBP becomes more prevalent and more demanding.

Conclusions: Some IPAs are succeeding at VBP. As VBP raises the performance bar, IPAs will have to demonstrate that they can achieve results equal to more highly capitalized and tightly structured large medical groups and hospital-owned practices.

Implications: Physicians should be aware of IPAs as a potential option for participating in VBP. Payers are aware of IPAs; the Medicare ACO program and health insurer ACO programs include many IPAs.

1. . Introduction

Medicare, Medicaid, and private insurers are moving toward value-based purchasing (VBP) – paying providers for improving the health of their populations of patients, rather than for the volume of services they provide.[1,2] Improving population health requires provider organizations to be large enough to accept financial risk and to have clinical and administrative leaders with the time and expertise to create infrastructure, such as sophisticated health information technology (HIT), the ability to analyze data, nurse care managers, programs to reduce hospital readmissions, and much more.[3] Larger organizations are also able to negotiate better payment rates from insurers,[4] leaving the substantial number of physicians still in solo and small group practices at a considerable disadvantage.

In this turbulent environment, some physicians are joining large physician-owned medical groups. But these are not common, and many physicians are selling their practices and seeking employment by hospitals.[5,6] Yet it appears – though data is scarce – that many physicians and patients prefer the human scale of the independent small practice setting.[6–10] This provides an opportunity for a form of organization that emerged in the early 1980s: the independent practice association (IPA).

In theory, IPAs can provide the best of both worlds. This viewpoint is stated clearly on the website of a nationally prominent IPA – the Hill Physicians IPA – which states:

You can maintain the independence of private practice while reaping the benefits of belonging to a large organized healthcare delivery system.[11]

Despite their potential importance as an alternative to physician employment by hospitals or large medical groups, almost nothing is known about IPAs. There have been only four articles focusing on IPAs in the peer-reviewed literature in the past 15 years,[12–15] and very few before that.[16,17] IPAs were originally created as a way for physicians to band together to negotiate with

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http://dx.doi.org/10.1016/j.hjdsi.2016.08.003
2213-0764/

health insurers, but the most successful IPAs developed the ability to take financial risk for the cost of their patients' care and to be rewarded for doing so.[4,15] Many IPAs failed, unable to handle risk, and others disappeared as risk contracting became less common from the mid-1990s. The re-emergence of risk contracting – in the accountable care organization (ACO) movement and in value-based purchasing more generally – provide new opportunities for IPAs; many are participating in Medicare and private insurer ACO contracts.[10,18]

In this article we identify advantages and disadvantages of the IPA model by describing four IPAs that vary considerably in their size, age, and organization. We focus particularly on the question of whether and how IPAs can compete with large medical groups and with hospital-owned physicians groups, given that IPAs lack the capital and the hierarchical control available to these better known forms of organization.

2. Methods

We reviewed the peer-reviewed and "gray" literature on IPAs and, using multiple resources (Appendix 1) constructed a national census of 368 IPAs. As noted in the Appendix, it is likely that additional IPAs exist that we were unable to identify. We selected four IPAs for this study that differ in location, size, age, structure, and strategy.

For each IPA we interviewed two top executives (typically the President and Medical Director). To gain an outside perspective on each IPA, we also interviewed a health plan and a hospital executive familiar with that IPA. We asked the leadership of each IPA to give us the names for two or three health plan executives and two or three hospital executives familiar with the IPA and selected one of each to be interviewed. We promised to keep the identity of the individuals we actually interviewed confidential.

We created a separate interview protocol (Appendix 2) for each of the four categories of individual; the protocols were based on our review of the literature and on interviews we conducted with three national experts knowledgeable about IPAs. Interviews lasted 45–60 min and were conducted via telephone by the authors between October and December 2014.

We created a short survey based on our review of the literature and interviews with national experts (Appendix 3) that was completed by a leader of each IPA. The survey was intended to provide basic information on the IPA. Interviews were recorded, transcribed, and reviewed and discussed by the authors to identify key themes.

3. Results

Tables 1 and 2 provide summary information about each IPA and about the services they provide to their physicians.

3.1. Health Connect IPA

Health Connect IPA (HCIPA), a relatively new primary care physician IPA that was created in 2011 by five primary care groups in Northern Virginia, currently includes six groups with 28 practice sites and 158 physicians – all primary care. HCIPA is a not-for-profit corporation owned by its member groups. Created within the context of health care reform, HCIPA focuses on obtaining additional revenue from insurers for its performance on quality measures and for its practices being certified as patient-centered medical homes, and is cautious about assuming risk. HCIPA leaders state that they created the IPA because:

> We felt there was a need for primary care groups in the area to start talking and working together … we had gone down the PCMH route and … wanted other organizations that were thinking the same way, so we reached out to different groups and identified leaders … who we felt were culturally compatible and [had] the same vision … with primary care taking on a more dominant role. We wanted to be able to move to pay for value instead of pay for service … We felt that the value of negotiating with health plans would be establishing real quality and controlled cost and by doing that we would be in a stronger position to actually work with them to create new value-based contracts.

Table 1
Characteristics of four independent practice associations.

	Health connect IPA	Heritage provider network	Hill Physicians	Mt. auburn cambridge IPA
Date created	2011	1979	1984	1985
Location	Northern Virginia	Southern California, Arizona, New York State	Northern California (especially San Francisco Bay Area and Sacramento)	Cambridge, MA and nearby suburbs
Ownership	physicians	one physician	physicians[a]	physicians
Percentage of IPA physicians who are owners	100	0	7	100
Physicians (N)	158	37,000[b]	3,619	507
Primary care	165	4,000[b]	971	111
Specialists	0	33,000[b]	2,648	396
HMO patients (N)				
commercial	0	yes[e]	175,000	27,000
Medicare	400	yes	32,000	3,700
Medicaid	0	yes	68,000	yes
PPO contracts?	yes	yes	yes	yes
Medicare ACO patients (N)	17,000[c]	82,509[d]	0	11,500[d]
Primary care physician payment	fee-for-service	capitation[f]	fee-for-service[f]	fee-for-service[f]
Specialist physician payment	fee-for-service (from health plans)	capitation (various forms) or fee-for-service	some specialties capitated; others fee-for-service	fee-for-service

[a] PriMed Management carries out most IPA activities.
[b] includes contracted and employed physicians.
[c] Shared Savings ACO.
[d] Pioneer ACO.
[e] Overall all types of payer, Heritage has over one million patients in risk-based contracts.
[f] plus a large potential performance-based bonus.

Please cite this article as: Casalino LP, Chenven N. Independent practice associations: Advantages and disadvantages of an alternative form of physician practice organization. *Healthcare* (2016), http://dx.doi.org/10.1016/j.hjdsi.2016.08.003