2022

Successful Allocation of Funds in Managed Health Care Programs Revenue

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This is to certify that the doctoral study by

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Managed care leaders of independent physician associations (IPAs) lack strategies for allocating existing funds to avoid business closure. Medical providers are concerned with the quality of care for patients if the allocation of funding is not executed correctly. Grounded in the competing values framework (CVF), the purpose of this qualitative single case study was to explore strategies managed care leaders of IPAs use to allocate funds to avoid business closure. Participants were six executive leaders of an IPA in Los Angeles, the United States, who successfully managed the allocation of funds in a managed healthcare system. Data were collected from semistructured interviews and a review of company documents relating to costs, revenues, and financial data. Through thematic analysis, five themes were identified: managing costs of primary care and specialist contracts, use management, provider training, the importance of the Centers for Medicare & Medicaid Services CMS STAR Measures, and market branding. A key recommendation for IPA leaders is to evaluate internal and external operational factors influencing the financial control of organizations. The implications for positive social change include the potential for increased access to care and education for patients.

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Acknowledgments

First and foremost, I would like to thank my God without His power none of this would have been possible. Without God we have nothing, with God we have everything! I literally prayed my way through the last parts of this study. Thank you Jesus!

I would also like to thank my family who gave me unending support by consistently asking “how is your study coming” and “when are you going to finish this thing”. These incredibly humorous and wonderfully loving people include my son Daniel, my parents Ron and Alise Holz, my sisters, John and Susan Carucio, and Kyle and Sandra Jones. My niece Alexandra and of course Frank and Waffles Loveall, my best friend, and faithful furry dog-steed.

Thanks to my friend V. Ayala for inspiring me to continue my education and was the reason this endeavor was pursued. To my friend Michael Daily, who encouraged me to sit and work, instead of go and play. Other friends and support include Ron Brandt, David Santillo, Roxan Malloy, Kristin Reynolds, Ellen Learned, Steve and Marie Trotz, and David Schultz. All of whom play a critical part in my day-to-day life and whose friendships will transcend all times. I have been truly blessed by my friends, employer, and family. I hope for many more happy years with all of them.

Last but certainly not least, Dr. Peter Anthony, whose patience is that of a saint being my Chair through this process. Through excessive life turmoil, he never let me feel like I was a failure. This would not have been possible without his patience, kind guidance, and assistance at every step. Thank you, thank you, thank you, Dr. Pete!

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Section 1: Foundation of the Study

The foundation of this study is relevance of maintaining and executing a healthcare system that benefits both patients and physicians. Independent physician organization (IPA) leaders giving adequate attention to multifaceted delivery systems allows these leaders to properly allocate funding. Appropriate funding by these leaders keeps IPAs in business and competitive with other IPAs. Historically, IPAs involve growth of the patient population by enticing providers to contract with their organization.

Background of the Problem

Managed care healthcare systems have become an increasingly popular mechanism in the United States to provide healthcare to patients. They are paid by the government through the Medicaid system or commercial lines in a health maintenance organization (HMO). HMOs have become increasingly popular for patients desiring to have lowers cost for care and still receive a wide scope of coverage. Additionally, patients still have a choice for privately held insurance to be chosen at their discretion. A multitiered system has been developed for delivery of funds from the government level to service providers. Providers bill their contracted IPAs which receive funds from the health plan. The health plan receives money from Medicaid which receives funds from the state and federal government.

Since the inception of IPAs, the managed care system has involved enticing providers to contract with their IPAs through the managed care system. IPAs provide ultra-high reimbursement for primary care physicians to the detriment of other facets of necessary care. The issue was that poor management of IPAs can result in lack of care for

patients if providers cannot be reimbursed properly. This problem deserves research as managed care has become prevalent. This applied research can help assist managers to diversify their focus aand incorporate facets of healthcare that can keep IPAs competitive and liquid.

In this study, I address current insurance practices, insurance and its effect on economy, healthcare expenditures, management training for employees and physicians, foreseeable problems, implementation strategies, legal ramifications, and ideas for reform. IPA leaders will understand the dilemma of IPAs remaining in business.

Problem Statement

IPAs within the managed healthcare system are suffering from misallocation of funds (Badano, 2019). As of June 2015, 308 IPAs closed or filed bankruptcy in the Los Angeles area (Cattaneo & Stroud Inc., 2018). The general business problem is that funding to IPAs through health plans is not enough to keep them in business without astute financial planning. The specific business problem is managed care leaders of IPAs lack strategies for allocating existing funds to avoid business closures.

Purpose Statement

The purpose of this qualitative single case study is to explore strategies managed care leaders of IPAs use to successfully allocate funds to avoid business closure. The population for the study iwas five participants from one managed care IPA in Los Angeles, CA. The leadership team of these IPAs have developed and implemented strategies to thrive in a difficult healthcare marketplace. Implications for social change

include providing more quality medical insurance choices for underserved individuals by keeping IPA medical groups in business.

Nature of the Study

The qualitative method fits the purpose of my study because the study was conducted as a single case study with a client organization under DBA consulting capstone program. The Quantitative methodology involves using data to test a theory, also known as a deductive approach (Yilmaz, 2013). Although the quantitative methodology could have been used for this study, I chose to use the qualitative method to keep the focus on socially constructed meanings of data. A mixed methods study is composed of both qualitative and quantitative data (Saunders et al., 2015). Because there is no need for quantitative data collection for the purpose of my study, a mixed methods approach was not appropriate.

The qualitative designs considered for this study were case study, phenomenological, ethnological, and narrative designs. The objective for case study research is to focus on and understand complex social phenomena (Yin, 2018). The qualitative methodology is appropriate for exploring how managed care leaders have successfully allocated funds to avoid business closure. Because I have not explored meanings of participants' lived experiences, the phenomenological design did not fit the purpose of my study. Ethnography is the study of how people live their lives in a specific culture or group (Anderson, 2009; Gorunović, 2020). Ethnography was not appropriate for this study because I did not need to explore group cultures. Narrative designers obtain and explore participants' life experiences as a source of analysis for research to

understand the way people create meaning in their lives (Zurlo & Cautela, 2014). The narrative design did not fit the purpose of my study because I did not explore personal stories.

Qualitative Research Question

What strategies do managed care leaders of IPAs use to successfully allocate funds to avoid business closure?

Interview Questions

1. What strategies did you use to successfully allocate funds to avoid business closure?
2. What were some of the major problems that necessitated developing strategies to successfully allocate funds from your health plans?
3. What are some of the areas that you considered with health plans when determining how much money to allocate to each IPA?
4. What decision criteria did you use when considering financial allocation to a physician or specialist provider?
5. What components of the decision criteria for considering financial allocation to IPAs by the health plans were known to be underfunded did you use?
6. What strategies did you use to reduce costs on the items to which health plans are not allocating sufficient funds?
7. What additional information related to the strategies for successfully allocating funds to avoid business closure would you like to include?

Conceptual Framework

The Quinn competing values framework (CVF) theory was the conceptual framework proposed for this study. The CVF theory is developed on the premise of two major indicators of effective organizations. It was created in 1983 by Quinn and Rohrbaugh. The first indicator is development of people within organizations as well as development of the organization. The second indicator is structure. This second indicator involves the difference between stability and control and flexibility and change as comparison points. The CVF theory is applicable to understanding findings from this study for exploring successful strategies leaders use to avoid IPA closures.

The CVF theory was chosen for this study in order for a comparison of operational factors as well as organizational structure between IPAs and physician offices. Using the CVF theory allowed me to study strong IPA structures which allow leadership to avoid bankruptcy. Using the CVF four-quadrant theory allowed for exploration of internal and external factors with IPAs.

Operational Definitions

Accountable Care Organization (ACO): A group of primary care providers, specialists, and hospitals that agree to share information and coordinate to make patient care more affordable and efficient. In addition, ACOs provide paperwork to governments, allowing them to take a share of the money they save (Dewey, 2018).

Independent Physician Association (IPA): An association of independent physicians who offer member-improved cooperation with insurance companies, which allows for reduction of costs and administrative burdens involved with contracting with

individual health plans. Members of an IPA maintain independent practices and make their own decisions about business policies (Woodcock, 2015).

Management Service Organization (MSO): An organization that provides administrative services to another organization. In the case of this study, this applies to management of claims payments, referrals processing, and other administrative services HMOs may provide to physicians or insurance offices (MedSynergies, 2014).

Risk Bearing Organization (RBO): Any organization assuming financial responsibility under a defined set of benefits by accepting prepayment for some or all costs of care (DMHC, 2019).

Assumptions, Limitations, and Delimitations

Assumptions are facts that are thought true but not verified (Nkwake & Morrow, 2016). Limitations are areas of the study that lack an appropriate amount of research (Byron & Thatcher, 2015). Delimitations are boundaries to the study (Berdychevsky & Gibson, 2015).

Assumptions

Assumptions are acceptance of an idea without proof of its truth (Nkwake & Morrow, 2016). I assumed any IPA can use this study to keep their IPA viable. I assumed any IPA can benefit from this research.

Limitations

A limitation is a restriction that can be a potential weakness in a study (Byron & Thatcher, 2015). There are three key limitations identified in this study. First, this study only includes interviews with individuals from one IPA in one city in the United States.

There are many cities, states, and countries using the managed care system that could be explored and compared to provide additional insights. Second, differences in laws and states also play a part in fund allocation and what is legally allowed. This includes bonuses and how IPAs are rewarded for cutting state or government costs based on data submission or other incentivized plans. Third, since this was a single case study, I did not consider the views and organizational strategies of other IPAs that could show other financial management perspectives.

Delimitations

Delimitations are fixed boundaries of a study (Berdychevsky & Gibson 2015). This study was limited to IPAs in the Los Angeles, California area. The study included one IPA, and participants were individuals who worked upper management departments within that IPA. I addressed what this IPA is doing to facilitate proper allocation of funds and different facets of management styles that can contribute to effective funding.

Significance of the Study

IPAs must stay in business for effective managed care healthcare systems.

Contribution to Business Practice

This study may be significant to business practice by providing practical means for developing and implementing effective strategies to better allocate financial resources. This case study can aid and support healthcare leaders in terms of implementation of new systems to keep IPAs profitable.

Implications for Social Change

Affordability of providing healthcare contributes to consumers' ability to obtain insurance in order to maintain or improve recipients' healthcare (Whaley et al., 2015). The more patients receive healthcare, the easier it is to educate and prevent illness. Positive social change can result when patients and providers work together for better healthcare outcomes. Benefits of improved healthcare outcomes include earlier treatment of disease and a more educated population for effective, preventative, and efficacious care.

Literature Review

A literature review a detailed analysis of literature, including its faults and merits (Saunders et al., 2015). It is a critical element of a doctoral study. The purpose of a literature review is full mastery of a topic.

Literature reviewed for this study includes peer-reviewed articles available on financial allocation of funds to health plans. Literature was selected based on its validity and usefulness to the study. The review includes journals and reports. In this study, I used the following databases: ABI/Inform, Academic Search Complete, Business Source Complete, EBSCOHost, Health Services and Science Research, National Center for Health Statistics, Open Library, ProQuest Central, SAGE Journals, ScholarWorks, Thoreau Multi-Search, and Walden Library Books. I searched for only peer-reviewed articles on the specific topic of IPA allocation and methods and strategies that can be used to effectively manage payments to physicians. In this research, 86% of sources published between 2018 and 2022, and 100% of articles were peer-reviewed.

Conceptual Framework

The CVF theory was the conceptual framework for this study. The four-quadrant model created by Quinn was later perfected by Cameron and Cameron and Quinn. Cameron and Quinn improved the study of Quinn and Rohrbaugh and introduced the CVF model. The new model included four culture typologies: adhocracy, hierarchy, market, and clan culture. Clan and adhocracy culture show flexibility while hierarchy and market culture show stability (Cameron & Quinn, 2011). . The CVF theory was considered and chosen for this study in order to examine corporate functions from both internal and external perspectives, which is important to determining reasons for IPA closures. Several assumptions underlie the CVF. First, four construct goals are common criteria for benchmarking the effectiveness of organizations (Cameron et al., 2011; Moen, 2017). Quinn and Rohrbaugh (1983) identified the four constructs as: rational goal, internal process, human relations, and open systems.

Rational Goal

The rational goal construct involves internal productivity of corporations along with performance and financial goals. IPA physicians deliver care to patients while attempting to remain within budget and medical care requirements (Achilles et al., 2019). Financial allocation and budgeting are rational goal constructs.

Internal Process

The internal process construct involves emphasizing internal efficiency and uniformity in processes. One of the directives of IPAs is to simplify and streamline internal processes that help them stay on budget.

Human Relations

Managers can use the human relation construct in order to emphasize mannerisms which encourage employee participation in terms of attaining company goals, trust, and adherence. Goals, trust, and adherence are factors that contribute to solid employee retention and satisfaction. IPA managers who train employees and have clear set goals to keep a unified corporate environment work in human relations.

Open Systems

The open systems goal construct has a primary focus on external growth, acquisition, and adaption of external factors. From the IPA perspective, the open system construct is relevant in terms of growth of number of patients and how it relates to health plans and other external corporate functions.

The CVF theory is a benefit to IPAs in terms of learning to manage internal and external issues as compared with human relations and internal productivity. Quinn (1988) said IPA viability increases when managing the four quadrants. Organizational effectiveness is affected by CVF's quadrant goals not being pursued with equal effort. Weighting on these goals appear different for each corporation.

Additional Supplemental Theories

The transformational leadership theory empowers followers to change and build relationships that that influence productive performance (Burns, 1978). The CVF theory is useful for differentiating leadership roles and is similar to the transformational leadership theory (Quinn, 1988). The constructs of the transformational leadership theory are (a) idealized attributes, such as behaviors and influences, (b) intellectual stimulation,

(c) inspirational motivation, and (d) individualized consideration (Bărbînta & Mureşan, 2017).

Cameron (1978) said organizational effectiveness is the proficiency of the organization in terms of having access to essential resources. Balduck and Buelens (2008) said effectiveness in organizations involves four main approaches: the system resource approach, goal approach, strategic constituency approach, and internal process approach. All four are approaches whose use is contingent upon the situation being explored. This was a possible theory to use for my study, but I that the CVF theory has a greater capacity to explore external and internal factors involving bankruptcies of IPAs.

Opposing Frameworks and Theories

Value based medicine (VBM) is the most advanced attempt to address which values are most important in medical practices. VBM involves perceived most important factors. VBM primarily involves a static view of values where the CVF theory involves internal and external factors that play a part in terms of outcomes in a business or significant situation. Although VBM is a significant part of medicine, it is important to take into consideration all aspects of a corporation to ensure financial and operational success. Due to incorporation of all factors, the CFV theory is a better fit to this study compared to VBM. Esposti and Banfi (2020) said VBM is a strategic method to manage rising costs in healthcare by establishing value-generating networks. The CVF theory is expected to be applicable to understanding findings from this study invovling successful strategies leaders use to avoid IPA closures.

Skinner's operant conditioning theory (OCT) is another theory that contrasts with the CVF theory. The three types of response to behaviors are neutral operant, reinforcers, and punishers (Skinner, 1938). Neutral operants are responses from the environment that neither increase nor decrease the probability of a behavior being repeated. Reinforcer operants are responses from the environment that increase the probability of a behavior being repeated. Punisher operants are responses from the environment that decrease the likelihood of a behavior being repeated (McLeod, 2018). Operant conditioning is a way of making learning possible via rewards and punishments for behavior (McIntosh & Goodman, 2016). The OCT allows people to relate consequences with their actions (McLeod, 2018). This theory did not work with this study because it does not involve considering all aspects of internal and external forces that are nonhuman that can influence business closures.

Background Information

IPAs created by individual physicians have served the managed care industry for decades. Qian et al. (2014) said there is a correlation between use of care and how easy it is to gain access to care. Results differ in terms of whether HMOs increase or decrease use of healthcare services and if these results have evolved over time. Further investigation is needed to ascertain whether HMOs will ultimately govern patient healthcare effectively while still retaining quality physicians. Essentially, managed care organizations operate within a system that is balanced between preventative care, patient education, financial allocation, and physician participation (England, 2016). Background

information on managed care systems in Los Angeles is necessary to understand why IPAs fail in this geographical region.

Managed care systems in Los Angeles, California date back to the early 1990s. In 1998, 77% of IPAs used capitation for primary care physicians and 30% used capitation remuneration for specialists (Grumbach et al., 1998). Most IPAs use financial incentives in addition to capitation related to referrals or correct use of ancillary services (England, 2016). There are many large HMOs and IPAs in southern California. These include Kaiser Permanente, HealthCare Partners, Regal Medical Group, and Community Family Care. There are many factors influencing the effectiveness of IPAs in both preventative, disease/illness treatment, and palliative care. Factors include patient and physician education, patient satisfaction, successful allocation of funds, physician office management and participation, and provider relations expertise (England, 2016). These factors play a role in effective managed healthcare and must be addressed by healthcare organizations to ensure state and federal compliance in addition to remaining viable financial organizations. Physician education is important to the financial viability of IPA structures (Gray et al., 2018).

Physician education has become more important as California has become more involved with patient care and addressing fraud and abuse within the system (Gray et al., 2018). HEDIS rules must be followed, and patients must be called in for their regularly scheduled exams and lab tests based on past diagnoses (Jianhui et al., 2018). Physicians are compensated for these services financially, and their organizations are not flagged as possible fraudulent abusers. Teaching these physician offices how to work lists provided

by IPAs to comply with state and federal regulations takes resources and time. IPAs must invest in teaching strategies or be sanctioned by state organizations (Gray et al., 2018). Since 2020, IPAs have been campaigning regarding teaching individual physicians offices how to comply with health plan requests (DMHC, 2019). If physician offices do not perform, IPAs are penalized in addition to the possibility of losing their assigned memberships. Rewards and incentives are issued by IPAs to help encourage timely participation. Patient satisfaction is also critical to the financial success of IPAs (Loughman & Peisert, 2013).

Patient satisfaction is taken into consideration when looking at the viability of IPAs (Loughman & Peisert, 2013). The number of grievances or noncompliant patients a physician office or IPA has can financially impact resources or force them to reduce incentives to physicians. Qian et al. (2014) said preventative care and consumer friendliness intertwine and play a part in consumption of services. Mismanagement of consumption of services is a problem within managed care and reason for the need for reform (Loughman & Peisert, 2013). Involving patients and making them responsible for their own care will help patient outcomes and satisfaction. Providers can help to foster a more patient-centered environment and decrease the belief that expensive plans are needed for excellent care (Zezza & Nacinovich, 2015). Educating employees can assist in performance outcomes and overall wellness of individuals (Torre, 2017). In addition to patient satisfaction, IPAs must be able to successfully allocate funds.

Improper use of funding is a main cause of IPAs going out of business. It is the IPA's responsibility to withhold enough funds to cover costs for ancillary care,

hospitalizations, pharmacy, and specialist claims while still paying providers capitation funding. Capitation funding involves allocating a monthly membership fee for patients enrolled in primary care providers regardless of whether they used services that month. For many providers, this is a way to guarantee funds in the office while still seeing fees for service patients. IPAs are known to entice primary care providers with better than average capitation payments in order to keep them enrolled in their medical groups (Gwynne & Agha, 2019). IPAs are then sometimes unable to pay other claims for specialists and other health services (England, 2016). This is where the problem of allocation arises. IPAs receive their money based on how many patients primary care physicians have enrolled in their practice. Good IPAs balance disbursement of funds so all services can be covered and still use all opportunities to educate providers about use management and proper charting (England, 2016). This is done so that IPAs can receive an adequate amount of funds from health plans.

IPAs must prove that services are being done and follow strict guidelines in office environments and charting notes (Bannow, 2020). Physician office management is key for IPAs to obtain funding from health plans (Linnander et al., 2017). Providers can be compensated monetarily for good documentation and management (Bannow, 2020). An audit is performed every 3 years to ensure offices are operating according to state and federal regulations. Audit scores are reported to the state (DMHC, 2020). If compliance cannot occur, the physician is dropped from the roster, and patients are transferred to another physician. IPAs will often request documentation from offices and sometimes pay providers for their timely compliance with requests. These incentive payments can

motivate providers to comply, and in return IPAs remain compliant with the health plan (Bannow, 2020). Primary care providers must participate in all audits and health plan and IPA requests. Being noncompliant can result in being dropped from the health plan (DMHC, 2019). Good office management and staff participation play a large part in the success of data collection and auditing (Paul et al., 2017). IPAs typically have a provider relations specialist who is assigned to each primary care office to answer questions and facilitate staff education.

Having discussed the factors influencing the viability of IPAs in the Los Angeles area, it is now necessary to discuss why IPAs are necessary in the healthcare system. There are several ways to deliver healthcare other than the private sector. The need for IPAs to help deliver and maintain satisfactory patient outcomes is discussed in the next section.

There is a correlation between use of care and how easy it is to gain access to care (England, 2016; Qian et al., 2014). Physician education is important to the financial viability of an IPA (Gray et al., 2018; Jianhui et al., 2018). Preventative care and consumer friendliness are intertwined and play a part in consumption of services (Qian et al., 2014; Loughman & Peisert, 2013). Coordination of care between patients, providers, and staff can benefit patient outcomes (Zezza & Nacinovich, 2015; Linnander et al., 2017; Paul et al., 2017). Management of utilization costs, patient outcomes, and provider participation will enable an IPA to render services within a conservative budget (Paul et al., 2017; Linnander et al., 2017, Bannow, 2020).

IPA Relevance with Regard to Conceptual Framework

Relevancy of physician association with IPAs has been established through the inception of medical groups for the good of the patients and reduction of costs for medical insurance companies (DMHC, 2019). Healthcare organizations face the issue of satisfying stakeholders and meeting healthcare objectives (Esparza & Rubino, 2018). IPA's manage funds allocated by the health plans. A national study done in 2013 showed that IPAs helped smaller medical organizations improve care in practices that employed 20 or less physicians. At least 25% of these practices were utilizing IPAs for a significant amount of their patient population (Casalino et al., 2013). IPAs provide the benefit of improved cooperation with insurance companies and the reduction of administrative burdens when negotiating payer contracts (Woodcock, 2015). An IPA also provides the benefits of networking, resources, education, and training. IPA's help an independent physician office stay current with administrative changes in the healthcare environment (Woodcock, 2015). Medical groups benefit from IPA's managing patient care and distributing funds allocated by the state. IPA's may also influence the type of insurance a patient may choose for their personal medical care.

Patients have a choice to be a part of a medical group or secure individual insurance privately. Babineau (2016) suggests that the IPA will act as an informational resource to patients accessing specialists in a cohesive unfragmented way. IPA's serve as a guide and advocate which will reduce ER visits, unnecessary testing and will streamline delivery of care. Although this information was written about Rhode Island, it appears to have the same relevancy for any state. A patient's level of income influences the type of insurance the patient will chose to utilize long term (Buckley et al., 2016). The number of

members assigned to a provider depends upon the number of members assigned to the IPA, location of the members, and member choice (Frech et al., 2015). Patients have the choice of the type of health care they choose for themselves. IPAs can coordinate this care and give patients the fluidity of services between PCP's and specialists.

In California, medical offices can become an IPA. For participation in the state Medicaid program called Medi-Cal, the medical office must be at least 51% owned by a physician and the other remaining 49% can be owned by a nurse practitioner or physician assistant (DMHC, 2019). There are no licensing requirements to become an IPA. IPAs provide the same function as a medical office and are required to follow the same obligations from the Medical Board of California. IPAs are important to coordination of care for patients.

IPA's coordinate care between providers, specialists, insurances, and the patient (Qian et al., 2014; Loughman & Peisert, 2013). The main concept of IPA's is that the coordination of care will provide better outcomes for patient health while balancing financial stability and cost effectiveness (Gray et al., 2018). Pros and cons of the use of IPA's have determined that IPA's do help to control costs and provide the patients a better system of preventative care and specialist coordination (Paul et al., 2017; Linnander et al., 2017). Coordination of care leads to the topic of the current insurance practice.

The reason CVF was chosen for this study is that looking for the reasons from both the internal and external perspectives is important to determining the reasons for IPA closures. CVF is widely accepted in the research community although it limits

empirical research and testing (Melo et al, 2014). Empirical research implies knowledge from actual experience rather than theory or belief (Gulosino et al., 2016). CVF has been used in many studies with a main focus on theories or beliefs.

Gulosino et al., (2016) used CVF to determine influence of balance within CVF and school academic success on teacher retention. Plugging in values into the four-segmented model, Gulosino's study concluded that a balanced CVF profile is associated with teacher retention when school environments are conducive to learning. Applying this model helped the researchers determine ways to improve the school's environment and that lead to improved learning by students by helping to create school environments that are conducive to learning. CVF has also been used to compare value theories for organizations.

Hsiao (2019) uses CVF to build a mutually beneficial value theory between merchants and customers using mobile payment services. The use of CVF allowed a comparison between customers resources and the value created; and a mediation between merchant's resources and value created. The CVF method enabled a positive "value co-creation" between consumers and merchants. This study allowed the combination of service dominant logic with extant theories describing correlation between mobile payment devices for merchants and customers. The CVF model was important to the core of this study. CVF models have also been used to compare organizational culture.

It is possible to compare organizational culture using CVF**.** The possibility of organizational comparison is the main reason I chose CVF for my study. Daneshmandnia (2019) said results-oriented and controlled characteristics of organizational culture were

observed to produce accurate demonstration of results. The presence of information silos proved that information governance was one of the reasons organizational culture was challenged. Trust, it was discovered, is one of the key components that can drive information governance in an organization. Organizational culture comparisons often use the CVF method (Daneshmandnia, 2019).

Lui and Johnston (2019) who used CVF and the multifactor leadership theory to validate nursing leadership in an Asian hospital setting. The intent of the study was to compare employees from different cultural and geographical occupational settings and the findings showed that interpretation of organizational culture and leadership varied. In this study, it was also necessary to evaluate using the multifactor leadership theory which applied to two different schools of thought on leadership in addition to CVF.

IPAs are necessary to the managed care system in terms of reduction of costs for medical insurance companies and meeting healthcare objectives (DMHC, 2019; Esparza & Rubino, 2018; Gwynne & Agha, 2019). CVF was chosen for this study because both the internal and external perspectives are important to determining reasons for IPA closures. CVF has also been used to compare value theories for organizations (Gulosino et al., 2016; Hsiao, 2019; Daneshmandnia, 2019; Lui & Johnston 2019). CVF is an appropriate conceptual framework for the examination of strategies leadership of IPA's can use to avoid bankruptcy.

Current IPA Practices

The business of obtaining insurance currently changes regularly. Despite international recognition of the importance of management in the development of high-

performing healthcare systems, the path by which countries develop and sustain a professional healthcare management workforce has not been ultimately defined (Linnander et al., 2017). In 2017, China attempted a process of integrating the new cooperative medical scheme (NCMS) and the urban residents' basic medical insurance system (URBMI) into the urban and rural residents' basic medical insurance plans (Kun et al., 2017). The integration determined that the amount of workforce in an area determines the outcome. More workforce was needed to make an impact, therefore, the authors found that the scale of financing for URBMI is insufficient for the increasing demands for medical services from the insured (Kun et al., 2017). Recently, with the implementation of Affordable Care Act and then its subsequent repeal, healthcare can still be privately attained outside of the exchange. Although many insurances are still available on a sliding scale, depending upon income and age, within the exchange. The insufficiency is relevant to the viability of IPAs in Los Angeles in addition to many other states and cities in the United States.

In Los Angeles, efforts to make healthcare more accessible are being made by the current governor. The Governor's proposal would offer financial help for young adults when they no longer qualify under parents' health plan and allow full-scope Medi-Cal coverage to qualifying young adults up to 26 years old, regardless of immigration status (Focus Economics, 2020). Recent data shows that health care and prescription drugs are a concern for families in Los Angeles. Healthcare recipients purchasing healthcare on the individual market will see an average 9% rise in cost this year, according to Covered California (Focus Economics, 2019). This push in medical coverage is filtered through

the states managed care system, impacting IPA's and their fiscal responsibility (Ibrahimipour et al., 2011).

Uninsured and foreign-born individuals are affected by lack of access to care (Alcala et al., 2016). The Affordable Care Act may help to mitigate some of these issues; however, the impact will not reach certain groups due to exclusionary factors. The main exclusionary group is undocumented individuals. As of 2010, 4.5 million Latinos live in Los Angeles county with 75% being of Mexican origin (Alcala et al., 2016). This group suffers from limited access with a wide range of adverse health outcomes. Current insurance practices need improvement and IPA's need to be careful on where funds are allocated to provide adequate preventive care to all recipients, not only the underserved (Kaplan, 2011).

Saluja et al. (2019) identified seven barriers to healthcare that included understanding value, finding a PCP, changing a PCP, wait times, availability, transportation, perceived cost, and a preference to use urgent care. These perceived barriers make healthcare more costly as patients do not have the education and knowledge needed to know how to take care of these issues. Healthplans attempt to focus on these issues so that the patients can utilize these benefits. Saluja et al. (2019) showed that despite these attempts to educate patients a huge barrier to care still exists. The financial cost of these barriers and the attempt to eliminate them can cause financial stress on the IPA.

Financial stress on IPA's can also come from the health plan itself as IPA's struggle to remain in compliance. The Department of Managed Health Care in the state of

California explains regulations and responsibilities of IPAs to the health plan administrators (DMHC, 2019). Access to information and assuring the healthplans that physicians are doing the required number of visits and services regarding their capitation is costly for IPA's and providers (DMHC, 2019). The struggle for the healthcare system to share information is costly and the industry where private physicians could care for a patient the way they see fit is no longer prevalent. With additional regulations and utilization responsibilities, IPAs impose and incentivize providers to submit information and proof of patients' visits. This causes offices financial stress since this can cost the time of one full-time employee. The IPA also shares the burden with staff visiting physician offices to explain and follow- up on the healthplans requests (Woodcock, 2015).

IPAs are required to submit data to the Department of Managed Care quarterly to prove their viability and liquidity (DMHC, 2019). A corrective action plan (CAP) may be issued if not in compliance. If the requirements of the CAP are not met within a given time frame the IPA will lose their credentialed status. A list of compliant IPAs' is listed on this website for IPAs to compare themselves to competitors and to alert the public of any potential disturbances in payment. All the rules for the state of California are governed by the DMHC and they have the final ruling in all appeals and discrepancies. In addition to the operational regulations, IPA's must plan and allocate funds appropriately so that providers and specialists can still be retained on the IPA's roster. Healthcare expenditures must be reported and accounted for on a regular basis to ensure the best patient outcomes. Most of the regulations for Los Angeles County are governed by the

DMHC, although the IPA is free to spend their allocated funds however they wish if they meet certain requirements. The next section will describe the IPA's costs and expenditures.

In summary, there have been recent attempts to make healthcare more accessible for California residents (Focus Economics, 2020). With more access to statewide care, more funding is necessary from the state. Barriers to care and financial costs cause stress to IPA's as they try to manage administrative requirements and patient outcomes (Saluja et al., 2009; DMHC, 2019; Woodcock, 2015). The DMHC places strict requirements on practitioners and IPAs for adherence to standardized medical practices (DMHC, 2009). The IPAs are under pressure and face financial restrictions if certain requirements are not met (DMHC, 2019; Woodcock, 2015). Auditing of medical practices and IPA practices have become more regulatory and costly for these organizations to thrive (Woodcock, 2015; Saluja et al., 2009).

Healthcare Expenditures

IPAs attempt to take full advantage of the limited funding for healthcare services. IPAs and other medical institutions must estimate costs to decide on spending plans (Lan et al., 2019). In addition, the government attempts to estimate their potential expenditures to create budgets (Lan et al., 2019). Currently IPAs are responsible for paying claims submitted by providers, hospitals, laboratories, and other ancillary providers (DMHC.org, 2019). Healthcare cost trends are followed to predict and evaluate critical next moves for healthcare executives (Achilles et al., 2019). Healthcare trends typically follow a constant pattern when disruptions are minimal and the population is consistent (Achilles et al.,

2019). Utilization trends reflect the change in the count of specialized services. Complex and elderly services tend to have higher utilization while younger healthier populations tend to use less services (Johnson et al., 2018). Demographics and delivery patterns influence utilization. The utilization of specialized services greatly impacts the outflow of resources for the IPA. In addition, there is also a financial change for the individual seeking insurance on the open market (Johnson et al., 2018).

The financial change for individuals was substantial when the Affordable Care Act was established. Newly insured people were seeing an increase in cost from what they would have been paying before due to the need to cover the costs for those who could not afford insurance (Achilles et al., 2019). The government, healthplans, IPAs and healthcare providers must balance costs to remain effective and financially viable (Lan et al., 2019). The balance between payments to contracted providers and allotted funds from the IPA is necessary for IPA survival. The system has a breakdown when there are not enough people enrolled to cover the cost of the people who cannot afford to pay anything for insurance or are on a sliding scale. The managed care system is important for people who cannot afford private insurance. This affects the IPAs by the healthplans changing or tightening their budgets allowing less cash flow into their system to pay the providers.

Lack of funds is the obvious reason that IPAs went bankrupt in the Los Angeles area. As of June 2015, 308 IPAs closed or filed bankruptcy in the Los Angeles area (Cattaneo & Stroud, 2018). Studies show that there are several reasons that these IPAs do not have the financial resources to thrive (DMHC, 2019). Lack of training for employees and physicians, overcompensation of primary care providers, poor contracting decisions

with specialists, and the use of inefficient MSO's all can be contributing factors to an IPA's inability to thrive (Linnander et al., 2017).

Addressing these factors individually provides an understanding of the challenges IPAs face. The IPAs must balance funding and expenditure to ensure survival (Gwynne & Agha, 2019). Training for staff and management in how to effectively control costs and report data is critical to the IPA's need to be solvent. The first area to explore is how the IPA's train employees of physician offices to effectively manage patient care.

The managed care system attempts to estimate potential expenditures and healthcare trends to create budgets (Lan et al., 2019; Achilles et al., 2019). These budgets typically follow a consistent pattern when population and disruptions are minimal (Achilles et al., 2019; DMHC, 2019). Utilization costs, capitation and ancillary payments, and office training are the major expenses for IPAs (DMHC, 2019). Expenditures need to be balanced and maintained for an IPA to remain viable (Achilles et al., 2019; Lan et al., 2019).

Healthcare Management Training for Employees

IPAs understand that employee management training is a critical component for the IPA to remain in compliance with the healthplans. Fiedler (1981) said the effectiveness of a leader, or the organization, depends upon two factors: the leader's management or personality style and/or the situational control or favorableness of the situation (Fiedler, 1981; Popp & Hadwich, 2018). Training for healthcare professionals assist medical groups in managing finances. Linnander et al. (2017) developed five components that created long-term national strategies for the profession of healthcare

management. These common themes include a demand for management expertise, elevation of the management role, standards for healthcare management systems, a graduate-level educational path, and professional associations. It was shown that educating and standardizing procedures for staff members increased the ability for better patient outcomes and a better financial outcome for the corporation itself (Ogbonnaya et al., 2018). A patient may choose to transfer providers or even transfer IPAs if staff is not well trained or for any reason they choose (DMHC.org, 2019). Ogbonnaya et al., (2018) reported positive cross-level correlations between employee outcomes and health care performance, measured by patient satisfaction. Patient retention is important for an IPA to maintain financial stability (DMHC.org, 2019**)**.

IPAs provide employee training on retention, provider service, standards of care, and other important roles the employees provide to the physicians' patients. Employees are a key component in patient retention **(**Ogbonnaya et al., 2018). Patient retention is important so IPAs and providers can continue to provide quality service to their members (DMHC, 2019). Physician offices that do not utilize the services offered for understanding IPA reporting need do not reap the full benefits of the funds available to them (Linnander et al., 2017).

In summary, educating and standardizing procedures for staff produced better outcomes for the patient and the corporation itself (Linnander et al., 2017; Ogbonnaya et al., 2018). IPAs and medical offices providing training to their staff will benefit from understanding IPA reporting requirements and reap the benefits of additional funding (Linnander et al., 2017; Ogbonnaya et al., 2018; DMHC, 2019). Training in the area of

management styes and situational control will help organizational outcomes in the way of staff management (Fiedler, 1981; Popp & Hadwich, 2018; Linnander et al., 2017).

Physician Education

Uneducated providers can cause an IPA to lose money. IPAs are meant to ensure providers are acting in line with health plan goals and requests (DMHC.org, 2019). Provider representatives are sent out to individual offices and facilities to train staff on better medical practices. The IPA shares the burden with staff visiting physician offices to explain and follow-up on the healthplans requests (Woodcock, 2015). The IPAs also request information from the offices to ensure that notes and professional visits are documented correctly. Proper documentation is necessary for reimbursement from the healthplans and if not done properly can cost the physician and the IPA money. One of the main topics of training is how to properly refer patients to specialists.

Referring a patient to a specialist is typically done by the primary care provider. How often a provider refers to the specialist is of concern to the IPA for financial reasons. Tzartzas et al. (2019) investigated what leads PCPs to initiate a referral or treat in office. The study showed that influential decision-making tendencies such as provider interaction with patient, emotional and clinical decision-making and interactions with specialists, colleagues, and supervisors. The IPA provides some manner of guidance for physicians on the issue of referrals (DMHC, 2019). IPAs have guidelines in place and ask PCPs to show they have performed certain tests before a referral is granted. The provider is advised on referral rates and utilization based upon other providers in their area.

In addition, providers and specialists within the network are trained on relations with each other and how to give negative and positive feedback when necessary. Feedback from specialists lacked required professional performance (Dossett et al., 2018). Structural barriers such as lack of time or contact information coupled with the uncomfortable feelings accompanying negative feedback support this claim. Defensive reactions and fears about not receiving future referrals were also an issue. The IPAs mitigate these fears and barriers to attain smooth referral processes. Utilization rates are explored regularly to ensure both astute patient care and resource allocation. Utilization can also be measured by the claims submitted on a provider's behalf.

Providers are educated on utilization of gap reports provided by the IPA. Gap reports allow a provider to see on a patient-by-patient level which preventative care services have not been performed for a patient. For example, a patient may have come in for a visit but not had a physical that year. DMHC requires that a patient have a physical every year (DMHC, 2019). Providers, IPAs, and healthplans are incentivized for successful completion of physicals for these patients. In addition to physicals, there are many other measures including pap smears, depression screenings, lab work, mammograms, and other preventative care tests based on age. The rate of completion determines the providers incentivized benefits. Provider education also extends to regular meetings to help the provider understand and perform these measures.

Providers are asked to attend regular meetings, monthly or quarterly. IPAs often include managers, physician assistants, nurse practitioners, and medical assistants in these town hall type meetings. The specific measures the IPA asks the providers to

complete are discussed and reviewed per DMHC guidelines (DMHC 2019). Proper coding techniques and exercises are practiced ensuring the physician's office is maximizing revenues. These exercises allow the physicians to code properly and exactly the way the healthplans' require. In doing so the IPA's also guide and train the physicians and employees on implementation of strategy (Dunphy et al., 2020).

Uneducated providers can cause an IPA to lose money (Woodcock, 2015; DMHC, 2019). Strategies for providers to earn more income and keep the IPA in compliance are learned from the healthplans and shared by the IPA (Dunphy et al., 2020; Woodcock, 2015). Training on referrals is one area that has been studied and proven to help reduce IPA costs (Tzartzas et al., 2019; Dossett et al., 2018). Well trained providers can help the financial stability of an IPA (Woodcock, 2015).

Implementation Strategies for Financial Success

IPA and health plan administrators teach implementation strategies to the physician offices. The healthplans require quarterly information from the IPAs that can only be collected from the medical offices (DMHC, 2019). The Centers for Medicare & Medicaid Services (CMS) imposes financial disincentives and monetary penalties when healthcare providers fail to achieve specified goals. Proper coding techniques and information sharing is required for IPA's and physician offices to receive financial incentives (CMS, 2021).

Implementation strategies include proper leadership skills in addition to physician and employee education. Leadership skills include management of staff, reporting techniques, follow up, management reports, and emphasis on items vital to business

(DMHC 2019; Popp & Hadwich, 2018; Linnander et al., 2017,). Utilizing these resources is a strong start to successful implementation. Proper leadership skills in management of staff are the start to excellent implementation of learned information from the IPAs and healthplans.

Staff management is imperative for a successful office environment. Homisak (2020) states that there are 10 "Go-To" staff management skills that are an indicator of a successful office environment. Saying thank you is the number one idea to make sure your staff knows their contributions matter. Daily communication and short 10-minute meetings give meaning to the day and make clear daily assignments and priorities. Be open to new ideas and implement when favorable. Staff members are great resources because they are on the front lines of a business (Linnander et al., 2017). Give annual reviews to determine strengths and weaknesses. Cultivating an engaged staff will improve employee satisfaction allowing management to both praise and critique employee behavior **(**Ogbonnaya et al., 2018). Train employees at the beginning of employment. Telling employees and training them are not the same. Providing enough training and not assuming staff immediately know what to do will improve patient satisfaction. Paying staff competitive wages will also improve staff performance (Lekić et al., 2019). Valuing work and encouraging a positive work environment makes employees feel more secure **(**Ogbonnaya et al., 2018). Management cannot ignore the need for rules and policies. Staff that have strong performance requirements are more productive than those who do not. It is important to not rush the hiring process and hire quickly to have someone on hand. In addition, let go of staff that are not productive or are negative

influencers. Utilizing the above tools will assist in maintaining a staff that is more productive and a successful workplace. Successful staff management will aid in the accomplishment of excellent contracting skills between IPAs and healthplans and IPAs and physician offices.

An IPA must contract with a health plan before providing care to commercial and assigned Medi-Cal members. The IPA contracts with the health plan for as much as they can get on a per member per month (PMPM) basis (Maeng et al., 2018). The rate that is agreed upon must pay for hospital, specialists, PCP services, medication, and other ancillary services. Poor rate and contract negotiation can cause difficulties for an IPA to stay in business. In addition, the contracting with the individual providers must also be negotiated. Problems can occur when an IPA contracts the PCP at a high capitation rate and then cannot pay the specialists when they bill for services. Excellent contracting skills are important for an IPA's survival including the contracting of a solid Management Service Organization (MSO).

An MSO provides claim management services to an IPA. The MSO generally manages claim payment and authorization services so IPA management can focus on growing the IPA, mitigating problems, and provider relations. Organizational planning allows an MSO to assist in the growth and development of excellent patient care (Mickan et al., 2019). A good MSO can aid and assist in reputation of an IPA for having great response times for payment and authorizations. A bad MSO is a detriment to the IPA and causes numerous problems amongst the provider community regarding delay in care and payments (Mickan et al., 2019). It is not necessary to use an MSO; however, an IPA must

have available staff and software to assess and pay claims and to provide authorization procedures. Using an MSO is an expense to an IPA, which leads to the issue of financial obligations and monetary requirements from the health plan.

In summary, strategies involving leadership skills such as staff management, reporting techniques, follow up, management reports, and emphasis on vital business elements, are key to an IPA's viability (Homisak, 2020; Mickan et al., 2019). A good MSO or management company can make marked difference in IPA financials (Mickan et al., 2019). Competitive wages improve staff performance and ensure employee security (Lekić et al., 2019; Ogbonnaya et al., 2018). Implementation strategies can increase an IPA's viability.

Financial Obligations of IPAs

IPAs are required to provide compensation to a variety of different specialties. Payments must be made to cover hospital, emergency room, recuperative care, nursing home, primary care physicians, specialist, and ancillary costs. California's Knox Keene Act (DMHC, 2019) dictates the rules and regulations for the entire state regarding patient care and healthcare delivery expectations. DMHC dictates reporting procedures and the rights and responsibilities of patients. Knox Keene Act and DMHC govern medical activity in the state of California.

An IPA organization must meet requirements set forth by the state of California to provide healthcare and receive renumeration from the state, health plans that know a contracted IPA is financially unsound has responsibility to pay for care for emergency services for any patient in that IPA (Richardson, 2016). Health plans must receive

quarterly reports from IPAs to ensure solvency for an IPA to remain contracted (DMHC, 2019). The DMHC will govern any IPA closely that is falling behind the threshold. Health plans will terminate affiliation with IPAs who are failing to thrive because they will need to cover costs of a poorly managed IPA. The table below shows PMPM premium revenue and PMPM premium costs for every county in California for the years from December 2017 through December 2019.

Table 1

Per Member Per Month Premium Revenue and Medical Expenses

Local Initiative (LI)	17-Dec PMPM Premium Revenue	17-Dec PMPM Medical Expense	18-Dec PMPM Premium Revenue	18-Dec PMPM Medical Expense	19-Dec PMPM Premium Revenue	19-Dec PMPM Medical Expense	19-Dec PMPM Net Rev [a]
Alameda Alliance	271	254	283	264	322	297	25
CalViva Health	247	235	247	235	241	230	11
Contra Costa HP	294	284	304	295	310	304	6
IEHP	325	297	328	312	345	322	23
Kern Health Systems	232	222	248	231	224	198	26
L.A. Care HP	340	324	291	268	326	306	20
San Francisco HP	318	289	335	301	343	321	22
Santa Clara HP	318	293	338	310	359	343	16
HP of San Joaquin	244	238	261	252	290	281	9

Table 1 shows the average costs for an IPA to manage patient care. It is from the table above that an IPA will begin to negotiate a contracted rate with the health plan. Location also seems to play a part in keeping an IPA viable. Cost of care to a patient

based upon location can play a part in an IPA's financial health. Table 1 shows that Los Angeles County is one of median areas for revenue in the state of California. This information shows that there is ample opportunity for IPAs to correctly allocate funding if properly managed. PMPM premium revenue is calculated by dividing the premium revenue by cumulative member months. PMPM medical expense is calculated by dividing the total medical expenses by cumulative member months. Utilization of medical services by members and amount of premium paid can cause fluctuations in PMPM premium revenue and expenses (Maeng et al., 2018). The difference between PMPM premium revenue and medical expenses does not equal net income because administrative and costs for taxes are not included.

Table 2 shows California is continuing to meet its Tangible Net Equity (TNE) requirements for 2019 by area health plan systems. This is important because if the healthplans fail, members will need to be transferred in a large capacity to other health plans. The large bulk transfer could cause interruptions in payments and operations.

Table 2

Medi-Cal Managed Care Plans: Counties Served, Medi-Cal Enrollment, and TNE

Health Plan	Counties Served	Medi-Cal Enrollment	Total TNE to Required TNE
Alameda Alliance	Alameda	244,095	595%
CalViva Health	Fresno, Kings, and Madera	351,063	576%
Contra Costa HP	Contra Costa	171,805	505%
IEHP	Riverside and San Bernardino	1,214,113	538%
Kern Health Systems	Kern	250,459	464%
L.A. Care HP	Los Angeles	2,008,825	816%
San Francisco HP	San Francisco	123,116	831%

Santa Clara Family HP	Santa Clara	242,423	633%
The HP of San Joaquin	San Joaquin and Stanislaus	334,929	781%

Table 2 shows LA Care, one of the major health care systems in Los Angeles, is meeting its requirement as far as its total TNE to required TNE. In fact, California is meeting its requirements in every area. This means that the failures of IPAs in this area is not due to the fault of the health plan in general, at least not in this circumstance. IPAs can make errors that can cause financial demise. In addition, administrative duties are incredibly costly (Erickson et al., 2017; Siddiqi et al., 2017). According to the Institute of Medicine (IOM), healthcare providers in the United States spends $361 billion annually on healthcare administration.

California's Knox Keene Act dictates the rules and regulations for the entire state regarding patient care and healthcare delivery expectations (DMHC, 2019; Center for Disease Control and Prevention, 2019). Payments are made to PCP providers and to cover ancillary costs (DMHC, 2019; Richardson, 2016). California is continuing to meet its Tangible Net Equity (TNE) requirements for 2019 by area health plan systems (DMHC, 2019: CMS, 2021). IPA's financial obligations must be met to keep an IPA from going bankrupt.

Identifiable Problems in Poorly Managed IPAs

IPAs can make critical errors in allocation of funding. Poor contract negotiations, lack of provider training, non-compliance with health plan requests, and non-solvency issues are attributable factors in the financial demise of an IPA (Dunphy et al., 2020). IPA's that do not assume full risk for patient care also cannot have 100% decision-

making ability for use of their resources (Dunphy et al., 2020). Up-front investment in an IPA can prove to be valuable in the long run. Implemented programs take time to show their value and when an IPA does not assume full risk the timeframe for reporting results is quicker and valuable programs may not stay in effect. For example, the value of home visits by a physician assistant or nurse practitioner reduces Medicare expenditures when in use by a costly segment of the Medicare population (Ruiz et al., 2017) Managing resources correctly is essential for the stability of an IPA.

Resources need appropriate allocation, or an IPA can be led into financial demise. Rural areas where there are few providers and hospitals are particularly at risk. Fewer providers and hospitals translate into higher costs for IPAs (DMHC, 2019). Although IPAs can choose the physicians working for them, it is up to the physicians to keep the IPAs viable (Pfefferle, 2019). A physician must be able to manage their patients effectively. A physician must make sure the patients are not over utilizing the emergency room at hospitals so costs for the IPA can remain low. Primary care providers must also see enough volume of patients to substantiate their capitation payments. For example, if a provider is paid $15.00 PMPM and they have 1000 members they are paid a capitation of $15,000 per month regardless of if the patient comes or not. Even though the provider is still paid, the health plan paying the IPA requires a certain amount of capitation data to keep that level of payment. A provider seeing only 100 members per month is being paid $150 per visit. The health plan administrators watch the IPA visit rates and require them to push physicians to see more patients or will reduce rates paid. In addition to having to encourage providers to increase patient volume, the IPAs face difficulty with adverse

patient assignment. Depending on the patient population, an IPA may be assigned patients that require more service than normal. For example, children have a lower utilization rate than an adult. Senior members typically utilize more services and require more care from specialists, hospitals, and rehabilitation centers when ill. Due to the differences in utilization the IPA depends on Risk Adjustment Factor (RAF) scores to help retain their payments from the healthplans.

The CMS Hierarchal Condition Category (HCC) assigns the RAF score based upon the probable cost of taking care of a patient based upon their diagnosis (DMHC, 2019). The original diagnosis submitted to the IPA is decided by the primary care provider and any other specialists where the patient has obtained care. Each year the RAF score is reevaluated by these providers and all their previous diagnosis are revisited to see if the patient still is under care for those illnesses. Each risk adjusted diagnosis is added together to give each patient a final RAF score. The higher the RAF score, the more money allocated to the IPA for that member. The physician does not partake in this additional allocation, but it is held in reserve by the IPA in case the member needs hospitalization or other ancillary services. Poor RAF scores for an IPA decrease the payments received by the healthplans. The only way to increase RAF scores is to train the providers to manage gaps in care and to evaluate the previous year's diagnosis.

Provider training is essential to the financial stability of an IPA. Reporting requirements requested by DMHC are reviewed quarterly by the health plan leaders. IPAs and providers not meeting health plan regulations are contacted by the IPA (Woodcock, 2015). Attempts to rectify out of compliance providers are made by the IPA,

however, the health plan is guiding these inquiries. A provider may lose their patient base if compliance is not attained and maintained. The IPA can also lose their members if too many providers are out of compliance or not providing data. Lack of provider education usually leads to lack of education for staff as well. Uneducated staff can lead to errors in eligibility causing the providers and IPA to lose money. In addition, staff not working care gap reports cause the IPA to lose revenue as well as lack of patient care. In addition to staff training, the emergence of remote access to care due to the COVID 19 breakout forces offices to reevaluate modes of care that can potentially affect revenues.

Emergence of Remote Access Care

With the sudden onset of COVID 19, medical offices are forced into creative means to maintain patient healthcare needs. The scramble to provide remote care via telephone or other electronic means has uncovered a basic inexperience in the delivery of care (Das & Sil, 2020). The remote deliverance of healthcare significantly reduced the need for physical contact between patient and physician (Silva et al., 2019). Physicians are beginning to utilize more electronic means for delivering care, however, struggles still occur when attempting to perform physicals and other basic vitals like temperature and blood pressure. The impact of learning new technology also impacts reporting procedures and numbers due to the decrease in-patient visits during the implementation period.

IPAs are requiring physicians to close gaps in care reported to them by the healthplans. Telemedicine helps to prevent the spread of disease by keeping sick patients out of the office. However, it requires more of the physician time due to interferences by other telephone calls or the patient being distracted from the provider. Providers are

required to visit with a certain number of patients and telemedicine presents an opportunity to keep the patient numbers up during a pandemic. New methods and more research need to be done on this topic to assess the true impact of telemedicine on day-to-day operations of a medical office.

Electronic medical record (EMR) systems make telemedicine and electronic visits easier to manage by providing a simplified location for patient charts. Sharing of medical information is also easier using electronic means such as (EMR) systems. IPA's and healthplans easily share data when using electronic means. Exporting information to the IPAs about gap closure and visits is typically done in this manner. Physicians can close gaps in care using telephonic and electronic visits with patients. Utilizing the providers reporting systems, an IPA can improve their HEDIS scores and receive additional monies from the healthplans.

Introduction of new IPAs

IPAs are forming regularly. As a physician's office or medical group expands in membership, they may choose to become an IPA. Following the DMHC guidelines an approved IPA can begin being assigned membership. An IPA can be formed with only one physician, or multiple physicians being contracted. Too many new IPAs can cause other IPAs to lose membership by members reassigning to the new one. Aggressive marketing and strong provider relations can help an IPA grow. As IPAs grow, others can shrink if new membership is not acquired. It is estimated that one provider must enroll 30 patients per month if they want to keep their capitation payments consistent. Reduction of membership occurs because patients do not fill out their paperwork sent by the state or

choose to be assigned to a different provider. The rules for a group becoming an IPA can be found on the DMHC website along with reporting information and other requirements. The intent of this study is to explore ways an IPA can manage resources to keep Los Angeles IPAs from filing bankruptcy. Exploring the concepts above indicate there are possibilities to keep IPAs in business. The following study will explore a local IPA in the Los Angeles area.

Transition

A successful IPA is multifaceted, and leaders must consider factors to remain viable. IPAs have been a part of the United States healthcare system since before 1990. Lessons were learned about the necessity for internal and external operations for IPAs to remain viable.

In Section 1, I explored current information on IPA practices and healthcare expenditures and showed there were several areas of importance that helped maintain healthy IPAs. Provider and employee training along with implementation strategies presented a strong argument that sound operational skills are required to maintain functional IPAs. In addition, healthcare revenue and expense charts for the Los Angeles area were explored to show that IPAs must be using every available resource to maintain low costs for delivery of service and keep patients healthy and out of the hospital. Healthy IPAs are effective for balancing patient care with minimal financial resources (Gwynne & Agha, 2019).

The qualitative interviews with this study were conducted by interviewing leaders from a local IPA. Questions about internal and external operations were answered by the

CEO as well as workers. The purpose of this study is to show how IPAs will be bankrupt if financial operations and costs are not analyzed properly. I explored ways and means for financial success in IPA management.

Section 3 includes an analysis of research provided in Section 2. Analysis and findings relate to the research as well as the conceptual framework. This section includes a discussion of how concepts can contribute to the field of medical management. In Section 3, I discuss and recommend possible solutions to the business problem of IPAs going bankrupt due to a lack of effective financial management.

Section 2: The Project

In Section 2, I address the purpose statement, role of the researcher, and participants who were interviewed in the study. I discuss the research method, research design, population and sampling techniques, ethical research, data collection instruments, data collection techniques, data organization techniques, and data analysis. I also explain the importance of reliability and validity in qualitative research. I use interview questions to assess knowledge of participants regarding keeping IPAs from going bankrupt due to financial allocation. Questions were approved from my prospectus and involve what strategies managers use to keep IPAs from bankruptcy.

Purpose Statement

The purpose of this qualitative single case study is to explore strategies managed care leaders of IPAs use to successfully allocate funds to avoid business closure. The population for the study was six participants from one managed care IPA in Los Angeles, CA. The leadership in this IPA have developed and implemented strategies to thrive in a difficult healthcare marketplace. Implications for social change include providing more quality medical insurance choices for underserved individuals by keeping IPA medical groups in business.

Role of the Researcher

I describe the data collection process along with any relationship I might have had with the topic or participants. This section also includes a description of my role related to ethics and *Belmont Report* protocol. In qualitative studies, researchers must mitigate

bias and avoid analyzing data through a personal lens or perspective. In this section, I also discuss bias mitigation and briefly describe my rationale for the interview protocol.

Role in Data Collection

Ary et al. (2018) said researchers in qualitative studies are data collection instruments. The role of the researcher is to be an objective outsider, and the researcher should remain detached and objective in terms of all information that is presented (Bonache & Festing, 2020). I have 21 years of experience in the area of IPA management as an observer who shares an office with the company where participants were interviewed. Interview questions were prepared to ensure strict topic adherence. Interview questions were not leading in order to ensure that participants' reflections were genuine. Although I am familiar with the research topic, I did not interrupt participants so they were able to freely share their ideas. I focused on ensuring participants' responses were not influenced by my personal experiences or ideas.

Yeong et al. (2018) said using an interview protocol allows for collection of quality data through use of comprehensive and consistent data collection procedures. I followed the interview protocol (seeAppendix). Naidu and Prose (2018) said member checking is useful in terms of confirming results of research with participants. I allowed participants an opportunity to identify any information that was not correctly represented or elaborate on points that required more explanation. I adjusted my analysis to include member checking.

Belmont Report

The Belmont Report summarizes ethical principles and guidelines for research involving human subjects. The Belmont Report, produced via the National Research Act of 1974, suggested three basic ethical principles of respect for persons, (beneficence, and justice (Cragoe, 2019). Maintaining research ethics is essential to the integrity of research projects (Shaw & Satalkar, 2018). I have been trained regarding ethical treatment of participants in a study.

Mitigation of Bias

Shaw and Satalkar (2018) said researchers need to uphold objectivity despite possible sources of bias that influence them. Researchers should be aware of their biases and attempt to stay objective during research (Shaw & Satalkar, 2018). I mitigated bias by adhering only to research questions and expressing only the opinions of those interviewed. Interview protocol and questions were not leading and I only asked questions which pertained to the topic as presented in the proposal unless I asked followup questions for clarification. My personal bias was mitigated by using an interview protocol, member checking, and ensuring data saturation to the best of my ability. I used bracketing to mitigate bias. Bracketing refers to setting aside personal beliefs and experiences with research before and during the research process (Baksh, 2018).

Rationale for Interview Questions

Yin (2018) suggested using a qualitative approach to collect non-numerical data. Based on Yin's recommendations, I selected a qualitative research method for this study

as nonnumerical data were required. Interview protocols are useful guidelines to ensure researchers collect data in a reasonable timeframe by controlling conversations (Yeong et al., 2018). I followed the protocols set forth for this study (see Appendix). I maintained privacy and confidentiality of participants by using codes instead of names or organizational names when discussing findings. I obtained consent from participants before recording interview sessions. My summaries of participant answers were reviewed with them to ensure correct interpretations of their responses.

Participants

In this section, I describe eligibility criteria for study participants as well as strategies for gaining access to participants. I identify strategies for establishing working relationships with participants and ensuring alignment with the research question.

Criteria for Selecting Participants

The purposive sampling methodology was used for determining strategies managers use to keep IPAs from filing bankruptcy. Purposive selection involves selecting participants who have knowledge and experience pertaining to the focus of the study (Palinkas et al., 2015). Purposive sampling is different from random sampling in that there is a purpose in selecting participants who have some knowledge about a subject versus random selection (Miguel et al., 2018). Verifying eligibility criteria is necessary when researchers choose participants (Chuan, 2018).

Strategy for Accessing Participants

Access to potential participants was gained via access to professional associations databases. AnIPA in the Los Angeles area was identified which had been in business for

over 10 years. The CEO or other accessible leaders were approached and asked if they knew any employees, contractors, or associates who would have knowledge about strategies used to keep IPAs from going bankrupt. The CEO or accessible leaders were asked to forward names or emails of potential participants so I could ask for potential participation. After participants were identified, I performed interviews with participants as allowed by the CEO. Hair et al. (2015) said use of the Internet via email is a useful tool in accessing participants. I considered using email as an initial point of contact for participants or direct contact during normal business hours. Times were scheduled for interviews and review of interview protocols. Interview questions were answered by participants, and if there were any answers that required further evaluation, participants were asked to elaborate. After each interview, I used member checking to ensure correct interpretation. I interviewed everyone available who had a working knowledge of the topic until I reached saturation at the completion of six interviews.

Establishing Participant Relationships

A working relationship was established with the participants by describing the importance of the study and how the participants will play a part in the research. The establishment of a protocol where several encounters with participants were made to ensure a smooth working relationship. The participants were informed about the study by use of an informed consent form and allowing participant's ample time for questions. In addition, a thorough explanation of the study and its components was relayed to participants. No reimbursement for time or compensation was made to the participants. Offers of payment for participation may have lead participants to deceive about eligibility

that could have jeopardized study integrity (Fernandez et al., 2019). A challenging issue for researchers is to find the appropriate amount of familiarity to study participants (Maier & Monahan, 2010). Misunderstandings can occur with participants if proper rapport is not achieved (Chenail, 2011).

Aligning Participant Characteristics

Correct criteria for selecting participants must be utilized. Molenberghs et al. (2014) stated a case study with a small sample size is acceptable but could be perceived as biased. A correct criteria of participant characteristics should allow for participants who understand the research question and will allow study of the question (McQuarrie & McIntyre, 2014). The criteria must align with the research question. In this study, participant characteristics must align with the knowledge of strategies for allocating existing funds to avoid business closure. I used only participants that have knowledge of strategies managed care leaders of IPA's use to successfully allocate funds to avoid business closure.

Research Method and Design

Research Method

Qualitative research is diverse and continuously evolving as useful mechanism of inquiry (Harrison, 2020; Krefting, 1991). The qualitative method fit the purpose of my study due to the synthesis of material necessary to derive a purposeful meaning. Yin (2018) suggests using a qualitative approach to collect non-numerical data. Based on Yin's recommendations, I selected a qualitative research method for this study as the intent is to use non-numerical data applicable to the focus of the research question.

Quantitative research methodology, with increased computing power and enhanced statistical software has made using this methodology enticing for researchers (Hochbein & Smeaton, 2018). Quantitative methodology is typically associated with a focus on using data to test theory, also known as a deductive approach (Yilmaz, 2013). A quantitative researcher uses numerical data and statistics to interpret findings and understand or guide the hypothesis (Henson et al., 2020). Although a quantitative methodology could be used for the purpose of this study, I did not chose it because I will not use statistics and numerical data to interpret data.

A mixed methods study is composed of both qualitative and quantitative data collection (Saunders et al., 2015). Mixed-method researchers use quantitative and qualitative methods to address complex phenomena (Creamer & Reeping, 2020). Because there was no need for quantitative data collection for the purpose of my study, a mixed methods approach was not appropriate.

Research Design

The qualitative designs considered for this study were case study, phenomenological, ethnographical, and narrative. Researchers use a case study design when the main research questions focus on how and why questions (Yin, 2018). In single case studies, researchers gather data from a single population, group, or organization (Archer et al., 2019). In multiple case studies, the goal is to replicate findings across multiple cases to draw comparisons so the researcher can predict contrasting or similar results based on a theory (Yin, 2018).

Gill (2014) stated phenomenological researchers focus on anything that appears in a person's conscious experience. Usually there is a close involvement between the researcher and participants and the interview becomes more than a collection of data and leans more towards an exploration of meanings (McKiernan & McCarthy, 2010). Because I did not explore the meanings of participants' lived experiences, phenomenology did not fit the purpose of my study.

Ethnography is the study of how people live their lives in a specific culture or group (Anderson, 2009). Ethnography is a type of social research involving the examination of the behavior of participants in a social group situation (Gorunović, 2020). Ethnography relies on participant observation, which requires the researcher to be present in the groups' culture (Ivanović-Barišić, 2018). Ethnography was not appropriate for this study because I did not need to explore groups' cultures.

Narrative designers obtain and explore participants' lived experiences as a source of analysis for research and a method to understand the way people create meaning in their lives (Zurlo & Cautela, 2014). Narrative studies offer analytical tools to make the authors' role significant in the interpretation of the participants' activity (Damodaran, 2017). Narrative research attempts to explore human experience in a textual form (Gholami et al., 2020). The narrative design did not fit the purpose of my study because I did not explore personal stories.

Population and Sampling

Population refers to an entire collection of items a researcher is interested in; a sample is a subset of that population (Knechel, 2019). The current section will describe

the population and sampling method proposed for this study. The population and sampling subsection will include a discussion on participants and the selection methodology.

Defining the Population

I explored, in this single case study, ideas on how managed care leaders can keep an IPA from going bankrupt. The population for the study included interviews of 6 participants from upper-level management of one managed care IPA in Los Angeles, CA. The participants needed to have knowledge of financial information and IPA management to participate in the study. These participants were considered appropriate to the study since they have extensive working knowledge of IPA management. The participants ranged from CEO to provider relations managers. Participant characteristics aligned with the knowledge of strategies for allocating existing funds to avoid business closure. I used only participants that had knowledge of financial allocation. Privacy protection, of each of the participants, influences the outcomes of studies (Yang et al., 2020). I kept names confidential, and no one will know the outcomes of other participants' responses.

Sampling

The method of purposeful sampling was used in this study. Purposeful sampling is commonly used in qualitative studies for its selection of information-rich participants in a limited resource environment (Patton, 2015). In my single case study of one IPA in Los Angeles, I attempted to identify a minimum of six participants to be included that meet the criteria designated for this study. The participant sampling was adequate for this

study because the participants will have a working knowledge of IPA financial management. Data saturation can be reached by a researcher doing an exhaustive exploration of the phenomenon being studied (Yin, 2018). Interviews are widely used in the collection of data in qualitative studies (McDermid et al., 2014). Additional interviews would have been conducted if data saturation was not achieved with the first six participants and documents analyses. Purposeful sampling also supports the research design of CVF by focusing on two major indicators. First, CVF focuses on the development of people within organizations as well as the development of the organization. Second, CVF focuses on corporate structure (Ikramullah et al., 2016). Purposive sampling also supports data saturation by ensuring that the most complete information was obtained by the participants knowing the most about the subject.

Data Saturation

Data saturation for ideas an IPA can use to avoid bankruptcy can be achieved by exploring upper-level management responses to a particular set of questions. Determining data saturation is solely dictated by the judgment of the researcher when no more new information emerges (Tran et al., 2017). Tran (2016) states only 15% of open-ended surveys reported a method of determining when the point of data saturation had been reached. I did not use a survey for this reason. Determining data saturation can sometimes be difficult because researchers can only rely on the information they have collected and therefore depend on their own experiences. (McIntosh et al., 2020), (Tran et al., 2017). Data saturation was ensured by exploring the answers given by the staff and making sure no new information was given that needs additional study as related to the financial

health of an IPA. No new data, information, themes, and the ability to replicate the study can be useful in determining data saturation. Saturation is reached when no new relevant information emerges with additional interviews (Fofana et al., 2020). Data saturation must also be combined with strong ethical values to ensure safety and security of the participants.

Ethical Research

Researchers must demonstrate ethical procedures to ensure excellence and integrity in their research (McIntosh et al., 2020). The Committee of Publication Ethics (COPE) established regulations to protect human rights in medical research (Wu et al., 2019). Participant's information and data is held for a period of 5 years to protect the rights of the participants (McIntosh et al., 2020). All data is kept in one single secure location and no names or other identifiable information was used. The Walden IRB approval number is 10-25-21-0682599.

Written consent was collected from each participant. The informed consent process must be adhered to during the process of collecting data. The collection of data was done by the use of interview questions. Please see Appendix to see a copy of the informed consent form used in this study. Following the protocols of the *Belmont Report*, I ensured that each participant had a full understanding of their part in the study. If a participant chose to withdraw from the study, all information collected was destroyed. If a participant chose to withdraw from the study, they did do so with a simple written request and with no penalty or timeframe constraint. A summary of findings of this study is shared with the study participants. Confidentiality represents the responsibility

researchers should protect personal information from unauthorized access and use (Colosi et al., 2019). The interview process was designed to protect the confidentiality of the participants. Participants were called in individually and no answers were shared with other participants. There was no financial incentive for participation in this study. Devlin (2020) argues that providing a high level of compensation will entice a participant to make a different decision than what they would have made had no compensation been offered. Following simple protocols, the empirical value of ethical research was upheld.

Data Collection Instruments

I was the primary data collection instrument for this study. Researchers who serve as a data collection instrument collect information about a specific problem (Saracho, 2017). Individual interviews offer the opportunity for participants to answer questions as well as to speak candidly regarding the research questions. (Hatch, 2002). Semi structured interviewing requires relational focus and practice in the art of facilitation (DeJonckheere & Vaughn 2019). The skills include: (a) determining the purpose and scope of the study, (b) identifying participants, (c) considering ethical issues, (d) planning logistical aspects, (e) developing the interview guide, (f) establishing trust and rapport, (g) conducting the interview, (h) memoing and reflection, (i) analyzing the data, (j) demonstrating the trustworthiness of the research, and (k) presenting findings in a paper or report. I conducted semi-structured interviews using predesignated questions. Using a semistructured interview protocol allowed for obtaining information by the use of open-ended questions (Mselle et al., 2017). The use of the predetermined open-ended questions was recorded using a recording device. A backup recording device was also used in case

of mechanical error. The use of a conference room ensured there were no distractions by telephones or other devices (Bozbayindir et al., 2018). Based upon Balbinder's recommendation, I used a quiet conference room to ensure little to no distraction. Another method to ensure correct interpretation of information was the use of member checking. Researchers use member checking as a process to identify if there are any misrepresentations of data between the participant and the researcher (Varpio et al., 2017). I conducted the interviews in a conference room where I adhered to community standards of social distancing. When this was not viable or suitable for the participants, I conducted the interviews using Zoom meetings.

The interview process was broken down into segments explaining each of the components individually. The participants had an opportunity to preview the research questions and the mechanisms of how I would be taping the interviews. A discussion of basic rules and how to disenroll from participation was also included. A detailed explanation of the interview process can be viewed in Appendix.

Data Collection Technique

The data component collection technique I used for my study is interviews and website reviews. Interviews are widely used in the collection of data in qualitative studies (McDermid et al., 2014). I held socially distanced interviews that are commensurate with the standards from the Center for Disease Control and Prevention (CDC) on social distancing. If some of the participants desired to do a Zoom meeting instead of meeting in person, I made that accommodation for them. The plan was to use pre-developed open-ended questions for the participants to answer. In addition, I adhered to a standardized

interview protocol (see appendix). A semistructured interview protocol uses prompting questions without strict guidelines (Cohen & Crabtree, 2006). The data collection method of interviews allows for a personal connection with the interviewer and the ability to ask other questions as they come up in conversation (McDermid et al., 2014). An advantage of interviews as a data collection technique is the ability for the researcher to ask follow-up questions, a disadvantage is determining the availability of the participants (Cohen & Crabtree, 2006). The use of member checking was applied by providing a copy of my analysis of responses for the participants to review to ensure the data was transcribed and understood as the participant intended. Open-ended questions are how I collected the data for this study. Document analysis and website reviews completed my methodological triangulation. Analyzing documents as a secondary source of data collection is beneficial because company documents often give insight to detailed information about the phenomenon being studied (Peyrefitte & Lazar, 2018). I obtained company documents relating to costs, revenues, and financial data. I obtained documents from public sources, websites, and government and company archives.

Data Organization Technique

Qualitative researchers create and maintain data logs with the intention of recording information about the types, times, and locations of data gathered (Marshall & Rossman 2016). Data analysis involves the review and evaluation of collected data to derive meaning, gain understanding, and develop empirical knowledge of a subject (Ary et al., 2018). Researchers collect field notes and use interviews and other means to support the analysis of case study data (Yin, 2018). The technique for organizing data for

this study was the utilization of a small filing system. Since this study was only using a small number of participants, the basic questions and answers were tape recorded then transcribed after the interview was complete. Notes were also taken at the time of the interviews. I kept a journal and followed trustworthiness protocols. The recorded interviews are kept in my home office and will be erased after a period of 5 years. A back up of the data was placed in iCloud storage for safe keeping and will be removed 5 years after completion of the study. Vos et al. (2017) suggested that a researcher inform interviewees that the researcher follow up with additional questions and ask them to review interpreted data for member checking. After the data was analyzed and turned into text, my analysis was provided to the participants for review to ensure the responses were interpreted correctly.

Data Analysis

Qualitative data analysis requires the researcher to identify, sort, and synthesize information gathered through interviews, note taking and observation of participants. The observations lead to the determination of patterns that answer the research question (Bengtsson, 2016). Data analysis is a progressive process of recognizing and associating themes for sufficient data interpretation (Yin, 2018). Critical analysis of data allows researchers to place themes and ideas in a narrative form (Rabinovich & Kacen, 2013).

During the interview process of the study, I took copious notes and recorded the interviews. I reviewed the answers with the participants to ensure correct interpretation. After interviews and member checking was complete, I began coding the data. Using Excel, I coded my data with numbers for the purpose of triangulation. Each response

theme was given a numerical value and placed in a table to easily view the commonalities or differences between responses. I synthesized my data according to the interview questions. Each of the numerical themes for each question was synthesized against one another to assess commonalities or differences. For example, each participant was renamed and placed on the tables axis. The other axis is a list of interview questions. Each theme of response was given a number and placed in the corresponding box per participant response. Later, question 1 was analyzed across the board for the responses from all participants. I looked at the answers to the interview questions and synthesized the data per question. After having synthesized the data between the participants answering each question separately, I looked for general commonalities and placed data into a new graph to show these commonalities and themes. The use of graphs provides a visual platform for easier comprehension (Miles & Huberman, 1994). Marshall and Rossman (2016) discussed and organized a four-part procedure to guide the data analysis process: (a) rerun the audio-recorded interview several times then provide a synthesized paragraph of findings after each question, (b) provide the interpretation to each participant for confirmation using member checking, (c) perform these steps simultaneously to ensure data saturation and to ensure there is no need for data exploration, and (d) make modifications as indicated by the participants to ensure valid data. By following this four-part procedure, I ensured valid data.

The modification process ensures the inclusion of new data that may have been introduced since the inception of the study that was not previously explored in the literature review. Responses were initially synthesized in an excel spreadsheet for easier

readability. The main purpose of triangulation is the confirmation of data and to ensure the data collected is comprehensive and valid (Morse, 2015). Triangulation assures validity through the verification process for the clarification of the theme being studied (Morse, 2015). According to Flick (2002), there are four types of triangulations: (a) data triangulation using different sources of data, (b) investigator triangulation using several people in the data gathering and analysis processes, (c) theory triangulation approaches data with multiple possibilities for approaching knowledge, and (d) methodological triangulation where two subtypes are studied. In my study, methodological triangulation was used. Methodological triangulation, first between the interview questions, then again through common themes, and additionally through document analysis and website review, ensured that the study remained valid from beginning to end (Wilson, 2016).

Although no software was used for methodological triangulation, data was compared between common themes on an Excel spreadsheet. Using a spreadsheet, I focused on key themes and correlation of those themes with literature including new studies published since my proposal was written. The themes were explored within the conceptual framework of CVF.

Reliability and Validity

Reliability

The analysis of data includes the review and evaluation of data to derive meaning, gain understanding, and develop empirical knowledge of a subject (Ary et al., 2018). Dependability is the awareness of data changing over time and alterations made in the researcher's decisions during the analysis process are considered and validated

(Graneheim & Lundman, 2004). Member checking ensures the dependability and reliability of data (Birt et al., 2016). Member checking was used to verify the data interpreted by the researcher (Morse, 2015). Member checking verifies the reliability of interpretation of data. Reliability is the assertion that data presented is true and correct (Graneheim & Lundman, 2004). My interpretation of participants answers, and my analysis of responses collected in this study were provided to participants for validation. The reliability of this study was upheld by member checking and identification of theories not discussed in this study that will need additional research at a later date.

Validity

Validation allows participants to approve of their participation and message (Marshall & Rossman, 2016). Interpreted data was provided to participants to ensure validity of my findings upholding the premise of member checking. Theory triangulation through the use of interview questions, document analysis, and website review is highly recommended by researchers, triangulation was used for the synthesis of data as strongly indicated by Morse (2015). Transferability is the ability to apply a researcher's findings to other contexts or groups (Noble & Smith, 2015). I addressed transferability in relation to the reader and future research by providing an easily readable narrative. Narratives are a simple way for readers to understand presented data (Rabinovich & Kacen, 2013). Researchers using confirmability ensure that they do not engage in research misbehaviors ranging from fabrication of data to leaving out outliers without a valid reason (Haven & Van Grootel, 2019). Researchers establish confirmability by member checking and by developing rapport with the participants where they feel comfortable taking a greater

stake in the outcome of the study. I established confirmability by member checking and taking time to engage with the participant before the study. Credibility is affirmed by member checking, participant transcript review, and triangulation (Shufutinsky, 2020). I performed all aspects of member checking, transcript review, and triangulation to ensure a credible study. Data saturation is reached when the researcher no longer discovers new information pertaining to the topic (Palinkas et al., 2015). Data saturation was reached when I no longer received any new data from interviews or review of documents or websites. When I reached data saturation, I concluded my data collection and analysis.

Transition and Summary

Section 2 included the role of the researcher and qualifications for the study. As the primary researcher, I selected the qualitative case study methodology using the four-quadrant CVF. Interview questions were developed and reworked to collect the most current and valid data possible. Member checking was implemented as the interview process began. Data tables in Microsoft Excel and synthesis of interview questions ensured valid data collection and saturation.

Section 3 includes findings from data. I explored current business practices of IPAs, implications for social change, recommendations for keeping IPAs from declaring bankruptcy, and recommendations for further research. Finally, I summarized all research and concluded the study.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative single case study was to explore strategies managed care leaders of IPAs use to successfully allocate funds to avoid business closure. Data were obtained from semistructured interviews and internal documents. Findings were based on methods IPA leaders used to evaluate the financial viability of their organizations.

The research question was: What strategies can IPA leaders use to successfully allocate funds to avoid business closure? After six interviews, I was able to reach data saturation. I transcribed interviews and placed responses onto a worksheet to analyze all participants. I organized common themes and addressed individual personal comments that were not mentioned in other participant responses. I analyzed data and placed common responses together numerically to determine the most freque nt results.

I analyzed data from six interviews. Findings are identified and discussed based on discovery of common themes. The participants are identified as P1, P2, P3, P4, P5, and P6 respective to order of interviews. Common themes were integrated using the Baldrige Excellence Framework and CVF theory.

Presentation of the Findings

I discussed each of the five common themes in detail and analyzed to what extent findings related to the conceptual framework and literature review. How findings contribute to the field of medical management was also discussed. I described ways that

findings confirm, disconfirm, or extend knowledge in this discipline by comparing findings with other peer-reviewed studies from the literature review.

I identified the following strategies to avoid business closure during interviews: managing costs of primary care, use management, provider training, and importance of CMS star ratings and market branding.

Theme 1: Managing Cost of Primary Care Providers and Specialists

The first theme that emerged was the importance of managing costs of primary care providers and specialists to support viability. All participants discussed using the cost of primary care providers and specialists as a tool for both leverage and managing costs. The discussion of all participants was noted in the interview questions when compared against the answers of another participant's interview. P1 said, "negotiating good contracts with specialists and primary care physicians is the best way to control growth and stability in the market". P2 said, "PCP's are not separately reimbursed for additional services to members with higher utilization so good capitation rates are necessary to retain providers". P3 said, "financial allocation issues of underfunding typically go to specialists and that it is imperative to develop and implement viable reimbursements and contracts with these providers". P4 said, "good contracting is important because different healthplans pay different reimbursement rates for the same demographic". Providers need to choose IPAs that can stay viable in spite of health plan differences. P4 said, "Though it isn't particularly fair for capitation to decrease because of only one health plan underfunding, it still does happen. It is up to the provider to decide if they still want to be with a health plan that is underfunding and where cap

(capitation) rates are lower". P4 said IPAs offer different rates depending on how many members providers have with a certain health plan. All participants made statements in support of leveraging capitation rates with primary care providers and good contracting with specialists as key to IPA viability.

P1 said:

> IPAs promoting growth will offer high capitation rates which are competitive in the market. An IPA choosing to maintain will offer capitation at lower less competitive rates. The fluctuation of market dollars stems from management's previous expenditure decisions and the costs of patient care. Cost of patients' care varies from month to month depending on utilization and overall patient's health.

Setting managed care capitation rates that account for higher expenditures is necessary to preserve access for patients with chronic conditions (Leibowitz & Desmond, 2020). P1 said available market dollars stem from costs of patient care. If patients are not using services at a high rate, more dollars are available to give to primary care where patients are using many services and more dollars are extended to services like specialists, laboratories, and hospitals. A recent rule set in place by the CMS gives individual states more flexibility in terms of setting capitation rates for managed care plans (King, 2020). This indicates that health plans can continue to cut costs if they decide to. IPAs are responsible for almost all costs for patient care except previously planned carve out costs. P4 said, "there are very few ethical ways an IPA can save money other than managing the burden of cost paid to the providers".

There is a balance between internal and external costs affecting the revenue cycle. I reviewed interviews, specifically focusing on fund management and administration costs and external costs, which are actual payments to physicians. P1 said, “50% of capitation costs are give to primary care providers and another 30-40% are given to specialists”. P2 said, “50% of capitation allocation goes to primary care providers.” P3 said, “50-60% of capitation funds go to primary care providers”. P5 said, “payments to providers and specialists were roughly 50-70% of the health plan’s allocation to the IPA”. External costs of payments to primary care physicians must not take precedence over payments that need to be made to specialists and other ancillary providers. The delicate balance of internal issues such as salaries and external payments to providers is what essentially keeps IPAs from either going bankrupt or remaining viable.

The development of individuals within organizations helps to mold decision-making processes when it comes to financial allocation (Beer, 2021). P1 said, “a failing IPA many times can be traced back to organizational greed”. P1 clarified that CEOs and owners need to be focused on growth and viability and not taking large paychecks. Additionally, how provider liaisons view disbursement of capitation is important for interpersonal development within IPAs. Liasons must “be adequately trained on growth and development and when to offer more or less capitation”. Growth and stability arise from the decision to allocate more funding to physicians and enhance organicational sustainability (Elnagar et al., 2022). Stability and control are compatible with the idea of consistency versus growth. P1 and P2 both stated that protocols for attaining consistency or growth include varying the capitation rates. Conservative rates promote consistency

and competitive rates promote growth. All participants confirmed attracting additional providers equated with corporate growth. P1 stated it is natural for liaisons to want IPA growth since they are typically paid commissions on new members brought into the IPA from other IPAs. P1 said, “the most important part is that liaisons know when to pull back the reigns,” indicating liaisons offering lesser capitation rates. P2 said, “liaisons must listen and be trained to move with the organizational goals”. Organizational goals may include introduction of new ideas for corporate growth.

Quinn’s model was relevant to business practice when determining how to develop and control the revenue cycle. Looking at Quinn’s model component of the revenue cycle could help an IPA to learn how to control growth at the rate that is relevant for viability. P1 – P6 all relayed the principle of management of costs relating to primary care physicians and specialists as an important part of keeping IPAs in business. P1 said, “Managing payments to these providers is a viable way to manage the stability of the organization”. Gywnne & Agha (2019) stated that healthy IPAs are an effective plan for balancing patient care with minimal financial resources supporting the idea of relevancy for this study. IPA’s are a viable way to manage healthcare costs and have the ability to learn to control their growth and stability.

IPAs are known to entice primary care providers with better than average capitation payments to keep providers enrolled in their medical groups (Gwynne & Agha, 2019). Financially enticing providers was confirmed by P1, P2 P3, P4, P5, and P6 indicating membership growth occurs when an IPA gives a higher capitation rate. Conversely, when the need to maintain numbers is pressing, the IPA will offer a more

modest rate. P3 stated “An IPA attempts to negotiate reasonable contracts for specialist services to keep cost at a minimum”. The idea of using more conservative rates when stability is needed is not a new idea and was confirmed by all participants to be the chief way of managing costs.

Effective business practice for IPAs to remain operable may be substantiated by curtailing the payments made to primary care providers. Data analysis is a progressive process of recognizing and associating themes for sufficient data interpretation (Mattimoe et al., 2021). CVF supports the idea that both internal and external factors have a direct impact on financial viability. P1, P2, and P3 confirmed that the idea of diminishing capitation payments externally reflects the internal savings for the IPA. “When you reduce the providers capitation it leaves more resources for other expenditures” stated P3. IPA’s are then able to operate efficiently and fulfill funding requirements. The responses from participants P1 – P6 confirmed the theme identified in this study compare to the previous literature review and new information since the inception of this study.

Theme 2: Use Management

Use management is the second most common theme discovered in the interview process. Five of the 6 participants identified utilization management as an important component in the financial management of an IPA. Utilization management covers such ideas as access to healthcare, having enough specialists, financial allocation to specialists, PCP reimbursement, providers with high utilization, and health plan reimbursement. Managed care organizations operate within a system balanced between preventative care and financial obligation (England, 2016, Leibowitz & Desmond, 2020). Utilization trends

affect the count of specialized services. Utilization can affect the viability of an IPA, although utilization alone is unlikely to cause an IPA to go bankrupt. P1 stated “An IPA won’t go out of business solely on specialist costs, unless you have a really bad patient mix. Stop loss kicks in when you have one patient that costs more than usual so that helps with cost issues that are not included in normal market trending”. Hospitalizations account for the majority of healthcare costs (Sabale, 2015). Complex and elderly services tend to have higher utilization while younger healthier populations tend to use less services (Johnson et al., 2018). Utilization of medical services by members and amount of PMPM paid to providers can affect expenses (King, 2020, Maeng et al., 2018). Most IPA’s are not at risk for prescription costs but if providers are frugal and costs are renegotiated it ultimately leads to more financial resources for the IPA since savings can be shared.

The internal training of providers within their managed care system helps the IPA to attain goals set down by the health plans. Providers can use the CVF method as a tool for planning. The IPA’s monetary reward plan for assisting their own physicians to do correct reporting actually helps the IPA to have a better reputation with the healthplans and may actually serve to improve public awareness of the corporation. The CVF framework serves as a tool for assessing how the IPA can better serve the community by utilizing financial and systemic training tools.

Yeong et al. (2018) states that using an interview protocol allows for the collection of quality data through utilization of a comprehensive and consistent data collection procedure. I believe the findings of this study confirm the already explored literature on effective business practice. Utilization management is a key way for an IPA

to keep costs within reason. IPA's and healthcare providers must balance costs to remain effective and financially viable (Lan et al., 2019). Five of six participants in this study stated that utilization management is key for IPA viability. The responses from participants confirmed the theme identified in this study compare to the previous literature review and new information since the inception of this study.

Theme 3: Provider Training

IPAs must balance funding and expenditure to ensure survival (Gwynne & Agha, 2019). Training for staff and management in how to report data is critical to the IPA for health plan reimbursement and good standing. Four of the six participants identified provider training as a key component for financial management of an IPA. "Training providers on better medical practices also helps an IPA to become more profitable" stated one participant. Another participant stated "A good business idea would be to not issue benefits until the patient has had an initial visit with their assigned provider. This would allow for better care and less utilization of emergency rooms and urgent care clinics". Proper provider training can help the IPA become more valuable to the health plan by increasing the value of STAR measures. STAR measures were covered in this study under a different theme however, provider training increases the probability of higher STAR measures.

The CVF method supports the idea that the effectiveness of a leader, or the organization, depends upon the leader's management or personality style and/or the situational control or favorableness of the situation (Fiedler, 1981; Popp & Hadwich, 2018). An organization's culture is influenced by its leaders. Organizational leaders

impart their knowledge onto their employees. A culture is typically developed by upper management and works its way down as a company evolves and grows. Many of the same characteristics of the leaders are developed within the staff, particularly when a small organization is growing. It is important for IPA leaders to train provider relations managers to effectively communicate desired results to physicians and their staff. When directives and incentives are properly aligned, maximum results occur. Using a simple graph, organizations can have a tangible tool for structuring organizational trainings.

Training for provider relations specialists should also include education for consolidation of members. Provider relations specialists not only trouble shoot problems and provide training for the physician, but they assist in the transfer of new members to the IPA. An IPA grows when patient membership grows. Provider relation specialists work in the field of medical management to increase IPA enrollment among patients who already carry membership with an IPA as well as assist new patients in obtaining insurance through the use of enrollment specialists.

When the subject of training was discussed as an answer to the interview questions, 4 of the 6 participants mentioned training as a key component to better HEDIS scores. In the other two interviews, provider training was not mentioned. HEDIS requirements must be measured and patients must be called for exams based upon their past diagnosis (Jianhui et al., 2018). It is the provider relations manager's responsibility to educate providers that can be compensated monetarily for good documentation and management (Bannow, 2020). The responses from participants confirmed the theme

identified in this study compare to the previous literature review and new information since the inception of this study.

Theme 4: CMS STAR Measures

CMS STAR ratings were mentioned by three out of six participants. CMS STAR measures includes a rating of plans on a one-to-five scale, with one star representing poor performance and five stars representing excellent performance. Star Ratings are released annually and reflect the experiences of people enrolled in Medicare Advantage and Part D prescription drug plans (CMS.gov, 2021). Patient experience was also identified by the participants as well as by CMS. One participant said “patient experience is so important that as long as the patients have a good experience, financial resources will always come”. Medicare beneficiaries use the STAR ratings to make important decisions about their choice of plan. Many plans have different benefits available to their members. Some of the advantages of a plan are varying prescription coverages, transportation, low or no deductible, dental and other services. Interestingly enough, nonprofit organizations frequently earn higher ratings than organizations that are for profit. For Medicare Advantage Prescription Drug (MA-PD) plans, approximately 82% of the nonprofit contracts received 4 or more stars compared to 62% of the for-profit MA-PD’s (CMS.gov, 2021).

CMS STAR measures impact an IPA’s financial performance. The following HEDIS requirements are measured and given STAR ratings by CMS: Breast cancer screening, colorectal cancer screening, annual flu vaccine, monitoring physical activity, special needs plan (SNP), care management for older adults (medication review and pain

assessment), osteoporosis management in women, diabetes care (eye, kidney, blood sugar), rheumatoid arthritis management, fall risk, bladder control, medication reconciliation, post-discharge, statin therapy, obtaining care, appointment wait time, customer service, healthcare quality, rating of care coordination, number of dissatisfied members, complaints, quality improvement, timely appeals and TTY availability. The list of HEDIS measures should be included in provider training to assist the IPA in helping the healthplans obtain the best ratings possible. The more of the measures attained, the better the ratings.

The CVF is a theory developed on the premise of two major indicators of effective organizations, development of people and organizational structure (Ikramullah et al., 2016). STAR measures can be compared back to the CVF model since it encompasses both internal and external factors that together create the STAR measure value. . Healthcare organizations that practice patient-centered care tend to have improved patient outcomes and increased quality of care (Kuipers et al., 2019). Patient satisfaction and internal review of HEDIS measures support the CVF internal and external review of systems networking. “Put the patients’ needs first” was stated more than once by P4. The responses from participants confirmed the theme identified in this study compare to the previous literature review and new information since the inception of this study.

Theme 5: Branding

Branding was named as another important part of IPA viability. Two of the six participants identified market branding as important tool for IPA success. Successful

branding creates a trusted pool of customers and the ability to retain it even in unstable economic conditions (Baurina, 2021). An IPA must set itself apart from competitors and establish a name in the community. The best way to do this is from outreach programs. Enrollment agents and other outside sources can assist in developing a market brand. Targeting specific markets and patient populations also makes tailoring outreach programs more effective. A relationship's value increases substantially when a demographic aligns with a corporation's target market (Greenhalgh et al., 2021).

One of the participants stated "primary care is the driver for marketing but also the driver for costs so it becomes a balancing act for the IPA". It was mentioned earlier IPA's should not issue benefits until the patient has had an initial visit with their assigned provider. Better market branding would occur on the referral side since patients would actually know their provider. The IPA leaders should identify the specific things they are doing to retain members keeping their predetermined goals in mind. Providers with good social media presence and ratings were allocated more financial incentives (Baurina, 2021).

CVF theory is applicable when looking at the internal and external objectives to building a branded product. Leadership in an IPA must be aligned with reform strategy, collaboration, flexibility, and support for new innovation (O'Neill et al., 2021). Applying these ideas to a table for CVF can assist with planning for IPA development. Although the topic of market branding was not researched in this study, it did come up as an important part of IPA financial viability.

Theme Summary

I found that the top three themes managing costs to providers and specialists, utilization management, and provider training are indispensable to the necessity for restructuring operations. The use of the CVF to create a simple chart to follow for each recommendation will allow the IPA leaders to formulate attainable goals and plans. Managing costs, utilization management, and provider training are not new ideas to healthcare management. Researchers have demonstrated that effective risk mitigation in healthcare settings decreases medical errors, poor patient care, and litigation (Darden-Robinson, 2020).

Applications to Professional Practice

The purpose of this research study was to identify and explore the strategies that healthcare leaders use to successfully allocate funds. For an IPA to remain viable it must develop better internal control processes to become more efficient (Elrod & Fortenberry, 2017, Frech et al., 2015). Healthcare leaders that implement new systems identified by market studies help to keep independent physician organizations profitable (David, 2020).

The study design was a qualitative multiple case study employing interviews, government websites and document analysis. I conducted interviews with 6 healthcare leaders who have experience in successfully allocating funds for managed care organizations. The five themes that emerged through data analysis were: (a) managing costs of primary care and specialists, (b) utilization management, (c) provider training, (d) importance of STAR measures, and (e) importance of branding. To successfully

implement funds in an IPA, healthcare leaders should build and implement their strategies based on the details contained in these five themes. It is important for IPAs to deliver excellent healthcare at minimal cost to meet healthcare regulations and financial constraints. This study may be significant because it examined themes that could potentially help keep an IPA in business.

Tangible improvements can be made in the way IPAs manage funding to keep excellent patient care as the first priority. When IPAs place an emphasis on providing the best care to patients they can streamline processes such as enrollment, access to providers, referrals, and hospital and other ancillary services. Physician engagement refers to a provider's willingness to learn and implement best practices for their patient population (Dunphy et al., 2020). P4 states "the training a provider office receives can make a remarkable difference in the way a patient is treated". Patient satisfaction increases when patients have a short wait time, receive timely authorizations, and attentive personal attention (Dunphy et al., 2020). Financially reimbursing specialists and training them for streamlined care, allows the IPA to focus on patient improvement and retention. An individual's health improves with regular preventative care (Whaley et al., 2015). The community improves with a team of providers working together to effectively manage their patients' health. Classes on diabetes, blood pressure, and cholesterol, and weight loss can be attended by the community when health plans stand behind the IPA on training the community. Often times, the classes are held at a local hospital and that will strengthen the community in which people live by the knowledge of where to go, when ill, decreasing the use of non-contracted hospitals. The effect on social behavior with the

implementation of branding will improve patient morale as CMS STAR ratings improve with the provider training. Overall, IPAs managing finances carefully make a difference in the community by improving knowledge and the need for preventative care.

Using the CVF method to identify the internal and external barriers to change will help to facilitate the necessary change. Since many healthcare leaders lack strategies for implementing successful financial allocation of funds, using or adapting this study's findings can provide healthcare leaders with potential strategies for implementing successful financial allocation.

Implications for Social Change

The findings of this study could contribute to social change by allowing the successful implementation of ideas that can help to reduce costs for an IPA. Healthcare leaders can provide a better format for the distribution of funds allowing the IPA and physicians an ability to continue excellent care for the patient population. The findings of this study could support healthcare leaders to define new processes, streamline existing processes, clarify training needs, and improve financial disbursements with providers potentially improving access to care for the community.

Recommendations for Action

The purpose of this qualitative single case study was to explore strategies managed care leaders of IPAs used to successfully allocate funds to avoid business closure. Although IPAs would not see the findings of this study as necessarily new information, the importance of the implementation of these findings may be pertinent to their financial health. Efficiency must be the core for developing better internal control

processes (Elrod & Fortenberry, 2017; Frech et al., 2015). IPA leaders are challenged with the complexity of health care delivery coupled with managing costs to achieve operational efficiency and cost effectiveness (David, 2020). Ideas and information gathered from this study could be disseminated through literature, conferences, and direct provider training.

Based upon Themes 1 and 2 which are managing the costs of PCP's and specialists and utilization management, my first recommendation is for an IPA to review internal and external operational costs, reevaluating the need for growth or stability. A self-assessment simplifies where a business may make changes and organizes the process of becoming more streamlined and viable (Grammer, 2019). The repetition of participant's responses in this study show that managing the costs of primary care and specialist services, utilization management, and provider training are of utmost importance in remaining viable. Internal characteristics must be evaluated by IPA leaders.

Using the four-quadrant model of CVF, IPA leaders can easily visualize applicable strengths and weaknesses. The beginning step is to create a simple graph. The art of writing and putting ideas on paper with a goal helps the mind to retain information and stay on task (Fanguy et al., 2021). There are other areas of importance to an IPA which may include internal training on operational costs, operational cost management, and other functional ideals but these were not separately mentioned by the participants during this study. The review and examination of controls within the organization can potentially help to keep organizational focus. There is a time to grow and a time to focus

on maintaining stability. An organization must decide where they fall within that spectrum. The financials within an organization is often a good place to start the review. A healthy organization may want to explore growth when there is financial stability. A struggling organization should stop growth and focus on reorganizing the existing lines of business.

Based upon Theme 3 which indicates that provider training is important, my second recommendation would be for the IPA to acquire the appropriate resources for training. Whether or not the organization decides to move forward with growth or limit growth by reorganization, enough human and/or operational resources must be available. It was discovered that increasing a nurse's workload by just one patient boosts mortality risk by 7% (AACN Bold voices, 2018). The findings from this study, in conjunction with studies showing that increased workloads for staff can decrease overall performance, supports my recommendation of ensuring an appropriate amount of human resources. In addition, IPA's and medical offices providing training to their staff benefited from adequate reporting requirements and reap the benefits of additional funding (DMHC, 2019; Linnander et al., 2017; Ogbonnaya et al., 2018). P3 stated "Lack of representative and provider training will result in lower HEDIS scores and thereby reduce the possibility of additional reimbursements". Having enough provider representatives to visit the providers within their network, along with a staff of training professionals for those offices will can increase an IPA's chance at sustainability.

Based upon Theme 4 which indicates a need for attaining excellent STAR measures, my third recommendation is for the provider relations department to ensure

training is completed by the training professionals. Many IPA's provide incentives to the physician offices for each HEDIS measure attained. I believe financial motivators are a great way to incentivize providers to have the patients come into the office. HEDIS measures for preventative care are essential (Jianhui et al., 2018). P3 stated "training for the physician offices would include teaching provider offices to call in patients that have not been seen for their yearly physicals and seniors that have not come in for their yearly senior assessments". P2 stated, "good training would also include teaching providers about capturing HEDIS codes while submitting encounter data". It appears as though good preventative care promotes good health and good health promotes incentives from HEDIS and STAR measures.

Based upon Theme 5 which indicates branding for the IPA for market recognition, my fourth recommendation is for quality improvement research and outreach. A barrier still exists despite attempts to educate patients (Saluja et al., 2019). The general population still requires more outreach and education for patients to remain in good health. P4 stated "good health is not only great for the patient, because the IPA will have lower utilization percentages resulting in lower costs". Quality improvement research can be completed by a contracted outside company or a specialized unit within the organization. The outreach effort should be to target underserved populations and educate on the need for preventative care and free services available in the community.

Recommendations for Further Research

The single purpose of this study was to explore strategies managed care leaders of IPA's use to successfully allocate funds to avoid business closure. Limitations identify

areas of study that do not have an appropriate amount of established research (Byron & Thatcher, 2015). This study included interviewed participants from one IPA in the Los Angeles area. It is possible that with a wider scope of area and the interviews of additional IPA leaders, more information may be discovered. Additionally, differences in laws from different countries and/or states play a part in fund allocation. The differences may include bonuses for delivery of care or other incentivized plans. The views and organizational strategies of other IPA leaders who could show other perspectives of financial management were not considered in this study. I believe much more information could be discovered by widening the scope of this study to include more IPA's in different geographic areas.

Reflections

During the duration of my study, I often wondered why I did not do something more directly related to what I do for a living! Although my study impacts my field indirectly, I felt it would have been easier to explore something I knew a lot about. As it turns out, I actually learned a great deal about something new and was able to work within a general scope of my knowledge developing a theory on how IPAs could better serve their industry.

Working in the same office with an IPA, I do have some intel as to the internal workings of an IPA. The study process of the literature review allowed a comprehensive and exhaustive study of IPA management outside the office I already knew. There was a degree of personal bias as I could not help to compare what my colleague's IPA was doing in comparison to the literature I was uncovering. My personal bias was that I had

an inclination that the corporation I was working alongside had been doing it right. Based upon my findings and knowledge of other IPAs in the community, I resolved to find a few areas that need improvement so that other IPA leaders could see where studies show that my conclusions would in fact increase their revenues.

During the interview process, I had to be careful that my study did not affect my colleagues and my reputation with them. I felt the possibility for affect more when a potential participant chose not to participate. I made sure that I did not, nor anyone else, treat them differently when they chose not to participate. I suspect this is not uncommon in studies in one's workplace. After completing the study, I feel I have a strong argument in my recommendations for ideas that will realistically help an IPA.

Conclusion

Lack of training for employees and physicians, overcompensation of primary care providers, poor contracting decisions with specialists, and the use of inefficient MSO's all can be contributing factors to an IPA's inability to thrive (Linnander et al., 2017). The truth of contributing factors was proved in this study by the answers to the interview questions. The stark reality that many IPA's could refrain from bankruptcy just by following a few basic guidelines is a wakeup call. Greed is a problem with many IPAs as many use the system for financial gain with little thought about the importance of social implications.

When an IPA is operating within good moral construct, positive social outcomes are likely to occur. Social improvements include providing more choices of quality medical insurance for underserved individuals. IPA's must stay in business to maintain

an effective managed care healthcare system. The benefits of improved health care outcomes could include earlier treatment of disease and a more educated population for effecting preventative care.

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Appendix: Interview Protocol

Interview Title: Successful Allocation of Funds in Managed Health Care Programs

PART I.
INSTRUCTIONS
Good morning (afternoon). My name is Sherri. Thank you for agreeing to meet with me today. This interview involves two parts. The first part is a series of interview questions, in which I will ask you about your experiences working for an IPA in the Los Angeles area. The purpose is to get your perceptions of your experiences with the financial expectations of working with healthplans and physicians. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable with saying what you really think and how you really feel. The second part will be reviewing your answers with you to be sure I have interpreted correctly.
TAPE RECORDER INSTRUCTIONS
If it is okay with you, I will be tape-recording our conversation. The purpose of this is so that I can get all the details but at the same time be able to carry on an attentive conversation with you. I assure you that all your comments will remain confidential. I will be compiling a report which will contain all students' comments without any reference to individuals.
CONSENT FORM INSTRUCTIONS
Before we get started, please take a few minutes to read this consent form (read and sign this consent form or much simpler – you can just respond back to my email with "I agree"). (Hand participant consent form.) (After participant returns consent form, turn tape recorder on.)

PART 2
INTERVIEW QUESTIONS
I would like to ask you a few questions. Please take as much time as you need covering the question thoroughly. If you do not understand the question, I will be happy to explain the question. Are you ready to begin?

1. What were some of the major problems that necessitated developing strategies to successfully allocate funds from your health plans?
2. What are some of the areas that you considered with health plans when determining how much money to allocate to each IPA?

3. What decision criteria did you use when considering financial allocation to a physician or specialist provider?
4. What components of the decision criteria for considering financial allocation to IPAs by the health plans were known to be underfunded?
5. What strategies did you use to reduce costs on the items to which health plans are not allocating sufficient funds?
6. How did your organization successfully address the key barriers to potential errors in financial allocations that could cause IPA closure?
7. What additional information related to the strategies for successfully allocating funds to avoid business closure would you like to include?

Thank you for your participation. I will be providing you with a transcribed analysis of your answers to ensure accuracy in my interpretation. We will go over either in person or by email or telephone this as soon as the answers have been synthesized.

Thank you once again for your participation.