

Vertical Integration Trends and Impacts:

(a) Physicians & Hospitals

(b) Payers & Providers

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Topics to cover

- Types of consolidation
- Extent of consolidation
- Drivers of consolidation
- Impact on quality, cost, price, profitability, alignment

Vertical Integration Physicians & Hospitals

Input Markets



Output Markets



Physicians & Hospitals

Types of Consolidation

- Three types of relationship often identified

market

~ *buy*

hospital medical staff

alliance

~ *ally*

PHOs, MSOs, IPAs

hierarchy

~ *make*

hospital employment

Extent of consolidation

- Alliance models (PHO, MSO, IPA)

dismal failures in 1990s

garnered few capitated lives from insurers

no impact on cost or quality

no impact on physician alignment

no infrastructure to manage risk

on the wane ever since

may make a comeback with PPACA

can serve as the chassis for an ACO

Extent of consolidation

- Hierarchy models (employment)

more hospitals now employ physicians

not entirely sure how many physicians are employed by hospitals

lots of WAGs

lots of group think

get out your BS detector

Extent of consolidation: Estimates

- Percent of Physicians Employed by Hospitals:

Credit Suisse (2013)	2/3 of physicians
WSJ (2014)	2/3 of physicians
SK&A (2012)	1/4 of physicians
AHA (2013)	1/7 of physicians
- Percent of Medical Groups Employed by Hospitals:

SK&A (2012)	14-18% of groups
MGMA (2012)	12-13% of groups
- Percentages vary a lot by specialty

HORIZONTAL AND VERTICAL INTEGRATION OF PHYSICIANS: A TALE OF TWO TAILS

Lawton Robert Burns, Jeff C. Goldsmith and
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ABSTRACT

Purpose Researchers recommend a reorganization of the medical profession into larger groups with a multispecialty mix. We analyze whether there is evidence for the superiority of these models and if this organizational transformation is underway.

Design/methodology approach We summarize the evidence on scale and scope economies in physician group practice, and then review the trends in physician group size and specialty mix to conduct survivorship tests of the most efficient models.

Findings The distribution of physician groups exhibits two interesting tails. In the lower tail, a large percentage of physicians continue to practice in small, physician-owned practices. In the upper tail, there is a small but rapidly growing percentage of large groups that have been organized primarily by non-physician owners.

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Drivers of consolidation

Hospital Goals

- Increase MD incomes
- Improve care processes & quality
- Share cost of clinical IT with physicians
- Prepare for ACOs and Triple Aim
- Increase leverage over payers
- Increase physician loyalty/alignment
- Minimize volume splitting
- Increase hospital revenues
- Capture outpatient market
- Mitigate competition with physicians
- Develop regional service lines
- Create entry barriers for key clinical services
- Recruit physicians in specialties with shortages
- Address medical staff pathologies

Physician Goals

- Increase MD incomes
- Increase quality of service to patients
- Increase access to capital & technology
- Uncertainty over health reform
- Low leverage over payers
- Escape administrative hassles of private practice
- Escape pressures of managed care
- Exit strategy for group's founding physicians
- Increase predictability of case load & income
- Increase physician control
- Increase career satisfaction & lifestyle

Literature on Hospital-Physician Integration :

Little Evidence for Efficiencies & Benefits

Evidence

Costs – No impact (early research), Positive impact (recent research)

Quality – Mixed impact

Prices – Mixed impact (early research), Positive impact (recent research)

Hospital profitability – Negative impact

IT linkages – Little impact

Clinical integration – Little impact

Physician alignment – Little impact

Bundled Payment

Seems to lower costs, improve quality

Overall, few consistent effects of integration

Impact seems to depend on specific form of integration

Most integration fails to align physician and hospital incentives

Most integration focused on financial, not clinical factors

Vertical Integration Payers & Providers

Buyers



Suppliers



History of Payer-Provider Integration

- 1930s & 1940s: Group/staff model HMOs (e.g., Kaiser, GHC, etc.)
- 1970s - 1980s: IPA model HMOs (e.g., Hill Physicians)
- 1970s – 1980s: Rural-based IDNs develop health plans (Geisinger, Carle, Scott & White, etc.)
- 1980s: insurers acquire primary care groups, investor-owned hospitals acquire insurers
- 1990s: insurers sell off primary care groups to PPMs
- 1990s: nonprofit hospitals get into insurer business in anticipation of capitated care partly stimulated by BBA '97 (Provider-Sponsored Organizations)
- Products rarely achieved substantial scale (failure to reach MES ~ 100K lives) and suffered from a host of financial problems and infrastructure issues

Provider-led Integration with Payors: Rationale

- Position themselves to manage risk-based contracts
- Position themselves to become ACOs
- Position themselves for population health management
- Gain some leverage over payers
- Never-ending effort to dis-intermediate payers
- Never-ending effort to manage care continuum and triple aim

Hospital Sponsored Health Plans: Research Evidence

- IDN investment in hospitals/MDs/health plans negatively associated with operating margin
- Hospital diversification into other business lines like health plans associated with higher debt-to-capitalization ratios
- Health plan investments to link with providers to serve the Medicare Advantage population linked to higher premiums

Integrated Delivery Networks: In Search of Benefits and Market Effects

Conducted for the Academy's Panel on Addressing Pricing Power
in Health Care Markets

by Jeff Goldsmith, Lawton R. Burns,
Aditi Sen and Trevor Goldsmith



IDN Financial/Performance Analysis

To study IDN performance, we selected 15 nationally prominent IDNs that are dominant actors in their respective metropolitan and regional hospital markets. We attempted to cover all regions of the U.S. (though three of the sample are in Pennsylvania).

The sample:

- Advocate Health Care (suburban Chicago)
- Banner Health (principally Arizona)
- Henry Ford Health System (Detroit)
- North Shore–LIJ Health System (suburban New York)
- Aurora Health Care (Milwaukee/Wisconsin)
- Intermountain Health Care (Utah/Idaho)
- Penn Medicine (Philadelphia)
- Sanford Health (Dakotas)
- Sentara Healthcare (Virginia)
- BayCare Health System (Tampa/St. Petersburg)
- Sutter Health (Northern California)
- UPMC (Western Pennsylvania)
- Geisinger Health System (Central Pennsylvania)
- Johns Hopkins Medicine (Maryland)
- Presbyterian Healthcare Services (New Mexico)

NASI Report Findings

- No relationship of IDN “revenue at risk” with
 - (a) IDN profitability
 - (b) IDN cost of care (adjusted for CMI)
- Comparing the *IDN flagship hospital* with its main in-market competitor:
 - (a) higher average cost per case in 10/14 sites
 - (b) more “revenue at risk” associated with higher Medicare spending in last 2 years of life
 - (c) no meaningful differences in clinical quality scores:
 - readmissions
 - infection rates
 - complication rates
 - (d) no meaningful differences in patient satisfaction scores or Leapfrog safety ratings
- NOT CLEAR that IDNs can coordinate care, lower costs, and deliver value

Payer-led Integration with Providers: Rationale

- Position for increased Medicare Advantage enrollment, which has been surging and will increase substantially with the retirement of the baby boomers, as well as for increased Medicaid enrollment following PPACA implementation in 2014.
- Develop networks to help manage the care of the sickest patients - - such as the chronically ill, the dual eligibles, and those with pre-existing conditions - - which are the target of several initiatives in the PPACA.
- Belief that the only way to manage risk contracts and satisfy the dictates of value-based contracting is by owning the front end of (ambulatory) care and incentivizing their employed physicians to treat enrollees cost-effectively
- Threat posed by hospital efforts to develop captive physician networks and ACOs which might have as their real goal limiting insurer contracting options and increasing the prices charged them. Insurers may be vertically integrating back into the physician market to develop countervailing power and/or avoid being locked out

Thank you for listening