Title:
Vertical Integration of Hospital and Clinic Systems: Impact on Care Delivery

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Abstract:

In anticipation of health reform, U. S. hospitals and integrated delivery systems have been rapidly acquiring physician practices. This trend toward vertical integration of physician practices with hospital systems facilitates the development of accountable care organizations. In theory, an integrated delivery system should be able to accept global reimbursement for care (from public or private payers) and more easily coordinate care, opening up the possibility of higher quality, lower cost care. However, a growing body of evidence indicates that physician practices owned by hospital-based systems deliver care at a higher annual cost than physician-owned practices, while not leading to demonstrably better quality.

We present results from a study that leverages changes in a large metropolitan area, in which three large multispecialty groups, comprising 22 primary care locations, were acquired by hospital-owned delivery systems between November 2007 and April 2008. Using a classic pre-post design with nine control clinic systems, we examine the impact of vertical integration with a hospital on measures of cost, patterns and quality of care delivery. A rich six-year panel dataset (two years pre-acquisition and four years post-acquisition, with more than 650,000 members in the panel) allows us to attribute patients to clinic systems, and adjust the clinics' outcomes for the health risk of the patients in the attributed population. The pre-post design allows us to distinguish between differentials due to physician practice selection and differentials driven by the acquisition itself.

These claims data from a regional health plan allow us to identify how the delivery of care changes over time and with changes in hospital affiliation. Our preliminary results include measures previously examined in the literature such as total cost of care, disease-specific screening rates (breast cancer, colorectal cancer, cervical cancer) and markers of inappropriate care (ambulatory-sensitive admission rates, inappropriate emergency department use, readmission rates). We also examine care delivery patterns not previously studied, such as changes in referral patterns and changes in pharmaceutical adherence rates. Importantly, we also complete a careful examination of changes in billing practices, examining changes in facility fee billing, looking for evidence of increased negotiating power, and differentiating between changes in total cost due to increased unit costs and changes due to shifts in utilization patterns.

Key Terms:
integrated delivery systems, cost of care, quality of care

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