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Providing Insights that Contribute to Better Health Policy

Vertical and Horizontal Integration in the Community Tracking Study (CTS) Markets

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Overview

- Provider Integration in CTS Markets
- Horizontal Integration
- Vertical Integration
- Hospital-Health Plan Sponsorship
- Hospital-Physician Relationships
- Implications

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The Center for Studying Health System Change (HSC)

- Independent, objective research
  - Changes in private markets
  - Effects on people
  - Implications for policy makers
- Fully funded by The Robert Wood Johnson Foundation
- www.hschange.org

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The Community Tracking Study (CTS) Site Visits

- Visit 12 randomly selected communities every two years
  - Tracking markets since 1996
  - Representative sample—speak to national trends; “average” health care market
- Conduct 70-100 interviews in each site
  - Broad cross-section of health care executives and stakeholders
  - Triangulate results
- Round 4 visits: September 2002-May 2003

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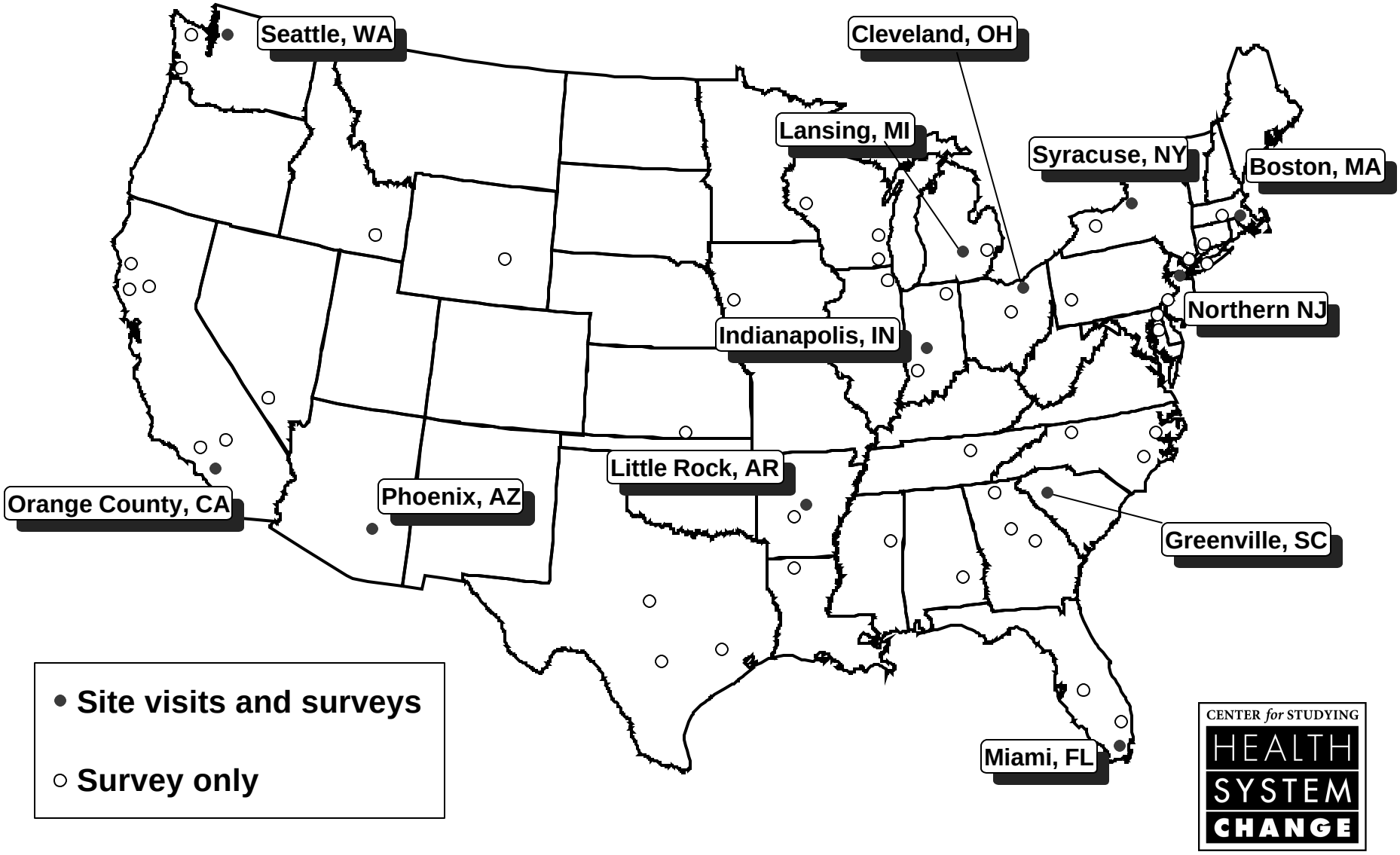
The CTS Sites



Evidence of Hospital Vertical and Horizontal Integration in CTS Sites

- Integration undertaken for multiple purposes through various forms of arrangements
- Horizontal integration increased then slowed as markets became consolidated
- Vertical integration activities slowing and in some instances reversed
- Vertical integration activities more targeted in their strategic aims
- Changing market conditions influence the value of integration to both health systems and markets

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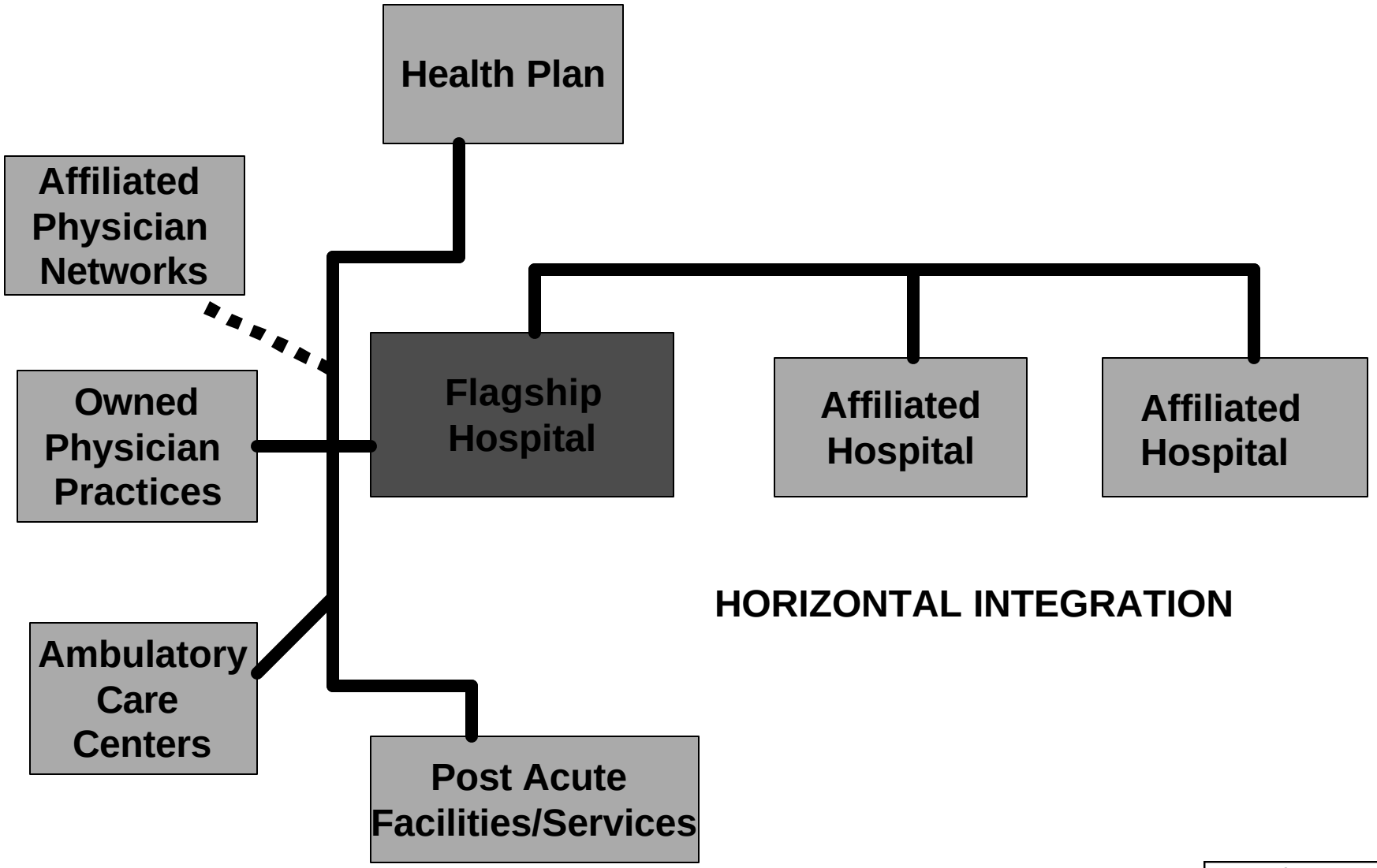

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Provider Horizontal Integration

- Examples:
  - Cleveland, Phoenix, Orange County
- Aims:
  - Operational efficiency
  - Minimize redundancy and duplication
  - Reduce number of competitors
  - Align and achieve strategic purposes among units
  - Promote channeling to flagship
  - Expand geographic coverage
  - Improve negotiating leverage with payers

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Yields from Horizontal Integration

- Service expansions in affiliated hospitals
- Hierarchical flow of patients among affiliates
- Fewer independent facilities in markets
- Markedly enhanced negotiating leverage with plans
- Potential to pursue exclusive affiliations with selected plans (geographic coverage)
- Impact on operational efficiency unclear

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Vertical Integration

- Examples:
  - Greenville, Indianapolis, Lansing, Orange County, Cleveland
- Aims:
  - Control patient flow/lock-in market share
  - Solidify affiliations, particularly with physicians
  - Position to receive and distribute capitation
  - Pursue seamlessness across continuum of care
  - Offer alternative distribution and contracting options
  - Diversify revenue sources

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Yields from Vertical Integration

- Expanded control over premium dollar flows
- Better contract terms with managed care plans
- Additional managed care product offerings
- Enhanced physician affiliations
- Decentralized delivery sites
- Continuum of care to improve patient flow

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Diminished Enthusiasm for Vertical Integration

- Inability to achieve expected returns
- Lack of proficiency in diversification efforts
- Conflicting goals of competing businesses
- Decline of capitation payments
- Increased demands of core business
- Substantial changes in payer environment for health plans, hospitals, and post acute services (BBA of 1997)
- Reduced resources for investment

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Hospital Sponsored Health Plans

- Interest peaked in late 1990s
- Products rarely achieved substantial scale
- Generally unprofitable but difficult to assess given nature of hospital contracting (self-dealing)
- Internal conflicts associated with promoting cost minimization v. revenue maximization
- Viable in selected markets where a large plan dominates market (e.g. Lansing, Indianapolis)
- Exclusive affiliations with plans obviate value of plan sponsorship (Cleveland, Little Rock, Greenville)

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Physician-Hospital Linkages

- Decline of risk based payments=abandonment of PHO models in many markets
- Some PHOs survive to align hospital and physicians interests (Greenville, Indianapolis)
- Distribute capitation or to assist physicians and/or hospitals to obtaining better contracts
- Plans vary in response to PHO roles as “messenger” organizations: some value full network; others refuse to deal through PHOs
- Unclear if PHOs result in higher physician payments

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Physician-Hospital Linkages (cont'd)

- Health systems face challenges from some specialty physicians
- Vertical integration initiatives may preempt or co-opt physician maneuvering
- Sponsorship of ambulatory surgical and imaging centers threaten full service hospitals (Syracuse, Lansing)
- Specialty/"boutique" hospitals are threat in other markets (Indianapolis, Phoenix, Little Rock)
- Integration activities include building, buying, and joint venturing to exert hospital control/influence

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Integration and Regulation

- Existing state regulation of Integration is uneven
- Horizontal integration may be subject to special scrutiny, especially if ownership conversion is involved
- CON in some states: addresses vertical integration activities but application may only apply to hospitals
- States without CON: hospitals feel vulnerable to entrepreneurial unbundling/dismantling of full service facilities
- Public payer policies have both encouraged and discouraged integration efforts

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Integration as Strategic Response to Market Conditions

- Integration is a means to modify organization boundaries and functions in the face of changing environment conditions
- Integration enables hospital systems to pursue both missions and margins
- Some integration activities reduce competition in markets and contribute to higher costs for consumers
- Whether integration activities primarily serve institutional vs. community needs varies and is subject to dispute

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