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Physician Organization Affiliation With Health Systems and Equitable Care Delivery

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Regulatory agencies need to strike a balance between ensuring competitive health care markets and organizational affiliations that enable better care coordination. Over the past decade, health system acquisition of physician organizations has accelerated, potentially affecting care for socioeconomically and clinically vulnerable populations, including dually enrolled Medicaid and Medicare beneficiaries.[1] Timbie et al[2] present findings from a novel and important study estimating changes in physician organization disparities for dually enrolled beneficiaries before and after affiliation with a health care system. They analyzed 7 years of Medicare Provider Enrollment, Chain, and Ownership System data paired with Internal Revenue Service Form 990 data, then integrated it with 100% Medicare fee-for-service claims data for beneficiary characteristics and to assess health care quality and utilization. The integration of these national and longitudinal datasets and the extensive use of manual checks and supplemental data sources to ensure the validity of the study measurements are major strengths of the study. They found that disparities between dual-eligible beneficiaries and non–dual-eligible beneficiaries in diabetic eye examinations and follow-up after acute events widened after health system affiliation, but disparities in statin prescribing and primary care continuity improved. Overall, study results suggest that complex dynamics underlie the integration of physician organizations into health systems and, importantly, that there may be negative unintended consequences for vulnerable populations associated with physician organization affiliation with health systems.

The results suggest that organizational integration across the continuum of care may improve quality and equity of care if physician organizations and health systems are sufficiently clinically integrated, rather than merely administratively integrated. When first acquired by or affiliated with a health system, physician organizations and health systems may begin to contract with payers jointly but not pursue significant clinical or operational integration efforts for years due to cultural and financial barriers.[3] Outcomes assessed in the study by Timbie et al,[2] including improved medication adherence, could take more time to materialize, especially for socioeconomically vulnerable populations such as dually enrolled patients who often experience barriers to access and have unmet social needs. Importantly, Timbie et al[2] defined the postaffiliation period as beginning in the first full calendar year after the year of the affiliation to ensure that each postaffiliation measurement reflected 12 months of exposure time for each physician organization. Given the time required for integrated organizations to move administrative integration efforts to clinical integration efforts, one might expect that integration within health systems would take multiple years. When more data are available, researchers should examine the longer-term effects of physician organization affiliation with health systems, including more distal patient outcomes, such as emergency department use and potentially preventable hospitalizations.

The widening disparities in care for dually enrolled beneficiaries in the context of organizational integration highlight a need to understand how variation in the context and degree of organizational integration is associated with disparities in patient care. Organizations integrate for diverse reasons, which highlights the need for theory-driven assessments to identify the mechanisms enabling the effective administrative and clinical integration of physician organizations into health systems through affiliation and/or employment. Transaction cost economics theory posits that health care systems acquire organizations across the continuum of care to reduce uncertainty, improve coordination, and avoid dependence on other organizations.[4] Market-level factors, such as market concentration, the opportunistic behavior of suppliers, and the availability of human resources, can,

therefore, affect health system decisions to integrate with physicians through employment or close affiliation. Transaction cost economics theory posits that improved continuity of care after affiliation would be associated with enhanced continuity across the continuum of care, including primary care, specialist, and inpatient care continuity, not simply within primary care, as examined in the study. Quantifying how organizational integration mitigates transaction costs for health systems, including reducing coordination and motivation costs, could help policymakers and organizational leaders understand the market-level conditions and health system capabilities that lead to improved care for vulnerable populations after affiliation.

Network theory can provide insights about the mechanisms connecting organizational integration with improved quality and equity of care.[5] An important function of physician organization and health system integration is joint contracting for global and/or value-based payments, including accountable care organization contracts. Integration of physician organizations into health systems can narrow physician specialist networks, improving care coordination between primary care physicians (PCPs) and specialists. Characterizing PCP-specialist network changes, including changes in their density and centrality before and after health system integration, may provide important insights for understanding when integration reduces or widens disparities for vulnerable patients. Research examining how changes in PCP-specialist network configurations are associated with quality and equity of care could also inform policies and organizational arrangements aimed at augmenting the benefits and reducing the unintended negative effects of physician organization affiliation with health systems.

A major limitation to understanding the association of health system acquisition of physician organizations with care equity is researchers' current inability to reliably characterize physician relationships with health systems on a national level. Timbie et al[2] were unable to differentiate different forms of physician affiliation with health systems, including direct employment, exclusive contracting, and other types of affiliations that reflect organizational arrangements that are relatively less integrated. Health system employment of physicians can be illegal in some US states; in these "corporate practice of medicine" states, medical group foundations enable exclusive contracting with a health system in an effort to achieve a similar level of administrative and clinical integration as an alternative to direct employment.[6] More evidence is needed to understand whether more integrated organizational arrangements between physician organizations and health systems improve equity of care for clinically and socioeconomically vulnerable beneficiaries and avoid the potential unintended negative associations of affiliation with care equity found by Timbie et al.[2]

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