ALTHOUGH ACQUISITIONS AND MERGERS REMAIN PREVALENT, MANY PROVIDER ORGANIZATIONS ARE CHOOSING TO FORM ALLIANCES OR JOINT VENTURES WITH PHYSICIANS AND OTHER INDEPENDENT SYSTEMS.

Alliances — which may include collaboration between regional health systems, clinical partnerships, accountable care organizations (ACOs) and clinically integrated networks — can present intriguing advantages for health care providers. Depending on the alliance type, they can encourage collaboration on best practices, reduce supply costs through group purchasing and improve population health management by coordinating patient care among members. Scale to reduce costs can also be found by sharing administrative functions such as information management and IT services.

Providers find initial appeal in alliance strategies with the prospect of reduced overhead through economies of scale, shared administrative costs.
Many networks are beginning to strategize how to fill those gaps, and some are reaching the conclusion that historical competitors, in a fee-for-service world, are maybe our partners in a value-based payment world, and so they’re considering these types of multisystem networks in order to be successful.  
— Dennis Butts, Director of Health Care Practice at Navigant

Balancing competing interests key for alliance longevity

Some alliances are seeing millions due to better economies of scale and improved care through collaborative patient management. However, coordinating as separate entities presents a separate set of challenges.

BIC Collaborative, a regional alliance that includes six systems in Kansas, Illinois and Missouri, has saved $65 million over three years by coordinating their IT services, consolidating the supply chain and collaborating on capital procurements.6

Mountain States Health Alliance, with 14 hospitals in Tennessee and Virginia, created the community-based accountable care organization AnewCare. That program saved the federal government $15 million and generated $7.5 million in revenues in its first year.7

The Together Health Network, a clinically integrated network consisting of Ascension and CHE Trinity Health, has a hospital within 20 minutes of 75 percent of Michigan residents and offers narrow network Medicaid plans in eight counties along with Blue Cross Blue Shield of Michigan.8

Despite losing one of its founding members to a merger,9 the Noble Health Alliance continues its growth. The Philadelphia-area alliance’s Physician Network topped 2,000 physicians in April 2015, entered an ACO partnership with Independence Blue Cross and became the preferred provider network for more than 39,000 members.10

The Long Island Health Network (LIHN) has nearly two decades of experience in providing clinically integrated care under pay-for-performance contracts.11 The 10-hospital organization shares best practices among its members and has generated performance-based revenue as a result.

• In 2004, LIHN hospitals contracted with payers to leave some of their revenue at risk. In 2007, all member hospitals were able to retain at least 95 percent of their at-risk revenue.
• Between 2004 and 2008, their Hospital Quality Alliance Process of Care measure steadily increased from 78 to 93.12

Leaders of the Accountable Care Consortium, Indianapolis, Indiana, announced their dissolution after 18 months, commenting that the partnered hospitals chose to focus on industry challenges separately. “It’s very difficult for one organization to make all the changes that we need to make, and trying to do all that in concert, it’s very challenging,” said Julie Carmichael, chief strategy officer of St. Vincent Health, a consortium participant.13

In addition to pursuing economies of scale, alliances should focus on population health management. Many current alliances were created to get bigger and maximize fee-for-service revenue. But in the value-based health care economy, many systems are seeing a significant drop in hospital admissions, medical surgical utilization and shorter lengths of hospital stays. To adapt, systems emphasize population health initiatives, which keep patients constantly engaged with the system.14

Regulatory requirements can hamper implementation. The Federal Trade Commission has detailed guidelines about clinical integration and only allows alliances or partnerships to proceed if the participating systems can show improved care and reduced waste.15

Waiting for the right moment can be counterproductive. Alliances happen when organizations have desirable strengths to bring to the table, whereas mergers and acquisitions typically happen when one organization is in a position of weakness.

Consolidation remains high: While mergers and acquisitions are still higher than historical levels, M&A activity decreased 14 percent in 2014, down to 72 transactions.5

Independent opportunities: There are approximately 600 clinically integrated health systems in the U.S., and most have not partnered with other systems.6 Experts expect that number to rise rapidly as systems shift from a fee-for-service model to value-based care.

What are the challenges for succeeding in an alliance?

Conflicts in strategic priorities can derail alliances. The Accountable Care Consortium, which included three systems with $2.5 billion in managed care contracts, dissolved 18 months after it began. In addition to challenges attributed to managing change individually rather than collectively, observers pointed to the decision by two members to join a narrow network plan while the third member decided to participate in a competitive marketplace plan as a potential reason for the alliance’s dissolution.16

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Alliances becoming a popular alternative to mergers and acquisitions

Business Impact

As the care delivery model shifts, those providers that choose to “fail fast” and continually adapt their efforts to build clinically integrated networks will create a place for themselves at the table.
— Jeffrey R. Hoffman, Senior Partner, Kurt Salmon

“Keeping together is the hard part, so you have to have successes to reinforce that. Everyone has strengths and weaknesses. Now we are all sharing best practices, which is really important — identifying who’s best at something and how you can help make us stronger.”
— Steve Lipstein, CEO of BJC HealthCare

Data Points

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What steps should be taken to better set up an alliance for success?

Establish explicit goals for each member, and then measure performance. Alliances succeed when their members succeed. While members may remain financially independent, the alliance needs to have clear standards where shared resources are utilized. Whether this is customer service, administrative costs, group purchasing or population health, clear goals for both the alliance and individual members need to be established, tracked and reported regularly.

Develop resources to reflect population health. As patients become healthier, pre-acute services, such as retail pharmacies, urgent care clinics, and outpatient clinics for rehabilitation and hospice, will become increasingly important. Alliances should also look at including long-term-care facilities within its fold to reflect shifting population needs. Looking at affiliate networks such as the Mayo Clinic and Cleveland Clinic, success is not only attributed to the brand opportunity but also seen in the clinical consulting and resources to help improve the care with its member hospitals.

The Mayo Clinic and Cleveland Clinic have created a successful business model around offering not only brand recognition but also clinical consulting and expertise through their affiliate hospital program.

Consider offering equal representation for all members. The BJC Collaborative gives every system three seats — two voting, one non-voting — on the governing board. The goal is to encourage every system to contribute ideas and resources, regardless of size.

**SOURCES**


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