Social Science & Medicine 190 (2017) 1–10

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The new frontier of strategic alliances in health care: New partnerships under accountable care organizations

Valerie A. Lewis [a, *], Katherine I. Tierney [b], Carrie H. Colla [b], Stephen M. Shortell [c]

[a] The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, 1 Medical Center Drive, WTRB Level 5, Lebanon, NH 03756, United States
[b] The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, United States
[c] School of Public Health and Haas School of Business, University of California, Berkeley, United States

ARTICLE INFO

Article history:
Received 1 June 2016
Received in revised form
3 February 2017
Accepted 30 April 2017
Available online 2 May 2017

Keywords:
Health policy
Health care reform
Health care costs
Health care quality
Alliances
Mixed methods research
Health care organizations

ABSTRACT

Accountable care organizations (ACOs) and similar reforms aim to improve coordination between health care providers; however, due to the fragmented nature of the US health care system, successful coordination will hinge in large part on the ability of health care organizations to successfully partner across organizational boundaries. Little is known about new partnerships formed under the ACO model. We use mixed methods data from the National Survey of ACOs, Medicare ACO performance data and interviews with executive leaders across 31 ACOs to examine the prevalence, characteristics, and capabilities of partnership ACOs and why and how ACO partnerships form. We find that a striking percentage of ACOs – 81% – involve new partnerships between independent health care organizations. These "partnership ACOs" generally report lower capabilities on care management, care coordination, and health information technology. Additionally, under Medicare ACO programs partnership ACO achieved somewhat lower quality performance. Qualitative interviews revealed that providers are motivated to partner for resource complementarity, risk reduction, and legislative requirements, and are using a variety of formal and informal accountability mechanisms. Most partnership ACOs were formed out of existing, positive relationships, but a minority of ACOs formed out of previously competitive or conflictual relationships. Our findings suggests that the success of the ACO model will hinge in large part upon the success of new partnerships, with important implications for understanding ACO readiness and capabilities, the relatively small savings achieved to date by ACO programs, and the path to providers bearing more risk for population health management. In addition, ACO partnerships may provide an important window to monitor a potential wave of health care consolidation or, in contrast, a new model of independent providers successfully coordinating patient care.

1. Introduction

Despite the growth in the number of physicians joining group practices and physician practices joining hospital and health systems, the US health care system remains largely a patchwork of independent health care provider organizations, including hospitals, physician practices, and nursing facilities. As a result, coordination of clinical care often requires working across organizational boundaries – for example coordination between hospitals and office-based physicians, or between primary care practices and the specialty practices to which they refer patients. This is particularly true when providing care to complex or high need patients who often require care from post-acute care facilities such as skilled nursing facilities, rehabilitation centers, and home health agencies. Thus, a central challenge facing US health care providers is how to best coordinate care across organizational boundaries.

Payment and delivery reforms such as accountable care organizations (ACOs) aim to encourage coordination through financial incentives. For example, ACOs include rewards for meeting quality performance targets and total cost of care benchmarks. Proponents hope that ACOs and similar reforms will reward and encourage better coordination of clinical care. To achieve such coordination, many providers under ACO contracts will need to build new ways of partnering across organizational boundaries. ACO success will largely depend on their ability to build effective new partnerships.

* Corresponding author.
E-mail address: valerie.lewis@gmail.com (V.A. Lewis).

http://dx.doi.org/10.1016/j.socscimed.2017.04.054
0277-9536/

The challenges include issues of governance, leadership, building trust, developing shared goals, managing highly interdependent work, clarifying roles and responsibilities and managing potential conflict.

Currently, little is known about the extent to which ACOs are developing partnerships, the types of partnerships developed, or the extent to which they are meeting desired cost and quality objectives. While a handful of studies have examined the involvement of particular types of providers in ACOs (e.g. hospitals or community health centers) and associated issues of partnering with those organizations (Lewis et al., 2014; Colla et al., 2016a, 2016b; Dupree et al., 2014), these studies cannot provide broader insight into the phenomenon of providers partnering under ACO contracts. In this paper, we address this gap in the literature by using mixed methods analysis (survey data, performance data, and semi-structured interviews) to describe the landscape of new partnerships between health care provider organizations associated with ACOs. We specifically examine the following questions: 1) to what extent are ACOs formed from new linkages between independent organizations versus from organizations that were previously part of the ACO?; 2) in what ways are partnership ACOs similar and different from ACOs that are existing organizations?; and 3) are there differences in performance between the different types of ACO partnerships? We discuss the implications of our findings for both policy and practice.

1.1. Current landscape OF US health care

Although there have been trends in consolidation of US health care providers over the last few decades (Goldstein, 2012; Peterson et al., 2015), a large proportion of US health care providers still currently practice outside of integrated systems or large practices. For example, as of 2013, 65% of office-based physicians were in groups of five or fewer physicians (Burns et al., 2013). Against this backdrop of consolidation, accountable care organizations are a popular reform aimed at improving health care outcomes and costs. ACOs mirror reforms taking place in other countries that also aim to better coordinate and standardize care, improve quality, and reduce health care costs, such as the vanguard health care systems in the United Kingdom and primary care provider networks in France. Accountable care organizations are groups of providers collectively held responsible for the cost and quality of care they deliver to a defined group of patients. There are over 800 Medicare and commercial ACOs in the country covering about 23 million lives and located in almost every state (Muhlestein and McClellan, 2016). Proponents of ACOs hope that financial incentives around both cost and quality will encourage coordination among providers. While visionaries hope to move US health care rapidly to value-based payment models such as accountable care organizations, most physicians are not practicing in organizations that have the capabilities or patient population necessary to undertake value-based contracts (Burns et al., 2013). Most office based physicians in the United States still practice in groups of five or fewer physicians; these groups are too small to undertake new payment models alone because ACO program requirements generally require a minimum number of patients to accurately measure providers' cost and quality performance. The fragmentation of health care providers in US health care markets will necessitate that providers partner with others to participate in accountable care organizations or similar value-based payment reforms. The strategic alliances literature based on an understanding of the foundations provided by resource dependence, transaction cost economics, and institutional theories provides a useful framework for understanding these types of new partnerships.

1.2. Theoretical framework

Strategic alliances are formal arrangements between two or more independent organizations to achieve shared or compatible goals. There was a significant growth in such relationships in the health care sector in the 1980s and 1990s as hospitals, in particular, merged with each other (Kaluzny and Zuckerman, 1992; Longest, 1990; Zuckerman et al., 1995). Notably, these are arrangements between autonomous organizations and refer to non-ownership-based relationships. Throughout this section we draw on the literature about strategic alliances; throughout the paper we refer specifically to ACOs that include independent providers working together in an alliance as "partnership ACOs."

The development of risk-based contracts through the ACO model may have triggered a new wave of strategic alliance formation involving not only physician practices, but potentially hospitals and post acute care facilities as well. The underlying motivation for these strategic alliance arrangements lie in understanding ACOs' need for resources and capabilities; the need to limit transaction costs; and the need to respond to external requirements from Medicare.

Potential benefits to joining an alliance include economic benefits such as sharing risk or gaining resources; personnel benefits, including improved recruitment and management capabilities; and organizational benefits, including growth, opportunities to learn and gain new competencies, and mutual support and group synergy (Zuckerman et al., 1995). Resource dependence theory highlights the organizations need to minimize uncertainty on its environment by engaging in behaviors (including forming alliances with others) that will bring additional resources or capabilities that the organization does not possess on its own (Pfeffer and Salancik, 2003; Aldrich and Pfeffer, 1976). Given the emphasis of ACO contracts on finances and controlling costs, it is likely that ACO providers are motivated to partner for economic benefits such as sharing risk and gaining resources.

Of course, there are also costs to participating in alliances, including loss of autonomy and control; shared costs of failure; loss of resources or technical superiority; potential conflict over goals or methods; and coordination challenges (Zuckerman, 1979). Transaction cost economics, in particular, suggest that ACOs may have to weigh the cost of purchasing services from other providers against the costs of building capacity internally or vertically integrating (Mick and Shay, 2016). Providers in partnership ACOs would certainly face costs. For example, an ACO that is bearing downside risk and fails to achieve performance benchmarks would be jointly responsible for any fiscal losses.

Finally, ACOs must respond to the institutional legitimacy demands of the CMS regulations requiring a minimum number of enrollees as well as cost and quality reporting requirements (Arndt and Bigelow, 2000).

1.3. Partnership selection and development considerations

Issues of resources, transaction costs, and maintaining legitimacy are particularly salient in the choice of alliance partners. Key factors associated with partner selection are complementarity, commitment, and trust (Shah and Swaminathan, 2008; Zajac et al., 2012).

Complementarity refers to skills and resources organizations have that are complementary as opposed to competitive; a classic example in health care would be the complementary roles of a rural community hospital and a large tertiary care center partnering. Providers entering into partnership ACOs will face challenges of partnership selection, and the literature would predict that successful partnership ACOs will have chosen partners carefully.