"Strategic Alliances: Some Lessons from Experience: A Commentary"

by Tim Size

Introduction

The American experience gives us many images, often contradictory. Barry Stein in "Strategic Alliances: Some Lessons From Experience" immediately takes us back to a New England farm to emphasize our comfort with individual control and ownership: "Good fences make good neighbors." But there is more to Robert Frost's poem Mending Wall: "I let my neighbor know beyond the hill, and on a day we meet to walk the line and set the wall between us once again..." Even this American icon to self-sufficiency is expressed within the cultural context of selective cooperation being used to maintain a local sense of self.

While alliances or collaborative enterprises have not been our primary experience, strategic alliances are not new to the American landscape.

More than one hundred health care cooperatives have been formed in rural America during this century. In various forms and with varying levels of success, rural medical cooperatives have experienced periods of popularity throughout the 20th century. Today, modified versions of the pure cooperative model are resurfacing as corporate vehicles to bring needed health care services to medically underserved regions of America. (Kushner 1991)

On the other hand, a last reference to one of our great traditional poets: "Two roads diverged in a wood, and I - I took the one less traveled by, and that has made all the difference." Those of us who have been attracted to cooperative models in health care have clearly been on a less traveled path, we have struggled to understand and develop alternatives between John Wayne look-a-likes and Ivan Boesky wannabes. Unfortunately, in many communities, the denial of need for change has only ended when the only options left require closure or acceptance of total dependency upon a large regional or national corporation.

Moss Kanter and Stein's demonstration of the widespread use of strategic alliances in industries outside of health care is welcome and particularly timely as we face national health reform and major shifts in our health delivery infrastructure - the experience of other major industries can help us to develop effective alternatives that balance traditional preferences for local autonomy with our country's mandate that health care serve more, better, for less.

With reform, providers based in rural or small communities will tend to have the choice of being part of multiple regional networks/HMOs or participating in a single public utility with state determined fee schedules and micro-regulatory oversight. In either event the model of strategic alliances is a viable alternative for rural providers to that of selling their practice or hospital to out of community corporations. In response to anticipated reform, several existing strategic alliances in Wisconsin have begun to build on a base of earlier collaboration to develop a new and more comprehensive relationship. This paper reviews and proposes a new strategic alliance between two existing alliances, the Community Physicians' Network and the Rural Wisconsin Hospital Cooperative. This is definitely not a plan for

merger or take-over of either organization, both will continue to grow independently and form other relationships while developing with each other those selected joint ventures that are win-win scenarios for the constituents of both organizations.

The Critical Importance Of Choice

From Washington, we have been hearing about six principles that will guide health care reform: security, simplicity, savings, choice, quality and responsibility. Large regional or multi-state medical-industrial corporations may be underestimating the importance and power of the "C" word - choice as the concept seems missing in much of their public statements. The cultural imperative of choice is a powerful, if not defining ally, for those of us whose business is to see the market niche for strategic alliances. The politics of reform and the market place are ultimately, if imperfectly, driven by the values of voter and consumer.

Choice among alternative health plans by consumers is clearly a defining value. The end of an era of almost unlimited choice should not be mistaken with the beginning of one with no to minimal choice for consumers and providers. President Clinton emphasized this point when he introduced the American Health Security Act to a joint session of Congress: "The choice will be left to you -- not your boss -- and not some bureaucrat." (The Associated Press 1993). It is safe to assume that the use of the term bureaucrat is not restricted to government employees, but may include staff of private corporations with a mission to acquire and control the decisions of others. He went on to say, "And we also believe that doctors should have a choice as to what plans they practice in. We want to end the discrimination that is now growing against doctors and permit them to practice in several different plans. Choice is important for doctors, and critical for consumers" (The Associated Press 1993).

However, community providers will not be left alone to do their own thing, they are unlikely to be allowed to "refuse to deal" with regional health maintenance organizations (as defined by current and future anti-trust enforcement) without forcing the alternative of regional single payer oversight. Increased and substantial accountability will be demanded. In less densely population areas, the development and maintenance of the competitive market alternative to a single payer system will depend in large part on the ability of rural networks to balance their traditional autonomy with a need to work cooperatively with regional health maintenance organizations.

A Requirement To Develop Systems Of Integrated Care

Whether or not reform takes the direction of single payer, managed competition or something in between, it is clear that providers and insurers will increasingly be expected to offer those patients seen at multiple sights or over multiple visits a unified or integrated experience. No longer will it be acceptable for each step along the course of a patient's care to act as if the individual was being seen for the first time. Even the Mayo Clinic has begun to accept CT and MRI studies from referring physicians.

There is a real danger that the myth of service delivery integration only being possible through corporate merger and consolidation can become self-fulfilling. It is clearly an increasingly common model but we are in danger of placing too much emphasis on this single approach. We may be artificially restricting our vision of the future by focusing on the means to an end, not the end itself. The end or goal should not be defined in terms of how services are owned or organized but how they are experienced by the patient. This is not just a play on words but something that makes a real difference in both the private and public systems we design. Systems do not design or develop themselves. If we wish to see empowered local communities, it is up to those same communities to develop the appropriate alternatives.

We know that integrated care will be an extraordinary challenge for all of us whether we work in vertically or horizontally integrated systems, whether our workplaces are characterized by a corporate culture of control or one of collaboration. The real issue is how do we integrate the receipt of high quality, cost effective services - not whether one corporation controls the delivery of care, but whether the patient experiences care as being provided with continuity,

without seams.

One of many potential practical implications of the system models assumed by reform lies in an area commonly most associated with vertically integrated delivery systems-integrated health information systems. In rural areas, we must develop regional systems to access individual medical records as the patient moves between rural clinic, rural hospital, urban specialist at rural hospital, urban specialist at home clinic, urban specialty hospital, rural home health agency, etc.. The exclusive use of the "single corporation in control" paradigm inevitably tends to lead towards the development of multiple individually owned and operated regional health information system networks, duplicative systems of parallel play among competing networks. Such a system forces rural providers to support duplicate local access into competing information systems as the only alternative to exclusive contracting or merger. "Providers and payers must begin to think of an information network as a community resource rather than a way to gain competitive advantage. Other matters to be resolved include achieving technical standardization, reaching political consensus and cooperation, and resolving system configuration and ownership" (Wakerly).

While supporting the development of competitive markets we can choose to focus on the integration of the receipt of care and less on the particular ownership model of the delivery mechanism. In this example we can begin to think in terms of an open shared electronic highway as opposed to competing private electronic networks. Just as we do on concrete highways, we can govern use and access of the common arteries while retaining individual privacy. Common highways are understood as a necessary part of infrastructure support for competitive markets. The space remains public but the choice and timing of destinations flexible. It is this latter model that I think will be mandated by regional buying cooperatives.

Reform must in every facet support the ability of rural providers to contract with multiple plans in order to not be subordinated to a declining number of increasingly larger urban based corporations. By working with multiple plans, rural providers will be able to meet their community's need for local access and choice amongst competing regional plans and their alternative specialty resources. To do this effectively, anti-trust laws and enforcement must be revised in order to facilitate regional risk bearing physician-hospital organizations that can negotiate at a level table with increasingly large health plans. While government needs to not limit network formation, the necessary networks can only be created by those with an interest in developing collaborative rather than control oriented models of local community care.

Background For A New Wisconsin Strategic Alliance

The Rural Wisconsin Hospital Cooperative (RWHC) was incorporated in 1979 as a shared service corporation and advocate for rural health. It was the major force behind the formation in 1983 of a non-stock, not-for-profit insurance corporation, HMO of Wisconsin. At the same time, community physicians organized themselves as an affiliated independent practice association, the Community Physicians' Network (CPN) in order to provide medical services for patients insured by the HMO. A parent corporation, HMO-W, Inc. was formed in 1987, when HMO of Wisconsin was converted to for-profit status in order to raise additional capital. The stock of HMO-W, Inc. is primarily held by rural physicians and hospitals and HMO-W holds all of the stock of HMO of Wisconsin.

In anticipation of state and national health reform, the HMO of Wisconsin signed in October of 1993, a letter of intent to merge with Physicians Plus Insurance Corporation, a Madison based company. "Two of south-central Wisconsin's health maintenance organizations plan to join forces next year in a merger that reflects the ripples of change that portend a possible wave of reform in the nation's medical system. The new organization would have one of the largest HMO enrollments in the state with a combined membership of 116,000" (Lautenschlager 1993). "The move will allow the health maintenance organizations to more effectively compete against DeanCare HMO, the major player in the Madison area and give them access to markets in which they are weak or have no presence at all." (Silver 1993) "The integration of HMO of Wisconsin and Physicians Plus brings together two organizations with complementary strengths. Physicians Plus serves patients in Dane and surrounding counties, while HMO of

Wisconsin provides care to individuals living in rural communities of south-central Wisconsin and the greater Oshkosh area" (HMO of Wisconsin and Physicians Plus 1993).

At the same time, the Community Physicians' Network and Rural Wisconsin Hospital Cooperative have begun movement towards an expanded working relationship to strengthen rural providers in their ability to provide community based integrated care in order to better work with the resulting merger of HMO of Wisconsin and Physicians Plus, as well as other regional HMOs and Multi-specialty group practices.

The Community Physicians' Network

The Community Physicians' Network (CPN) is an independent practice association owned and governed by physicians. It is a partner with HMO of Wisconsin providing health insurance and care through 400 primary care physicians in 100 Wisconsin communities and 2,000 specialists in Wisconsin, Minnesota and Iowa. The CPN's board and committee structure insures physician governance from each primary care community. HMO of Wisconsin provides administrative support and data for utilization review, quality assurance and reimbursement. CPN has begun to offer volume purchase programs through medical and office supply facilities and arranges management consulting, seminars and other practice enhancements.

Through the CPN, Primary Care Physicians (PCP) are compensated on a capitation basis for a broad array of primary care services provided to members of HMO of Wisconsin. The PCP capitation is adjusted based on age and sex of the enrollee and the benefit plan under which the enrollee is covered, a 10 percent withhold is applied to capitation payments. Non-capitated services provided by PCPs and all services provided by specialists are paid according to the CPN Fee Schedule, a 20 percent withhold is applied to fee-for-service payments.

Two mechanisms have been established by the CPN to limit the PCPs risk from capitation, the Equalization Fund and the Outlier Fund. The Equalization Fund provides supplemental reimbursement to PCPs who have demonstrated particularly effective case management. PCPs who demonstrate prudent use of referral services are guaranteed a minimum capitation reimbursement equal to 80 percent of actual charges. The Outlier Fund provides supplemental payment to PCPs whose capitation payment is adversely effected by catastrophic cases (HMO of Wisconsin 1993).

Capitation does place a degree of risk on the PCP. The risk is magnified when a PCP has a small panel of capitated patients. CPN pays PCPs on a fee for service basis with a 15 percent withhold until the PCP's panel reaches 100 enrollees. In rare situations where capitation is determined to be an unsuitable payment arrangement, PCPs are paid according to the CPN Fee Schedule with minimum withholds ranging from 5 percent to 25 percent (HMO of Wisconsin 1993).

The Rural Wisconsin Hospital Cooperative

The Rural Wisconsin Hospital Cooperative (RWHC) originated in 1979 as the result of informal discussion among several hospital administrators in southern Wisconsin. RWHC is owned and operated by 19 rural acute, general medical-surgical hospitals and one urban hospital (University of Wisconsin-Madison); the rural hospitals serve a population of nearly 300 thousand people over 15 counties. The hospitals in the Cooperative are owned and governed by a variety of structures including local non-profit associations, municipalities, counties, the state, or churches. Most members are geographically contiguous with member hospitals located in central and southern Wisconsin. The model of the dairy cooperative was chosen because it respected the autonomy of the sponsors and was a type of organization familiar to the community boards that would have to approve individual hospital participation.

The purpose of RWHC was and is to act as a catalyst for regional collaboration. Since its incorporation, it has tried to be an aggressive and creative force on behalf of rural health care. It now employs or contracts

for the services of approximately 150 people (full- and part-time) with a $5 million dollar annual budget, exclusive of affiliated corporations.

RWHC staff provide services directly in areas such as advocacy, audiology, multihospital benchmarking and other quality improvement initiatives, grantsmanship, occupational therapy, per diem nursing, physical therapy, respiratory therapy, physician credentialing, speech pathology, emergency room physician staffing, and ongoing rural specific continuing educational opportunities. RWHC has negotiated special group contract arrangement for members to obtain high-quality consultant services in areas such as legal services, personnel consulting, market research, patient discharge studies, and consultant pathology services.

With private investors and operators, the Cooperative has implemented a mobile CT, MRI, nuclear medicine, and ultrasound service to rural hospitals, reducing cost and improving access to this service for RWHC members and other area hospitals. RWHC established a pilot loan guarantee program for RWHC hospitals in cooperation with the Robert Wood Johnson Foundation and the Wisconsin Health and Education Authority, which in turn was used as a model for the State

A particularly productive and popular RWHC activity has been professional roundtables that regularly bring together RWHC hospital staff of the same discipline for mutual sharing, problem solving, continuing education, and advising the RWHC Board and staff on program and policy development. This has been recognized as one of the primary benefits of RWHC - learning from each other. The number of these roundtable groups that are active has significantly increased and now includes 22 professional groups (i.e., lab, pharmacy, and radiology).

–––"Strategic Alliances, Some Lessons from Experience" - Part II –––

A New Wisconsin Strategic Alliance

Wisconsin is a health care market with a greater use of health maintenance organizations than all but a few states and is already beginning to experience the consolidation of HMOs predicted to accompany national health reform. Wisconsin also has a high concentration of multi-group specialty clinics that have been aggressively investing in the vertical control of physician practices in smaller communities, primarily through their outright purchase. Amundson (1993) makes a strong case that external forces such as the inequity of Medicare payments and the shortage of primary care providers are not the complete story re the challenges facing rural health. He argues that the rural providers and communities themselves have been a significant part of the problem and can become a major part of the solution.

> While the primary responsibility for the current situation resides within many rural communities, the strongest potential for sustaining rural services also resides primarily within our communities. The history of this nation is replete with documentation that the strength of community, particularly in rural America, is incalculable. The power of a group of residents, acting in concert to improve some aspect of their community infrastructure that they care deeply about, has been demonstrated for generations. It is the essence of rural America at its best to put such shared values above individual self-interests and to mount major action. Admunson, 1993

In the context of this environment, two existing strategic alliances, the Community Physicians Network and the Rural Wisconsin Hospital Cooperative have significant long range plans of their own but also recognize that specific joint ventures between the two alliances can foster local and regional community physician-hospital collaboration. The purpose of this initiative will be to form a united front to support community based health care in balance with the outreach of large regional HMOs and multi-specialty group practices.

For a change, seed capital may not be its usual problem: RWHC has already developed with the support of the Robert Wood Johnson Foundation a $500,000 loan reserve fund that is very suitable for the envisioned projects. The current holding company of HMO of Wisconsin, HMO-W, Inc. will be asked to invest in the

maintenance and strengthening of the regional network of community providers that constitute its stock holders. Both organizations will be positioned to work with the merged health maintenance organization as well as with other regional health maintenance organizations.

The Community Physicians Network has significant experience organizing physicians around the negotiation of HMO contracts and the Rural Wisconsin Hospital Cooperative primarily has experience with shared services and advocacy among multiple partners. Both organizations have begun a discussion to explore the possibilities of developing selected joint ventures in the following areas: (1) Rural Network Negotiations, (2) Network Based Practice Support (3) Local Infrastructure Development and (4) Rural Network Advocacy.

Rural Network Negotiations - negotiating equitable relationships with regional and multi-state insurers, networks and regional purchasing alliances. "Where network arrangements among rural providers already exist, health plans (health maintenance organizations) seeking to serve these areas likely will attempt to take advantage of existing networks in establishing their delivery systems. This could, in turn, cause existing rural networks to organize more formally to function as contracting entities for negotiating with health plans. Once organized in this manner, rural networks could contract with multiple health plans." (Christianson and Moscovice 1993) "During the transition to the new health care system, physicians and other providers may require some protection to negotiate effectively with health plans. To protect physicians and other providers from the market power of third party payers forming health plans, providers are provided a narrow safe harbor to establish and negotiate prices if the providers share financial risk." (Clinton Task Force 1993)

Network Based Practice Support - developing an alternative for community physicians to that of selling their practice to large regional multi-specialty clinics. Extensive surveys by RWHC indicated that the availability of practice support and employment opportunities is a major factor in the decision in a physician's site selection decision. In 1992, a written survey was conducted by RWHC of over 1,000 physicians who graduated from Wisconsin's two major medical colleges during the years of 1983-85.With an impressive response rate of 44 percent (usable surveys) RWHC obtained valuable information regarding in-state practice site selection factors that are important to physicians. Four key area of importance surfaced as: assistance with malpractice premiums (66 percent of all respondents), practice management support (52 percent), practice set-up assistance (47 percent) and retirement/benefit packages (36 percent). In most cases, family practitioners, physicians practicing in small towns and small cities had higher percentages ranking the above areas as important.

Malpractice premiums were felt to be amenable to immediate intervention, RWHC is working collaboratively with Physician's Insurance Corporation of Wisconsin to develop a unique professional liability policy with rates reflecting a purchasing pool discount. The purchasing pool will consist of RWHC related health providers (hospitals and physicians). It is envisioned that this prototype will be expanded to all members of the partnership with CPN. Research and development is also underway for local practice management support that goes beyond a "consulting" relationship, providing support typically obtained only through joining a larger clinic. Various models, such as clinic without walls, are being explored. A partnership between CPN and RWHC will allow many of the physician services to be fast-tracked and the critical volume to support a shared service will be easier to obtain.

Local & Regional Infrastructure Development - supporting the integration of high quality, cost effective services within and among communities as noted earlier in this paper. In addition, we need to go one step further. Again I would like to quote President Clinton's address to the Joint Session of Congress: "Responsibility also means changing the behavior in this country that drive up our health care costs and cause untold suffering. It's the outrageous costs of violence from far too many handguns, especially among the young. It's high rates of AIDS, smoking and excessive drinking, it's teenage pregnancy, low-birth weight babies, and not enough vaccinations for the most vulnerable." (Clinton Task Force 1993)

Hospitals and physicians must break out of their traditional isolation from the community at large. Partnerships must be aggressively pursued with a variety of public and private community based organizations that do not lend

themselves to a system of regional or intra-community vertical integration - schools, city councils, local public health agencies, community development agencies, churches to name just a few. From the perspective of community oriented primary care, one can argue that compared to inter-community networking, an equal challenge and perhaps greater pay-off will be the development of broad based intra-com?munity partnerships.

Rural Network Advocacy - advocacy for community based primary care and working with state organizations to create a more favorable environment for primary care and rural health. CPN and RWHC leadership have traditionally been very active in the development of broader strategic alliances with many state-wide organizations in order to better serve Wisconsin, CPN and RWHC interests in primary care and rural health. CPN and RWHC has helped to develop the Wisconsin Primary Care Consortium, the Area Health Education Center System, the Wisconsin Rural Health Development Council and worked as part of major advisory committees or governing boards with the University of Wisconsin Medical School, the Wisconsin Department of Health & Social Services, the Office of the Commissioner of Insurance, the State Medical Society, the Wisconsin Academy of Family Practice, the Wisconsin Hospital Association, and the Wisconsin Health and Educational Facilities Authority.

With reform, additional organizational linkages will have to be developed in order to achieve the appropriate resolution of a series of reform issues critical to the future of community based health care:

a. Employees and individuals should be assured an unrestricted choice amongst all eligible plans offered through a regional health council. This is good politics because it maximizes individual consumer choice. It is good public policy because it reduces the likelihood of monopolistic systems forming based on a coercive claim that they can exclude non-participating providers from multiple employee groups.

b. Systems or HMOs, at least in rural counties, should be precluded from requiring participating rural providers to sign exclusive contracts.

c. If regional alliances will set fee schedules for self-insured and indemnity plans, assurances must be given that the negotiation process is not dominated by a few large multi-specialty clinics - that the interests of individual physician and other primary care providers and networks are fairly represented.

d. The shortage of primary care providers is expected to get worse before it gets better as we are faced with (1) the loss of a large number of retiring rural providers, (2) an increased demand for primary care providers due to the shift towards HMO delivery systems and (3) an increased demand for primary care services resulting from a larger insured population. This issue must be aggressively addressed and funded if rural areas are not to be made worse by the reform initiative.

e. More explicit language is needed re the scope of and development processes for retro-adjustments or risk-adjustments on payments from regional health clinics to networks and from networks to individual providers. The market needs to be managed so that networks compete based on the quality and cost of their services, not on their ability to avoid sick people.

f. "Charity care/bad debt" and losses stemming from government payments (at a level below reasonable cost) tend to make rural and inner city providers less competitive than they otherwise would be. To create an equal playing field, Council's should be required to spread these losses equally across all providers in a region so that competition is based on quality and cost and not one's ability to avoid the poor and elderly and uninsured.

Steps to Developing a CPN/RWHC Strategic Alliance.

After the initial work group finalizes its sense of what specific activities are appropriate for a joint venture between the CPN and RWHC, the focus will shift to the development of an initial business plan that will include at a minimum the following:

- Conceptual Approval by RWHC & CPN Boards.
- Development of an Initial Partnership Agreement.

- Draft Development of an Initial Operations Plan.
- Investigation of Corporate Alternatives for Joint Activities.
- Securing Commitments for Initial Capitalization.
- Establish Parameters of Current Wisconsin Limits on Joint Negotiation.
- Approval and Formation of the Corporate Structure for Joint Ventures.
- Approval of an Initial Partnership Work Plan by New Corporate Governance.
- Implementation of the Initial Operations Plan.

Summary

While leaders of both organizations are optimistic about both their individual futures and possibilities for joint action, neither minimizes the challenges to be faced. The development of strong mutually beneficial physician-hospital relationships at the local level are not easy, they are no more so when aggregated at the regional level. Experience within and outside of health care indicates that community based providers can develop effective alternatives that balance traditional preferences for local autonomy with our country's mandate that health care serve more, better, for less. In Wisconsin, two existing strategic alliances, the Community Physicians Network and the Rural Wisconsin Hospital Cooperative have significant individual objectives but are also committed to the development of selected joint ventures that can foster local and regional community physician-hospital collaboration to the advantage of both parties and the communities they serve.

Resources

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