

AN HFMA REPORT

# Health Care 2020

A series of reports examining how to prepare for major healthcare market trends over the coming years

REPORT 3 of 4

## Consolidation



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healthcare financial management association

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# Health Care 2020

## Report 3 Consolidation

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# Dear Colleagues

Consolidation has been accelerating in the healthcare industry in recent years—and generating considerable controversy along the way. On the one hand are concerns about the effect of consolidation on prices. On the other are claims that consolidation is essential for achieving greater efficiencies and facilitating population health management. Resolution of the issues raised by consolidation is important because it appears to be a trend that's here to stay. Among the key takeaway messages in *Health Care 2020: Consolidation* are that provider consolidation will continue to build and that the health insurance sector will remain highly consolidated for the foreseeable future.

Experts interviewed for this report point to the importance of the execution of mergers in determining whether consolidation will have a positive impact on the market and benefit consumers. They also conclude that any value created by consolidating organizations will be passed through to consumers “only if a way is found to buck historical patterns.” In fact, the healthcare industry is in the midst of a volume-to-value revolution that is likely to turn historical patterns upside down, across the board. That pivot to a value-based business model could cast consolidation in a new light.

Previous research conducted by HFMA (*Acquisition and Affiliation Strategies*, available at [hfma.org/valueproject](http://hfma.org/valueproject)) found that value-focused acquisitions and affiliations are more likely to be well received in the marketplace than those seeking market dominance. Key drivers of value-focused consolidation, according to HFMA research, include improving operational efficiencies, creating clinically integrated care delivery networks, and accessing sufficient populations for population health management. When it comes to consolidation, motivation matters.

HFMA greatly appreciates the contributions of the following individuals who served as resources in the development of this report: David Balto, attorney, Law Offices of David A. Balto; Leemore Dafny, PhD, professor at Harvard Business School; David Johnson, CEO, 4sight Health; Sonal Kathuria, managing director, Life Sciences & Health Care, Deloitte Consulting; Eb LeMaster, managing partner, Ponder & Co., Paul T. Liistro, managing partner, Arbors of Hop Brook Limited Partnership; Terry Rappuhn, healthcare adviser and leader of HFMA's Patient Friendly Billing Project; Chris Stanley, MD, vice president-population health, Catholic Health Initiatives; Adria Warren, partner, Foley & Lardner LLP; and David Young, COO, Privia Medical Group.

The *Health Care 2020* series, which also addresses the transition to value, consumerism, and the need for innovation, is designed to provide strategic guidance for healthcare organizations to prepare for major healthcare market trends over the coming years. We hope you will find these resources useful.

Best,



**JOSEPH J. FIFER, FHFMA, CPA**  
PRESIDENT AND CEO, HFMA

# Executive Summary

In conjunction with the release of this *Health Care 2020* report on consolidation in the healthcare industry, HFMA issues the following guidance for stakeholders:

## A Murky Forecast

Will further consolidation of the healthcare industry be needed to succeed in an era of value-based care delivery and payment? Health plans, physician practices, health systems, and other provider organizations are all asking this question, but in the opinion of experts watching the healthcare industry from a range of perspectives, there is no clear answer.

Much depends on the degree to which changes in the industry represent a break from historical trends. In the past, neither health plan consolidation nor provider consolidation has led to lower consumer prices. However, prior mergers have occurred in an environment where prices (and price increases) are opaque. Transparency may act as a brake on the inclinations of merged entities to take advantage of pricing power. Either market forces—brought about by increasing patient out-of-pocket amounts—or public disclosure of negotiated rate increases may discourage aggressive pricing strategies in the face of reduced competition.

New to the scene are a range of alternative payment models that require more sophisticated contracting and analytical capabilities; changes in physician compensation that the Medicare and CHIP Reauthorization Act (MACRA) has introduced (which may well disadvantage solo practitioners and small practices); and increased consumer demand for affordable prices, better access, and better quality. These factors have contributed to the belief that it will be necessary to consolidate to compete.

## Drivers of Consolidation

For hospitals and health systems, the transition from volume to value and a corresponding move to population health management will require sophisticated management expertise and significant capital investments. Experts foresee a dramatic reshuffling of the landscape, based on changes in industries such as banking that have faced similar pressures to change. One forecast sees the health system

sector reorganizing into three broad categories: huge national systems, regional systems with clinical integration throughout the continuum of care, and “specialist” organizations (including academic medical centers, critical access hospitals, and independent post-acute providers).

The need for more sophisticated management and improved access to capital is also changing the nature of merger transactions. Instead of looking to acquire weaker systems, a stronger system is increasingly likely to seek to combine resources with another high-performing system. And while much activity to date has involved mergers within local or regional markets, anticipated future payment cuts designed to stem high healthcare costs may well trigger the need for more systems to look across geographic regions in an effort to gain greater strength through size.

Independent community hospitals—especially those in rural areas—are the most vulnerable as the industry transitions to value-based payment and care delivery. Because they are smaller organizations that rely more on general traffic, they typically have slimmer margins and lack the money needed to invest in population health. Consolidation may provide access to greater resources, but often at the cost of community control. At the same time, merging or partnering with a larger system may enable the community hospital to focus on what it does best and refer other cases to a high-value provider when necessary.

**Physician practices.** For physician practices, MACRA is among the factors raising new questions about the long-term viability of solo or small practices. Changes from the proposed rule to the final rule are expected to make the short-term payment impact less severe for smaller practices, although the need to use electronic health record technology to document quality and resource utilization will add a financial burden. In the long term, pressure on physician payment from various sources remains likely to push providers in smaller settings to seek employment in either a big multispecialty group or a hospital-based clinic.

**Health plans.** The health plan sector is already more consolidated than the provider sector, and recently proposed mergers between several national health plans would increase consolidation. Yet the health plan sector is also facing new

financial pressures in the individual, small-group, and large-group health insurance markets. Also, mergers can combine strengths—for example, with one partner bringing experience with chronic care coordination in Medicare Advantage plans and another bringing expertise in serving financially vulnerable Medicaid managed care beneficiaries.

The move to consolidation among national health plans may be offset by greater competition resulting from the growth of provider-based plans. Providers had purchased or started 106 health plans by the end of 2014, up from 94 in 2010, according to a report by McKinsey & Co. Although provider-based plans may struggle to achieve the scale they need for financial success, they also may allow health systems to add the sort of data and analytic capabilities needed to execute population health strategies.

**Post-acute providers.** Post-acute providers have emerged as especially important partners to health systems seeking to improve the quality of care their patients receive after discharge, avoid penalties under the federal Hospital Readmissions Reduction and Value-Based Purchasing programs, and improve patient outcomes under accountable care or bundled payment models. But health systems generally are seeking to partner with post-acute providers, not acquire them.

The post-acute care sector is also under payment pressure, and many post-acute providers require investments in technology, staffing, and other supports needed to participate in value-based payment models. High-performing post-acute care facilities are already well-positioned to thrive. The industry is also likely to see consolidation of post-acute care providers into large regional and national chains.

### Regulatory Pushback

Increased interest in consolidation is also drawing increased scrutiny from the federal antitrust enforcement agencies. The Federal Trade Commission (FTC) has challenged several health system mergers in recent years, and the Department of Justice (DOJ) has filed suit seeking to block proposed mergers between national health plans, with rulings expected in 2017.

After a long winning streak, the FTC hit a few road bumps in recent actions, with two federal district courts disagreeing with the FTC's definition of the *relevant geographic market*; in both instances, the court ruled that the market defined by the FTC was too narrow and did not adequately account for nearby competitors. In one of these cases, the district court judge also highlighted changes in the marketplace hospitals now compete in, noting that “the federal government ... has created a climate that virtually compels institutions to seek alliances such as the hospitals intend here.”

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These setbacks proved temporary, however, as the FTC has successfully secured reversals of both decisions on appeal. In both cases, the appellate courts accepted the FTC's more narrow definition of the *relevant geographic market*, giving significant weight to the question of whether a health plan could successfully market a product that excluded the merged systems.

In one of the cases, the appellate court also called into question the notion that efficiencies from a merger could offset any anticompetitive effects. Responding, for example, to arguments raised in the district court that a merger would help the combined health systems perform in risk-based contracts, the appellate court held that these arguments were irrelevant unless the systems could demonstrate a benefit that would be passed on to consumers.

With respect to the proposed health plan mergers that the DOJ has challenged, less competition among insurers historically has been associated with higher premiums for consumers. It will be important for the health plans to provide detailed analysis of how they expect to realize cost savings or quality improvements that will balance against potential anticompetitive effects.

A wild card over the next few years will be whether the FTC and DOJ alter their approach to oversight under the presidential administration of Donald Trump.

### The Value Question

Much about consolidation depends on the answer to a fundamental question: Will the healthcare consumer gain value from consolidation? If value-based payment methods and the rise of consumerism in health care sufficiently incentivize providers to be low-cost leaders in their markets, and if consolidation is necessary to help them achieve lower costs and improve quality, the answer to consolidation may be “yes.” But if consolidation reduces competition and raises prices, the answer is probably “no.”

# Consolidation: A Means to an End?

The healthcare industry will continue to see rapid consolidation as key sectors— notably hospitals and health systems, health plans, and post-acute providers— assert the need to seek the economies of scale and efficiencies they claim are required to succeed in the era of value-based care delivery and payment.

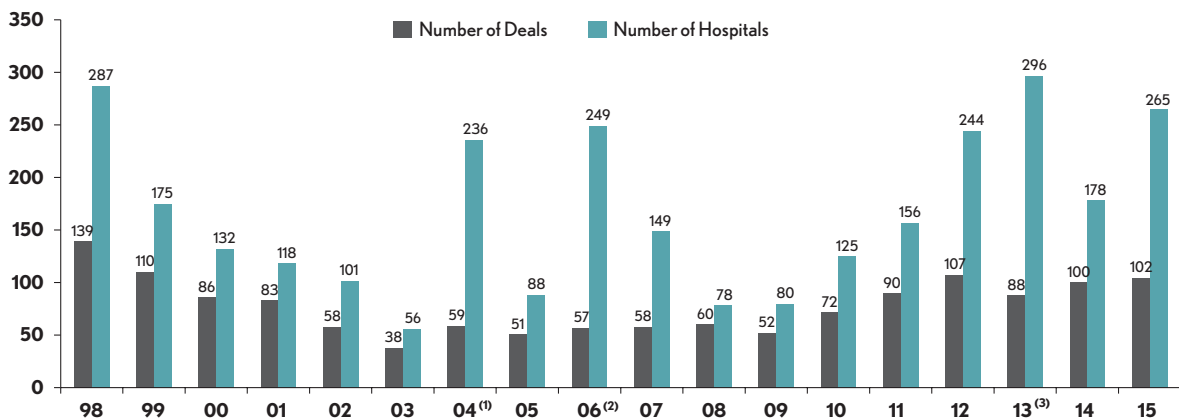
Whether the positive attributes of consolidation can be achieved largely depends on the execution of mergers. And any value that consolidating organizations realize will pass through to consumers of healthcare services only if a way is found to buck historical patterns.

That is the assessment of experts watching the healthcare industry from a range of perspectives as it transitions from a volume-based business model to one that rewards value.

Neither health plan consolidation nor provider consolidation has led to lower costs for consumers in the past. But the pivot to a value-based business model for provider organizations should change that dynamic going forward, says Sonal Kathuria, managing director and value-based care leader in Deloitte Consulting’s health care practice.

“Increased consolidation in healthcare delivery should allow providers to take on increased investments to shift from volume to value,” she says. “In this new world, that value inherently is going to go back to the payers and to the consumers in terms of affordable care, better access, and better quality. I’m keeping my fingers crossed. I think consolidation is a means to the end, not the other way around.”

## ANNOUNCED HOSPITAL MERGERS AND ACQUISITIONS, 1998–2015



Source: [www.healthcaremanda.com](http://www.healthcaremanda.com). Used with permission. Previously published in the American Hospital Association’s *Trendwatch Chartbook*.

- (1) In 2004, the privatization of Select Medical Corp., an operator of long-term and acute-care hospitals, and divestiture of hospitals by Tenet Healthcare Corporation helped to increase the number of hospitals affected.
- (2) In 2006, the privatization of Hospital Corporation of America, Inc. affected 176 acute-care hospitals. The acquisition was the largest healthcare transaction ever announced.
- (3) In 2013, consolidation of several investor-owned systems resulted in a large number of hospitals involved in acquisition activity.

# Hospitals and Health Systems

The transition from volume to value and the corresponding move to population health management require major capital investments and sophisticated management expertise of the sort that may prompt even the most independent-minded hospitals and health systems to consider their consolidation options.

Deloitte forecasts that only 50 percent of the health systems operating in 2014 will remain independent by 2024. It projects that today's landscape—some 80 national health systems, 275 regional systems, 130 academic medical centers, and 1,300 small community systems—will morph into just over 900 multihospital systems.

Looking to the consolidation of the banking industry as a guide, Deloitte foresees the healthcare sector reorganizing itself into three broad categories: huge national systems; regional health systems with clinical integration throughout the continuum of care; and “specialist” organizations such as academic medical centers, pediatric and other single-service systems, critical access hospitals, and post-acute providers.

“In terms of the amount of merger-and-acquisition (M&A) and affiliation discussion going on out there, it continues to be very high,” says Eb LeMaster, managing director at Ponder & Co., a financial advisory firm for not-for-profit healthcare providers.

That said, he expects the 2016 total for announced change-of-control transactions to be down as compared to

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—Eb LeMaster, managing director, Ponder & Co.

the previous two years. In fact, announced transaction activity for the nine months ending Sept. 30, 2016, was down more than 35 from the same period in 2015.

LeMaster attributes that slowdown to several factors:

- Concern about obtaining regulatory approvals as systems get larger
- The need to digest the many acquisitions and mergers completed in the recent past
- Poor performance by some large for-profit entities such as Community Health Systems, which inhibits their appetite for acquisitions
- A preference for looser affiliations, such as clinically integrated networks, instead of mergers
- Uncertainty about the effect of changes to payment and healthcare delivery models

## HOSPITAL AND HEALTH SYSTEM CONSOLIDATION DRIVERS

Deloitte points out that health system acquisitions are getting bigger—the average deal in 2013 was \$224 million, up from \$42 million in 2007—and it expects the trend to continue.<sup>a</sup> It cites several factors that prompt health systems to seek strength through consolidation:

**Need for capital.** Many health systems do not have the predictable cash flow needed to borrow money at manageable rates, Deloitte says.

**Upcoming investment needs.** To succeed in the value-based environment, health systems need to invest

heavily in technology, ranging from electronic health record systems to data-sharing capabilities.

**Competition from new entrants.** Few health systems have demonstrated themselves to be “invaluable” to stakeholders. Consumers, health plans, and employers are demonstrating their willingness to try new ideas. These range from freestanding urgent care and emergency facilities to national telemedicine vendors to “centers of excellence” contracts, in which employers steer their workers to a few health systems nationally for procedures performed under bundled-payment arrangements.

<sup>a</sup> “The Great Consolidation: The Potential for Rapid Consolidation of Health Systems,” Deloitte Center for Health Solutions, 2014.

## Hospitals and Health Systems (CONTINUED)

The nature of mergers is also changing in a way that makes negotiations go slowly. “It’s not just the strong helping the weak anymore,” LeMaster says. “These days it’s two stronger systems trying to be proactive about the transition to value-based care, to building a system with the number of lives they need to be pertinent, and to expanding their geographic region. As consolidation evolves more to healthy systems, the speed is not quite as fast.”

Despite this near-term slowdown in announced transactions, the level of active dialogue and negotiations continues to be very high as hospitals and health systems explore their options. LeMaster expects activity to pick up as large for-profit systems face the need to divest assets.

In the immediate future, LeMaster anticipates that most transactions will continue to involve mergers within a single market or regional systems expanding their reach statewide. Looking five years out, he foresees that the reach of M&A activity will widen as health systems search for strength in scale to offset payment cuts and the challenges associated with new payments models.

M&A activity has been particularly strong in certain states, according to a Kaufman, Hall & Associates analysis of its proprietary database. Reviewing transactions between Jan. 1, 2008, and Sept. 30, 2016, analysts found that deals in Texas, New York, Pennsylvania, California, and Illinois accounted for 30 percent of all M&A activity in the nation—and those transactions accounted for 39 percent of the total revenue of M&As involving provider systems during that period. (Kaufman Hall’s analysis focused on provider organizations with at least \$250 million in annual net revenue.)

The five next busiest states for M&As—Michigan, Georgia, Ohio, North Carolina, and New Jersey—accounted for another 20 percent of all M&A activity, meaning that half the transactions in the past nine years were concentrated in just 10 states.

Looking ahead, Texas may be the M&A leader to watch. A whopping 13 deals were announced in the first nine months of 2016, more than double the annual average during the previous seven years, according to the Kaufman Hall analysis. By contrast, New York’s healthcare M&A activity may have peaked—it had 26 deals in 2014 and 2015, but just five in the first three quarters of 2016.

## → KEY TAKEAWAY

Hospital and health system consolidation will continue to build, significantly remaking the delivery system landscape over the next decade.

## → ORGANIZATION TO WATCH

In October 2016, Catholic Health Initiatives (CHI) and Dignity Health announced their intent to explore “aligning their organizations and expanding their mission of service” nationwide. The *Wall Street Journal* reported that the conversations would include the possibility of creating a combined organization with \$27.8 billion in annual revenue. The combined organization would operate in more than 25 states and offer services across the continuum of care.

Both organizations touted the ability of alignment to increase the value of the care they deliver. “The potential to align the strengths of these two organizations will allow us to play a far more significant role in transforming health care in this country,” Kevin Lofton, CEO of CHI, says in a release. “Together, we could enhance our shared ministry as the health industry transitions to a system that rewards the quality and cost-effectiveness of care.”

Moody’s Investors Service gave the proposed affiliation a positive rating: “While challenges are inevitable during the process, the decision to possibly align would be a discreet credit positive as it would likely create expanded market access, improved efficiencies and the opportunity to achieve a number of synergies.”



## Hospitals and Health Systems (CONTINUED)

## CONSOLIDATION AMONG SMALL AND/OR RURAL HOSPITALS

As a category, independent community hospitals are the most vulnerable in the move from a volume-based business model to one based on value.

“They are most at-risk because they are smaller and get the general traffic where you don’t make a lot of money, and these are the ones who would never have the money to invest in population health,” says Sonal Kathuria, managing director and value-based care leader in Deloitte Consulting’s health care practice. “If they don’t get bought out because they’re not that profitable, some of them may not weather the storm.”

The trustees and executive leadership teams of community hospitals, particularly in rural areas, see a special kind of value in their organizations. The facility is likely a major employer—and the one that provides some of the best-paying jobs in the community.

Conflating the economic impact of hospital operations with the value of healthcare services delivered is a mistake, says David Johnson, CEO of 4Sight Health. Employers and consumers within a community benefit from high-value healthcare services—meaning good quality and good customer experience at low costs—so that should be the sole focus for hospital leaders.

“Providing jobs in a community is a benefit of a hospital, but it’s not the reason for the hospital to exist,” says Terry Allison Rappuhn, a consultant to rural hospitals and leader of HFMA’s Patient Friendly Billing Project. “When you’re too focused on providing jobs, you’re not going to continue to exist.”

Likewise, hospital leaders often consider it their responsibility to preserve local access to healthcare services, another idea that Johnson says needs thoughtful reconsideration. Hospital-based care is rarely going to be the most efficient way to deliver most services.

The survival strategy, in Rappuhn’s view, is an honest assessment of what services a community really needs, what it can support, and how those services can best be delivered. Most communities need and will support emergency care, for example, but they may be better-served by a first-class emergency management service rather than by an emergency department. Physical therapy is generally needed but does not need to be hospital-based. Orthopedic and cardiac services may be more appropriately provided in larger hospitals than in smaller ones.

For that reason, merging or partnering with a larger system allows a community hospital to concentrate on what it does best and refer patients to a high-value provider when necessary. Further, especially for smaller hospitals participating in Medicare’s mandatory Comprehensive Care for Joint Replacement bundling program, a minimum number of cases is required to ensure the statistical stability of the episode price, to support investments in data analysis and care redesign, and to make gainsharing a meaningful carrot for physicians.

“My belief is that they can survive with independent ownership in the right situation, but they can’t survive without having an affiliation and without, most importantly, being true to the healthcare needs of their community,” Rappuhn says.

Rural hospitals often have lower costs than larger systems, and their leaders—and patients—have a different mind-set than their metropolitan peers. Rappuhn says leaders must find a way to maintain the rural community culture—clean floors, not marble floors—while adding the level of clinical integration and care coordination needed to provide value-based care.

“It’s a tricky balance, but done well it will benefit consumers and payers alike,” she says.

## Physician Practices

A May 2016 survey of 1,300 physician groups with five or fewer physicians indicates that the Medicare Access and CHIP Reauthorization Act (MACRA) may be the death knell for small practices. The changes required to succeed under value-based payments are excessive for many independent physician groups, according to the survey by Black Book Research, a market research firm that serves the healthcare industry. In fact, 67 percent of respondents with a high volume of Medicare patients said they were planning to sell their practices to a larger group or health system or to close their practice by 2019.

At ANI 2016, Danielle Lloyd, vice president for policy and advocacy for Premier Inc., reported that Medicare is projecting that small practices will suffer financially under MACRA. Specifically, 87 percent of solo practitioners and 70 percent of physicians in groups of two to nine are likely to see a payment decrease in 2019—while larger groups benefit from pay increases, she said.

Provisions in the final MACRA rule, released in October 2016, may offer a measure of relief to smaller practices. Physicians will be exempt from reporting requirements under the Merit-based Incentive Payment System if they

**“It’s not just MACRA alone. There is a general push towards more alternative payment approaches, which require more sophisticated contracting and data analysis, and systems to improve care.”**

—Bob Leibenluft, Hogan Lovells LLP

treat fewer than 100 Medicare patients or are paid less than \$30,000 through Medicare Part B (an increase from a threshold of \$10,000 in the proposed rule).

MACRA also authorizes \$20 million in annual assistance for clinicians in practices of 15 members or fewer and for those working in underserved areas. Local organizations are authorized to use the funding for, among other functions, helping small practices select appropriate quality measures and health IT to support their unique needs.

## PHYSICIAN PRACTICE CONSOLIDATION DRIVERS

Physician practices have been consolidating for several years—through mergers among practices and acquisitions by health systems—but physicians remain fragmented in many markets.

As of 2014, nearly 61 percent of physicians were in small practices of 10 or fewer physicians, according to a survey conducted by the American Medical Association. The percentage of physicians employed by a hospital or who worked in a practice that had some hospital ownership increased to nearly 33 percent that year, up from 29 percent in 2012.

Consolidation among practices is expected to pick up speed as a result of the Medicare Access and CHIP Reauthorization Act (MACRA), which replaces Medicare’s much-maligned sustainable growth rate formula.

MACRA requires physicians who participate in the Medicare program to choose one of two payment systems:

the Merit-based Incentive Payment System (MIPS) or selected alternative payment models (APMs). MIPS will financially penalize physicians who do not meet standards for technology use, quality, and value; APMs require physicians to bear “more than nominal financial risk” associated with the value of care they deliver.

The federal government expects that a majority of small physician practices will see their Medicare pay fall when MACRA payment takes effect in 2019, based on performance in 2017. Furthermore, especially for small practices, investments in the infrastructure required to submit quality measures as part of MIPS could be daunting, as could the task of developing the care management capabilities needed to succeed under outcomes-based payment models. Beyond that, the annual physician fee schedule update under MACRA is unlikely to keep up with the growth in practice expenses.

## Physician Practices (CONTINUED)

Nonetheless, succeeding under MACRA will require physician practices to document quality via electronic health record technology and, equally important, to analyze their data to find ways to improve care and operate efficiently.

Furthermore, “It’s not just MACRA alone,” says Bob Leibenluft, a healthcare attorney in the Washington, D.C., office of Hogan Lovells LLP. “Private payers are doing more value-based purchasing as well, so there is a general push towards alternative payment approaches, which require more sophisticated contracting and data analysis, and systems to improve care.”

The physician consolidation trend of the past decade thus is expected to continue. In 2015, 35 percent of physicians were working in groups of nine or fewer, down from 40 percent in 2013. During that same time, the proportion of physicians in groups of 100 or more increased from 30 percent to 35 percent.<sup>a</sup>

Privia Medical Group, with more than 1,400 providers in six states, is one of the nation’s fastest-growing physician practices. Formed less than three years ago, the group is concentrated in six markets—the mid-Atlantic, defined as Maryland, Virginia, and Washington D.C.; Georgia; Houston; and Dallas-Fort Worth—that match up with health plans looking to engage providers in at-risk contracts.

Physicians in Privia Medical Group own their individual practices but assign their revenues to a management services company, Privia Health, which provides population health management technology, resources and operational strategies—and negotiates performance-based payer contracts on behalf of providers.

“Our goal is to build medical groups that are provider-owned and provider-managed and are being rewarded for lowering the cost of health care by making the appropriate choices and educating patients about the appropriate

choices,” says David Young, Privia’s COO. “We believe physicians should remain independent, and we also believe that we don’t run those inherent conflicts of having to worry about filling beds or using other resources.”

Backed with \$400 million in capital from Goldman Sachs, Privia will expand into other markets with a high concentration of patients, an opportunity to consolidate many primary care physicians and specialists, and health plans that embrace risk contracts, he says.

## → KEY TAKEAWAY

Small, independent physician practices increasingly are becoming an endangered species as the healthcare industry’s transition from volume to value gains steam.

## → ORGANIZATION TO WATCH

Much of the recent consolidation among physician practices has involved being sold to hospitals, but other models are also in play. In Monterey, Calif., for example, 650 providers—including specialists, primary care physicians, counselors, physical therapists, and others—joined the Monterey Bay Independent Physician Association in the past three years, giving them a way to participate in value-based contracts. The IPA’s first at-risk contract was with the Medicare Advantage plan owned by a local hospital; subsequently, the IPA became the provider panel for that hospital’s employee- and dependent health plan, as well as for another hospital’s plan.

## Health Plans

The private health insurance sector is already more consolidated than the provider sector and will become more so if pending merger proposals—Anthem’s plan to buy Cigna for \$54 billion and Aetna’s \$37 billion acquisition of Humana—proceed as planned. The Justice Department filed lawsuits in July seeking to stop both mergers, citing anticompetitive effects. Court rulings are expected in 2017.

A wild card will be DOJ’s approach after Donald Trump becomes president. Even if both cases are decided before Trump takes office, his Justice Department could have a say in any appeals or settlement process—conceivably by negotiating settlement terms that are more favorable to the insurers.

America’s Health Insurance Plans (AHIP) says anticompetitive effects of consolidation in the provider sector may not extend to the insurance sector, which is highly regulated.

“This level of regulation distinguishes health insurance from other markets. In some cases, mergers can have pro-competitive effects,” AHIP says in a written statement. “For example, a plan with strength in chronic care coordination through Medicare Advantage could join a plan with strong support for its financially vulnerable Medicaid beneficiaries. Leveraging those strengths could provide complementary benefits for members in both programs.”

The American Hospital Association asked the Federal Trade Commission (FTC) to “thoroughly investigate” the proposed mergers, which are being opposed at both the state and federal levels by many consumer groups, provider organizations, and trade unions. Antitrust attorney David Balto, former policy director for the FTC, disputes one of the basic arguments for consolidation.

“A lot of what we hear from different participants is that they need to merge because other people are becoming big—and antitrust regulators have never permitted organizations to consolidate just because they need to get larger to battle against other large firms,” he says. “That would just permit monopolies to be formed.”

Historically, less competition among insurers is associated with higher premiums for consumers and lower payments for providers, says Leemore Dafny, professor at Harvard Business School.

“In these particular cases, the industry executives will supply the authorities with their detailed—often

**“A lot of what we hear from different participants is that they need to merge because other people are becoming big—and antitrust regulators have never permitted organizations to consolidate just because they need to get larger to battle against other firms.”**

— David Balto, antitrust attorney

confidential—analyses of how they expect to realize cost savings or quality improvements, and the authorities will balance that against the potential anticompetitive effects,” she says. “So, without having access to the information, all I can say is that if past is prologue, these are unlikely to be good for consumers.”

Dave Jones, California’s insurance commissioner, acknowledged that insurance mergers do not generally benefit consumers in March 2016 when he approved St. Louis-based Centene Corp.’s acquisition of Health Net, the fourth-largest commercial insurer in California. The \$6 billion transaction makes Centene, which now covers more than 10 million members across the country, the nation’s largest Medicaid managed care organization.

The commissioner said he approved the merger to keep Health Net, which has been struggling in the state’s highly consolidated insurance marketplace, from going out of business.

“I concluded that this transaction provides an opportunity to bring new capital and resources from a major national insurer outside of California (Centene) to enable a California health insurer (Health Net) to continue to compete and offer consumers additional choices in California’s individual, small group, and large group commercial health insurance market,” Jones said in a press release.

## Health Plans (CONTINUED)

If the Anthem-Cigna and Aetna-Humana mergers proceed, the organizations may be required to divest businesses in markets in which they would have a large market share. When Humana acquired Arcadian Management Services in 2011, the FTC required divestiture in 51 markets. This could create opportunities for provider organizations that want to grow their own health plans or to enter the insurance business as a strategic initiative.

Indeed, as the major insurers consolidate, some health systems are trying to carve out their own space in the insurance industry. Providers owned 106 health plans by the end of 2014, up from 94 in 2010, according to McKinsey & Co.<sup>1</sup>

With the exception of a few giants—the UPMC Insurance Services division has more than 2.8 million members—most provider-led health plans are small, notes Gunjan Khanna, a partner in McKinsey’s Pittsburgh office and a core member of the Healthcare Systems and Services Practice. Although provider-led plans combined cover more than 15 million lives, only five providers own plans that cover at least 500,000 members. Most therefore struggle to achieve the scale needed for financial success, although the plans have data and analytic capabilities that may help health systems execute their population health strategies.

Speaking with *NEJM Catalyst*, Glen Steele, chairman of xG Health Solutions and former president and CEO of Geisinger, says insufficient market size and issues with leakage are common pitfalls. “If you don’t have an adequate market size,” Steele tells the website, “and you’ve got an important cohort of patients or leaders of big employer groups that are outside your market, and you’re losing a huge amount of either significant high-intensity care or you’re losing a significant number of key opinion leaders outside that market because you can’t service it, you’re going to be looking at a huge challenge.”<sup>2</sup>

## → KEY TAKEAWAY

Regardless of whether the Anthem-Cigna and Aetna-Humana mergers are allowed to proceed, the health insurance sector will remain highly consolidated for the foreseeable future.

## → ORGANIZATION TO WATCH

Aetna, one of the nation’s largest insurers, has formed joint venture health plans with two health systems—Inova, in Virginia, and Texas Health Resources. In these arrangements, traditional health plan-provider negotiations are replaced by fully aligned financial incentives, with the health plan and provider each owning 50 percent of the health plan. Brigitte Nettesheim, Aetna’s CEO of Accountable Care Solutions, says the insurer intends to partner with health systems to create joint-venture health plans in several markets over the next decade.

Aetna also has formed an ACO with Houston-based Memorial Hermann Health System and Memorial Hermann Physician Network. The organization cut costs by 11 percent between 2013 and 2014 while exceeding targets on all six quality measures. Aetna says the two keys are rewarding physicians for collaborating to increase the value of the care delivered and providing timely data that allow physicians and patients to make better, more informed decisions.

## Post-acute Consolidation

In the value-based care movement, hospitals are tied financially to the skilled nursing facilities (SNFs) their patients use, even if the hospitals do not own them. For one thing, about 18 percent of patients discharged to SNFs are readmitted within 30 days, threatening hospitals' performance in the federal Hospital Readmission Reduction Program. For another, the Medicare Spending per Beneficiary measure, which includes all spending for a care episode through 30 days after discharge, is an element in the government's Value-Based Purchasing formula for hospitals.

Moreover, accountable care organization (ACO) and bundled payment contracts may hold health systems accountable for the cost and quality of care delivered by SNFs that accept their patients after an inpatient discharge. And post-acute spending patterns vary significantly: As the Institute of Medicine reported in 2013, hospital referral regions with low overall Medicare spending levels spent \$50 below average on post-acute care on a per member per month basis. Those with high overall spending levels spent \$100 to \$150 above the average.<sup>4</sup>

Rapid consolidation of SNFs and other post-acute care providers into large regional and national chains is expected to continue, although health systems are unlikely to be enthusiastic suitors, Kathuria says. Managing a post-acute facility requires different skills than running a health system, meaning a natural synergy is not guaranteed. Perhaps more importantly, the post-acute sector is under payment pressure and being pushed into the value-based movement, for which many SNFs are not prepared. Post-acute providers looking for a buyer likely need investments in technology, staffing, and other supports to deliver the quality hospitals want to see—and health systems may have better ways to spend their money.

"Buying post-acute may not be the best way to build upon the continuum of care," Kathuria says. "There are other ways of building partnerships, including innovative alliances such as joint ventures," Kathuria says.

Meanwhile, high-quality SNFs can thrive in value-based payment systems, thus reducing their incentive to be acquired, says Paul Liistro, managing partner of Manchester Manor Health Care Center and Vernon Manor Health Center in Connecticut. Both facilities consistently receive "5-star" recognition from the U.S. Department of Health & Human Services, highlighting them as among the best SNFs in the country. Because of that, Liistro's facilities are in the preferred provider networks of all area hospitals.

"We're not seeing hospitals buy up post-acute centers, good, bad, or indifferent," he says. "What we are seeing is ACOs, especially those that are involved in shared savings programs, partnering with high-performing facilities, setting objectives, and working with the facilities diligently to improve clinical pathways for certain conditions.

Similarly, health systems participating in the federal government's Bundled Payments for Care Improvement or Comprehensive Care for Joint Replacement initiatives are intently focused on managing post-acute care utilization, which has been identified as an opportunity for cost savings. Some systems, such as Catholic Health Initiatives, are partnering with "preferred" post-acute providers that collaborate on care protocols, staff training, and quality improvement projects.

That type of close working relationship benefits quality-minded post-acute providers that want to remain independent, Liistro says.

"As the post-acute partners, we are seeing this as a very positive experience," he says. "Where we may have had vacancies, we now have waiting lists, performance is being improved, and we are having a lot of fun."

### → KEY TAKEAWAY

Although post-acute facilities are consolidating, hospitals and health systems are generally not the buyers in the foreseeable future.

### → ORGANIZATION TO WATCH

CHI, an 18-state health system, has created post-acute care continuing care networks (CCNs) of preferred SNFs in each of its markets to support its joint-replacement bundled payment initiatives.

CHI evaluates SNFs to identify those that meet its quality standards and are willing to collaborate with CHI to minimize readmissions and improve patient outcomes, says Chris Stanley, MD, vice president of population health.

Typically, about 10 percent of the SNFs in a market are chosen to participate in a CCN. CHI care coordinators work with patients and families to guide them to high-value SNFs that are part of the CCN—although patients can go to any SNF of their choosing.

## Antitrust Enforcement

After a long winning streak whenever it opposed health system mergers, the FTC was dealt two setbacks this year, both of which involved the concept of *geographic market*. These setbacks have proved temporary, however, as the FTC has successfully appealed the decisions in both cases. In each reversal, a crucial dynamic was the ability of health plans to negotiate in the market.

### Penn State Hershey/PinnacleHealth

In denying the FTC's request for a preliminary injunction to block the merger of Penn State Hershey Medical Center and PinnacleHealth System, a district court judge commented:

We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the hospitals intend here. Like the corner store, the community medical center is a charming but increasingly antiquated concept. It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither.

The FTC had argued that the merger would reduce the number of meaningful competitors in the Harrisburg geographic market from three to two. The court's ruling focused on the fact that many patients in central Pennsylvania travel at least 30 minutes for care—and 20 percent travel more than an hour—and there are 19 hospitals within a 65-minute drive of Harrisburg. Thus, the judge ruled that the benefits of the merger outweighed any concerns about reducing competition among providers.

But in September, the district court judge's decision was overturned by the Third Circuit Court of Appeals. That court held that the district court had erred in its definition of the *relevant geographic market*. One compelling fact was testimony from insurance companies about the difficulty of selling health plans in the Harrisburg market that excluded PinnacleHealth and Hershey from their network: One plan that had tried to do so suffered a 50 percent drop in membership. Without the possibility of network exclusion as a bargaining tool, the circuit court ruled, the insurance

**“We have never formally adopted the efficiencies defense. Neither has the Supreme Court. Contrary to endorsing such a defense, the Supreme Court has instead, on three occasions, cast doubt on its availability.”**

— Ruling by the Third Circuit Court of Appeals

companies would have little leverage if a combined PinnacleHealth and Hershey raised prices.

The circuit court also cast doubt on a defense claiming that efficiencies resulting from the merger could offset any anticompetitive effects. The court noted, “We have never formally adopted the efficiencies defense. Neither has the Supreme Court. Contrary to endorsing such a defense, the Supreme Court has instead, on three occasions, cast doubt on its availability.” Whether the Supreme Court takes up an invitation to review the efficiencies defense remains to be seen.

### Advocate/NorthShore

In another much-watched case, a federal district court judge in Chicago in June denied the FTC's request for a preliminary injunction to stop the merger of Advocate Health Care and NorthShore University HealthSystem. Had the deal closed, Advocate NorthShore Health Partners would have become the largest healthcare delivery system in Illinois and the 11th largest not-for-profit system in the country.

The FTC had argued that a combined system would operate the majority of the hospitals in Chicago's North Shore area and control more than 50 percent of acute care inpatient hospital services within that geographic market. Advocate

## Antitrust Enforcement (CONTINUED)

and NorthShore countered that many people who live in the area go to hospitals in downtown Chicago or are treated at neighborhood outpatient facilities that are owned by downtown-based hospitals.

Although the district court found the arguments by Advocate and NorthShore compelling, the federal court of appeals did not. Again, the role of health plans in the market for hospital inpatient acute services was a deciding factor in the definition of *geographic market*. The court of appeals identified a “critical flaw” in the district court’s reasoning: its focus “on the patients who leave a proposed market instead of on hospitals’ market power over the patients who remain, which means that hospitals have market power over the insurers who need them to offer commercially viable products to customers who are reluctant to travel farther for general acute hospital care.”

The essence of the *geographic market* question, the court ruled, is “how many hospitals can insurers convince most customers to drive past to save a few percent on their health insurance premiums? We should not be surprised if that number is very small.”

## Keeping Value at the Forefront

In the Hershey/Pinnacle case, the district court judge directly addressed the value movement in health care by agreeing that the merger would help the organizations perform under risk-based contracts. “This decision further recognizes a growing need for all those involved to adapt to an evolving landscape of health care that includes, among other changes, the institution of the Affordable Care Act, fluctuations in Medicare and Medicaid reimbursement, and the adoption

## IT SHOULDN'T BE ALL ABOUT SIZE

While most health systems may recognize that risk-based contracts represent the future of payment, many have not taken significant steps in that direction, says David Johnson, CEO of 4Sight Health, a consultancy. Johnson previously spent nearly three decades as an investment banker for health system clients, and he understands why regulators are suspicious that mergers are primarily about bargaining power.

“Driving the majority of the consolidation activity is health systems’ desire to increase negotiating leverage with payers,” Johnson says. “It’s still largely a fee-for-service driven world, and while there are opportunities for economies of scale and cost cutting, hospital consolidation today is more about how to get the upper hand in price negotiations. It’s more about getting bigger, not necessarily better.”

That concern won the day in the FTC’s challenge of an Idaho health system’s purchase of a physician practice—even though the federal judge complimented the health system on trying to proactively prepare for the changing healthcare delivery environment.

At issue was the 2012 acquisition of Saltzer Medical Group by St. Luke’s Health System. The FTC filed suit in

2013, alleging that the combination of St. Luke’s seven adult primary care physicians with Saltzer’s 16 in the small town of Nampa, Idaho, increased St. Luke’s bargaining power with health plans and the system’s ability to raise prices.

In siding with the FTC, the judge forced St. Luke’s to unwind the merger more than a year after it had been completed. A competitor had sought a preliminary injunction to keep the merger from happening in the first place; that request was denied, but its complaint caught the attention of the antitrust enforcers. “I think what really got the FTC attracted to this is that a competing system was concerned that it was going to lose a major source of referrals and could not compete effectively,” says Bob Leibenluft, a healthcare attorney in the Washington, D.C., office of Hogan Lovells LLP.

The case shows that no merger should be considered safe from antitrust scrutiny, Leibenluft says. “We could see more of these kinds of cases where people are choosing up their dance partners in a way that may get a competing system concerned enough to file an antitrust complaint,” he says.



## Antitrust Enforcement (CONTINUED)

of risk-based contracting,” the ruling stated. But the circuit court rejected this argument, stating that any increased ability to engage in risk-based contracting is irrelevant without a demonstration of how “such a benefit would be passed on to consumers”—a demonstration that must go beyond a “mere assertion” that this would be so.

In Chicago, the judge did not address the evolving nature of the healthcare industry, but the point came up during the litigation. Advocate and NorthShore are combining so they can offer full-risk insurance products to employers throughout the Chicago area, Leibenluft says.

“This deal is not about Advocate acquiring a hospital so it can raise rates for inpatient services,” he says. “In fact, they want to be at risk and they actually want to keep people out of the hospital. They don’t want to raise rates for hospital stays—under risk contracts, they want to avoid hospital stays altogether.”

Because the district court’s ruling did not address this line of argument, the court of appeals likewise did not address the argument. But Leibenluft encourages other health systems to consider Advocate’s track record in clinical integration, population health, and new payment methods when they evaluate their own merger opportunities: “That may be something that’s increasingly raised as an issue: Are the hospitals really moving to a different kind of product offering that needs to be analyzed differently than in the past? In the Advocate case, there was very good evidence that this is what the hospitals are doing, but that may not be the case in all hospital mergers.”

### A Trump Administration

The FTC currently consists of three commissioners appointed by President Barack Obama, with two vacancies. Trump will have an opportunity to fill both vacancies and replace one commissioner when her term ends in 2017.

With potentially a 3-2 edge in Republican appointees, whether the FTC takes more of a hands-off approach to oversight of matters such as healthcare provider mergers remains to be seen.

### → KEY TAKEAWAY

Although rulings at the district court level earlier this year dealt the FTC some temporary setbacks, reversals of both these rulings by appellate courts mean that the FTC is likely to keep a close eye on proposed health system mergers. The Pennsylvania and Illinois cases marked the first time the FTC litigated two health system mergers simultaneously. It had prepared to challenge a third—Cabell Huntington Hospital’s acquisition of nearby St. Mary’s Medical Center in West Virginia—but it dropped that case in July after a new state law shielded hospital mergers from antitrust scrutiny. The FTC says it remains concerned about the merger.

### → ORGANIZATION TO WATCH

Boston-based Partners HealthCare completed an acquisition of a 70-physician group in the South Shore area. And this spring, one of Partners’ flagship operations—Massachusetts General Hospital—announced a plan to acquire Wentworth-Douglass Hospital in Dover, N.H. If approved by regulators, it will be Partners’ first out-of-state merger.

In announcing its agreement to be acquired, Wentworth-Douglass cited several benefits of the affiliation, including a plan to adopt evidence-based best practices created by Massachusetts General and a shared electronic health record system that will make care transitions safer, reduce unnecessary testing, and improve the efficiency and coordination of care.

## Where's the Value?

The question of the value of consolidation between healthcare organizations requires a two-pronged analysis. First, will there be benefits to the merging organizations? And second, will those benefits ultimately be passed on to consumers, employers, and other healthcare purchasers in terms of higher quality, lower total cost of care, or both?

As HFMA's 2014 Value Project report on acquisition and affiliation strategies notes, "Acquisitions and affiliations designed to improve the quality or cost-effectiveness of care are more likely to deliver value to care purchasers, demonstrate an organization's superior value proposition in a competitive marketplace, and accordingly, improve that organization's market share."<sup>e</sup> In other words, a consolidation that remains focused on improving value to the purchaser can result in an affirmative response to both prongs of the benefit analysis.

The potential increase in care value from provider consolidation is easy to see. The small and medium-sized community hospitals that are typical acquisition targets lack the capital to make investments in population health management and the ability to recruit physicians, both of which they gain when they merge with a stronger entity.

"There is obvious value to the acquirer as well," LeMaster says. "This helps grow the top line. They are able to gain scale and efficiencies. You need market relevance, and at some point, you need enough lives within your network just to be relevant to payers."

Merging entities typically see several benefits of coming together: sufficient market presence to have a competitive network for local employers; potential reductions in administrative costs by combining finance, human resources, and other functions; and the ability to take on population health management.

Executing mergers so that the maximum value is realized is challenging, however, and some transactions work out better than others. Melding disparate organizations and the changes to staffing, IT, protocols, and other aspects is expensive and time consuming.

Regardless of whether the merging organizations accrue increased savings or efficiencies for themselves, end purchasers historically have not appeared to benefit from provider consolidation. Rather, consolidation generally results in higher prices, according to research published by the Robert Wood Johnson Foundation.<sup>f</sup>

The potential value of each merger must be evaluated on a case-by-case basis, in the view of AHIP.

"In some instances, consolidation may help advance the goals that the health system is demanding—more

**"In some instances, consolidation may help advance the goals that the health system is demanding—more coordination, better-quality care. But when consolidation leads to higher costs for patients ... that poses serious consequences for patients."**

— America's Health Insurance Plans

coordination, better-quality care," AHIP states in written responses to questions. "But when consolidation leads to higher costs for patients, as we have seen time and time again when providers consolidate in markets that are already anticompetitive, that poses serious consequences for patients."

The Health Care Pricing Project reviewed claims from three insurers—UnitedHealthcare, Aetna, and Humana—between 2007 and 2011 and found that market power is associated with higher hospital prices. Hospital prices in "monopoly markets" are more than 15 percent higher than those in markets with at least four hospitals.<sup>g</sup>

Going forward, however, price transparency likely will curtail the inclination to capitalize on pricing power following a merger.

"Everybody says, 'Whenever hospitals consolidate, prices go up,' so there's a lot of concern that they can demand higher prices," Deloitte's Kathuria says. "But my opinion is that we need to consider reality before we draw such conclusions."

Today's reality: Rising consumerism is bringing transparency to the healthcare marketplace, where provider organizations increasingly must demonstrate to patients that they offer competitive prices. That onus has the potential to help keep prices in check following consolidation. If not market forces alone, then public disclosure of negotiated rate increases could discourage aggressive post-merger pricing strategies.

The new ways in which health systems are being paid also may change the dynamic, requiring even hospitals with large market shares to put cost-conscious consumers at the center of their business and operational strategies. Deloitte's interviews with health system CEOs found overwhelming consensus about the importance of being able to perform in

## Where's the Value? (CONTINUED)

value-based contracts, in which raising prices to purchasers and patients does not make sense.

“They all expect that all hospitals will take on significant financial risk for patient care,” Kathuria says. “That means they’re going to adapt themselves to take on these emerging payment systems, which inherently require the delivery of better value.”

A full merger may not be needed to realize the benefits of consolidation. Adria Warren, a partner at the law firm Foley & Lardner LLP, says that non-merger alignment activity is increasing across the full spectrum of care, as hospitals and other providers, including post-acute providers, seek new models to share risk and increase value. She sees increasing interest in clinically integrated networks (CINs) that bring hospitals and other providers together to pursue value-oriented initiatives while each party retains its independence.

“The alternative payment models that are encouraging alignment to improve efficiency and quality, and CINs, which are short of a full merger, really allow providers across the spectrum of care to work in partnership,” she says.

## → KEY TAKEAWAY

Although hospital consolidation historically has not added value from the consumer’s perspective, emerging value-based payment systems and an increased emphasis on price transparency may motivate merging organizations to pass along their savings.

## → ORGANIZATION TO WATCH

Geisinger Health System, based in Danville, Pa., acquired AtlantiCare, an integrated health system in New Jersey, in 2015 after winning approval from the state attorney general’s office and a state court.

The two systems are consolidating specifically because the nation’s healthcare delivery system is moving to a value-based model, they state in a press release. “As a result, the emphasis is on deploying evidence-based medicine programs, enhancing capabilities and clinical services, optimizing the use of the electronic health record and clinical informatics, and implementing population health management and value-based payment models,” the release states.

## Consolidation in the Years Ahead

Consolidation will be an important strategy for all segments of the healthcare sector as the industry moves from volume-based payment to value-oriented delivery and payment methods.

Mergers are likely between competing health plans, health plans and providers, competing health systems, health systems and physician practices, and other combination types as all parties seek to integrate operations to reduce costs.

Those who look to the past will oppose the ongoing consolidation, pointing out that mergers among health plans and among provider organizations have historically led to higher prices for employers and consumers. A comparison to the past may no longer be relevant, however, if value-based payment methods and the rise of consumerism in health care sufficiently incentivize providers to be low-cost leaders in their markets, including on a per member per month basis.

Clinically integrated networks, joint ventures, and other partnerships that do not involve a full merger will be

increasingly common. But outright acquisitions are likely to dominate if providers hold to the belief that consolidation offers economies of scale, opportunities to improve care coordination, and greater impact on their population health initiatives.

Antitrust enforcers will be on guard as the pace of consolidation picks up steam, but courts may support a new level of consolidation. That, however, remains to be seen. Although the district court judge in the Hershey and PinnacleHealth case earlier this year agreed that provider organizations must adapt to “an evolving landscape,” these factors were not sufficient on appeal to deny the FTC’s request to enjoin the proposed merger.

The healthcare landscape is changing. Ultimately, it will be incumbent upon healthcare organizations to prove that these changes have created an environment in which consolidation does in fact improve value to the healthcare consumer.

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