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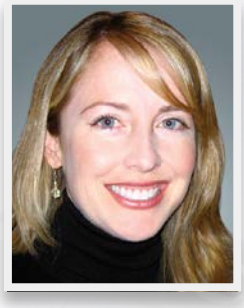

As I write this letter, it is only a few days away from the inauguration and President-Elect Trump's new cabinet has not yet been confirmed. News articles speculate daily what might happen next in healthcare policy as Trump emphasizes an immediate repeal and replace.

What we do know is despite certain healthcare policy shifts (whatever shape they may take), there will still be a push for physician-led, patient-centered, value-based delivery and payment reform models. It is important that boards remain focused on the long-term while addressing short-term challenges. It seems clear at this point that the major changes will be related to insurance coverage and structure, but the care delivery innovations that we have all begun should still continue at a strong pace. It remains imperative to place physicians and nurses at the forefront of these efforts.

The articles in this issue address these challenges head on. In our lead article, in partnership with ACHE, Chad Wable describes St. Mary's Health System's experience joining Trinity Health and going through a subsequent governance restructure. Our Advisors' Corner from Guy Masters outlines some anticipated trends and strategic considerations regarding healthcare policy changes in 2017. Our special section in this issue, from Juniper Advisory, focuses on hospital consolidations from 2010–2016 and thoughts about what shape hospital system structure might take going forward. The authors are optimistic that the industry will continue to encourage innovative thinking and pave the way for the strong organizations that can provide healthcare in new and unique ways, regardless of ownership, location, size, or other factors.

Kathryn C. Peisert

Kathryn C. Peisert, *Managing Editor*

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Governance Restructuring after a Merger

BY CHAD W. WABLE, FACHE, SAINT MARY'S HOSPITAL, INC. AND TRINITY HEALTH—NEW ENGLAND, INC.

Many hospital board members are executives who may have experienced the effects of a merger and acquisition in their careers, particularly if their field is manufacturing or finance—two segments that have already undergone a great deal of consolidation. In recent years, healthcare has seen its share of M&A activity, including at my own organization.

Chad W. Wable, FACHE
President and CEO,
Saint Mary's Hospital
Senior Vice President, Operations and Chief Transformation Officer,
Trinity Health—New England

In August 2016, Saint Mary's Health System in Waterbury, Connecticut, joined Trinity Health—New England, becoming the fifth hospital to affiliate with the regional health ministry, which is part of Trinity Health, one of the nation's largest Catholic healthcare systems. Trinity Health serves many communities and people in multiple states across America with 92 hospitals.

Joining Trinity Health—New England was a strategic decision that gives Saint Mary's access to resources, ideas, and innovation from a large, national system. It makes it easier for us to advance clinical quality in significant ways at the local level, and provides economies of scale that reduce our costs structure. It also allows us to contribute our knowledge and best practices to enhance care in the 24 states where Trinity Health operates.

Since joining Trinity Health—New England, Saint Mary's is better positioned to achieve our vision and accelerate the implementation of our strategic plan, which is closely aligned with Trinity Health's People-Centered 2020 strategic plan. The plan includes five focus areas: people-centered care, engaged colleagues, operational excellence, leadership nationally, and effective stewardship.

Although the changes that come with M&A activity can be difficult, there is also great excitement at Saint Mary's. As with any merger and acquisition, some of the most significant changes relate to governance approach, structure, and activity.

Since joining Trinity Health—New England, my governance responsibilities have increased. I continue to sit on the local board, but I'm also involved at the regional level as Chief Transformation Officer and Senior Vice President of Operations for Trinity Health—New England. I attend each regional board meeting and make presentations to the board; I get to peek into both governance windows—the local and the regional—and it is exciting to see the evolution of governance occurring. Here are some of the key changes we've experienced.

Role of the Local Board

Saint Mary's will continue to maintain its own local board of directors focused on the needs of its community. The local board will provide input to Trinity Health—New England, which is governed by a separate regional board of directors comprised of local community members (including from Saint Mary's service area), physicians, and representatives of Catholic organizations.

Some of the changes at the local level include eliminating Saint Mary's capitated insurance board and merging it with Trinity Health's capitated insurance company. The hospital is also restructuring its physician network organization, which will ultimately fall under the regional board. The local board, however, is still responsible for medical staff credentialing. And the local board continues its sharp and dedicated focus on quality and safety oversight, which is essentially the most meaningful work of the board with perhaps the exception of its commitment to ensuring our community's health and well-being.

Another important change is that the local board will no longer focus on the financial performance of the hospital—the regional board takes on that responsibility. Even though this traditional oversight responsibility won't be handled at the local level, this doesn't diminish the role and need of the local board. In fact, it is important that the board receives meaningful, regular updates in order to stay informed and have an appropriate context for other issues and decisions. As the hospital President, I am able to get local input and bring it to the regional level, which in turn informs capital decisions that are made regionally. There are two previous members

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Key Board Takeaways

Last year, Saint Mary's Health System joined Trinity Health—New England. Saint Mary's is now better positioned to advance clinical quality at the local level, reduce costs, achieve its vision, and accelerate the implementation of the strategic plan. Some of the key changes the organization has experienced include:

- The Saint Mary's board will maintain its own local board focused on the needs of its community, and will provide input to Trinity Health—New England, which is governed by a regional board.
- A new streamlined structure with the Trinity Health—New England regional board taking on fiduciary responsibilities (for example, financial oversight, strategic planning, and governance of the physician network organization).
- An efficient governance decision-making process where decision rights are well-defined and decisions are made at the most appropriate level—either local or regional depending upon the subject.

Why Your Nurses Should Serve on Community Health Boards

BY LAURIE BENSON, B.S.N., NURSES ON BOARDS COALITION,
AND KIMBERLY J. HARPER, M.S., RN, INDIANA CENTER FOR NURSING

Although the fate of the Affordable Care Act (ACA) is uncertain, this landmark legislation, and its accompanying regulations, has placed a renewed focus on community and population health.

Nurse leaders are able to impact the health of the communities they serve not only though their roles as clinicians, but also through service on non-profit and community boards of directors.

Despite being the largest health profession with 3.6 million registered nurses across the nation, nurses comprise less than 1 percent of voting members on hospital and health system boards.[1] This trend, unfortunately, carries over to the governance of community health efforts. According to a 2014 study examining a dozen successful community health partnerships, nurses comprised only 4 percent of the direction-setting bodies.[2]

In contrast with this low representation, public health nurses specialize in "community-building, health promotion, policy reform, and system-level changes to promote and protect the health of populations" to improve health and promote health equity.[3] Further, board service, conducting community needs assessments, and participating in community groups are all competencies required for nurses to receive the American Nurses Credentialing Center's Advanced Public Health Nursing Certification.[4] Clearly, nurses are well positioned to positively impact community and population health.

There are major benefits for all parties—community members served by a healthcare organization, the nurses these organizations employ, and the hospitals and health systems themselves—when nurse executives are encouraged to serve on boards of community health organizations.

Benefits for Communities

Nurse leaders provide assets to the communities in which they live and serve in areas that reach beyond their formal employment. Through their volunteer appointments on community boards, philanthropic organizations, governmental task forces, and commissions, nurse leaders carry their substantial expertise into the boardrooms of community organizations across the nation. Further, nurses have been rated by consumers as the most honest and ethical profession in the nation 15 years in a row, and are thus best positioned to leverage the trust of the communities they serve to improve health.[5]

"I have seen the impact that it is possible to have by moving beyond the bedside to serve in a broader, more far-reaching capacity," says Christine Schuster, RN, M.B.A., President and CEO of Emerson Hospital in Concord, Massachusetts. "Emerson nurses are working in collaboration with our community agencies, such as Councils on Aging and regional senior care assistance organizations, to develop best practices in reducing readmissions. These collaborations improve patient quality of life, lower costs, and advance patient care quality. I am very proud to see our nurses stepping forward to achieve measurable goals in enhancing patient care by working *outside* the walls of our hospital."

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Key Board Takeaways

Everybody wins when nurse executives serve on the boards of non-profit and community health organizations. Communities experience improved health; nurses increase their job satisfaction and grow professionally; and healthcare organizations reap the benefit of new insights, best practices, and enhanced reputation. It is therefore beneficial to healthcare organizations to support the volunteer efforts of their nurse executives in community service, including board service.

1 Kathryn C. Peisert, *21st-Century Care Delivery: Governing in the New Healthcare Industry,* The Governance Institute's 2015 Biennial Survey of Hospitals and Healthcare Systems.

2 Lawrence Prybil et al., *Improving Community Health through Hospital–Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships,* Commonwealth Center for Governance Studies, Inc., November 2014.

3 American Public Health Association, Public Health Nursing Section, "The Definition and Practice of Public Health Nursing: A Statement of the Public Health Nursing Section," 2013.

4 ANCC's Advanced Public Health Nursing Certification (see http://nursecredentialing.org/AdvPublicHealthNursing-PCO).

5 Jim Norman, "Americans Rate Healthcare Providers High on Honesty, Ethics," Gallup, December 19, 2016.

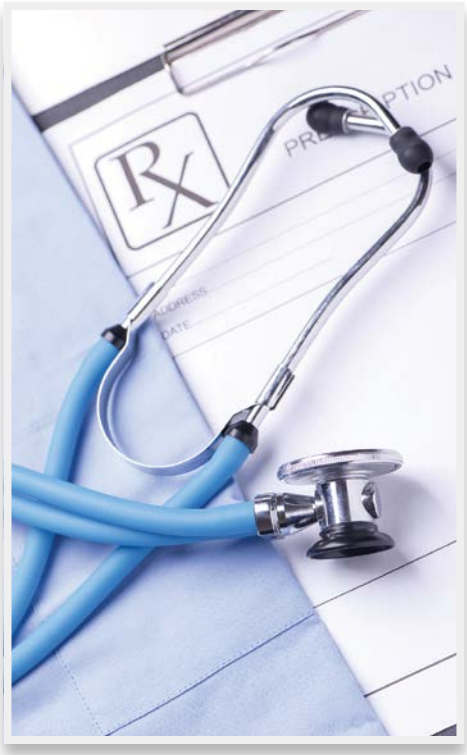
Hospital Industry Structure: Considering the Impact of the Affordable Care Act

BY JAMES BURGDORFER, JUNIPER ADVISORY

In its 2010 Governance Institute white paper, Juniper Advisory described the ownership structure of the hospital industry in anticipation of the impact of healthcare reform and the Affordable Care Act (ACA) on hospital consolidation.[1] Leading up to enactment of the ACA, health policy experts had concluded that the U.S. healthcare delivery system was consuming too great a share of the economy. Essentially, the industry was viewed to be too expensive for the country and patients, and providing mediocre health outcomes. These factors were the economic rationale for healthcare reform and, eventually, implementation of the ACA.

In 2010, the ACA was viewed to have two primary objectives: control the cost of healthcare and provide improvements to the healthcare system including expanding the number of people with insurance coverage and adding safeguards for patients. The hospital industry believed that the ACA would impact the economics of the industry in two fundamental ways. First, the cost of doing business would increase as the industry moved from fee-for-service to a value-based structure. Second, reimbursement would decline as Medicare rates were reduced.

As a result, it was believed that the ACA might significantly increase consolidation between hospitals and result in the creation of larger systems of care so as to achieve economies of scale. Juniper felt this could result in more transactions, larger transactions, interstate transactions, and more transactions involving non-profit buyers. Further supporting the notion of creating larger companies, evidence suggested that better health outcomes were achieved by larger organizations that were able to devote greater resources to standardizing protocols. Now, more than six years into the ACA, and at the beginning of likely change to it, it is useful to consider the impact of the ACA on the ownership of the industry and its level of concentration.



1 James Burgdorfer et al., *Hospital Consolidation Trends in Today's Healthcare Environment* (white paper), The Governance Institute, Summer 2010.

Key Board Takeaways

As boards think about the impact of the ACA on the ownership and structural concentration of the hospital industry, the following points are important to consider:

- There has been only a moderate level of business combination activity since 2010. However, there have been two significant changes to structure: the proportion of hospitals that are part of a multi-hospital system has increased to 65 percent, and there are now fewer companies (1,890) in the hospital industry.
- Multi-hospital systems remain small, less than six hospitals per system. There continue to be dramatically more companies than in similar-sized major industries.
- There has been significantly more business concentration in the non-hospital sectors of healthcare services: insurance, pharmaceutical, and devices.
- The proportion of hospital boards that are considering independence has grown from 15 percent to 80 percent. Only investor-owned and Catholic-sponsored hospital companies have combined into large companies. Both of these ownership forms have boards that are appointed by, and accountable to, owners.

Impact of the ACA on Hospital Industry Structure

This section updates the hospital industry's structure since our 2010 analysis and considers changes since implementation of the ACA. In 2010, we reviewed the various ownership forms, the trends in horizontal consolidation, and the size of companies that comprised the hospital industry. In this article, we update that information through 2016 and provide a first look at the impact of the ACA on industry ownership and concentration.

The information on hospitals in the American Hospital Association (AHA) database is focused on facilities. As a result, an understanding of the commercial structure of the industry is accomplished through considering, in sequence, the number and type of hospital facilities, the development of hospital systems and companies, and the size and nature of these companies.

The data on hospital *facilities* provides basic information on the number of individual hospitals and their ownership forms. The information concerning the development of hospital *systems* provides further insight into the overall ownership and control of the industry. The data on hospital *companies*, describes the formation of business entities in the industry and their access to capital and relative size.

Hospital Facilities

As noted in 2010, several features of the AHA database necessitated adjustment to fit these goals:

- Certain facilities included in the AHA data categorized as "other" have business characteristics that differ from general acute care hospitals. These include long-term acute care, psychiatric, and Veterans Affairs hospitals. We eliminated these from the data in the charts below so as to focus on the general acute care hospital industry only. We believe this provides a more accurate picture of the hospital business.
- Similarly, the AHA data concerning investor-owned facilities includes long-term acute care, psychiatric,

behavioral health, and specialty hospitals. For the same reason, we excluded these from the data.

- The AHA groups academic, local government, and 501(c)(3) systems into one "non-profit" category. We believe the majority of these are 501(c)(3) community hospitals. The majority of local government-owned systems are single hospitals, and most academic systems, at least at present, are freestanding facilities.
- Religious-sponsored facilities tend to be part of systems. We believe the number of stand-alone religious-sponsored facilities is insignificant.

Table 1 reflects changes in the number of general acute care and critical access hospitals, as reflected by provider numbers, over time and by ownership type. It also indicates the proportion of all hospitals held by each ownership group.

Overall, there was no meaningful change in the ownership structure of the hospitals during the 2008–2016 period. The gradual decline in the total number of hospitals over the past 20 years continued through 2016. The largest declines have occurred during periods of externally stimulated consolidation (i.e., in the mid-1990s and during the ACA years). Community 501(c)(3) non-profit hospitals had the largest proportionate decrease between 2008 and 2016 (11 percent) due to consolidation and closures of very small hospitals.

The number of investor-owned general acute care hospitals increased slightly during the 2008–2016 period, after declining slightly during the 1995–2008 period. However, there are fewer well-capitalized and investor-owned companies in 2016. Also, this sector's participation in M&A transactions is declining.

Table 1: Hospital Facilities

Ownership	1995	2000	2005	2008	2013	2016
501(c)(3) non-profit hospitals[1]	2,507	2,341	2,295	2,265	2,079	2,015
Proportion of total hospitals	50%	50%	50%	50%	47%	47%
Governmental hospitals	1,350	1,163	1,110	1,105	1,068	971
Proportion of total hospitals	27%	25%	24%	24%	24%	22%
Faith-based hospitals	585	662	663	658	667	726
Proportion of total hospitals	12%	14%	15%	15%	15%	17%
Total non-profit hospitals	**4,442**	**4,166**	**4,068**	**4,028**	**3,814**	**3,712**
Proportion of total hospitals	88%	89%	89%	89%	87%	86%
Total investor-owned hospitals	**589**	**514**	**514**	**513**	**574**	**618**
Proportion of total hospitals	12%	11%	11%	11%	13%	14%
Total hospitals[2]	5,031	4,680	4,582	4,541	4,388	4,330

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.
Notes:
1. Includes community 501(c)(3) and academic hospitals.
2. General acute care and critical access hospitals only. Long-term acute care, Veteran Affairs, and other specialty hospitals excluded.

Table 2: Change in Hospital Facilities

	1995	2000	2005	2008	2013	2016
Total hospitals	5,031	4,680	4,582	4,541	4,388	4,340
M&A market						
Announced transactions	128	86	50	60	100	90
Avg. number of hospitals per transaction	NA	1.5	1.8	1.3	2.5	1.2
Total hospitals involved	**NA**	**132**	**88**	**78**	**247**	**111**

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 2 describes the source of change in the number of hospital facilities.

The majority of change resulted from M&A transactions. Net hospital closures have not played a significant role in consolidation. However, it is possible that closures could increase somewhat in the foreseeable

Table 3: Hospital System Development

	1995	2000	2005	2008	2013	2016
Total hospitals	5,031	4,680	4,582	4,541	4,388	4,330
Total hospital systems	253	266	314	330	362	386
Hospitals in systems	2,040	2,291	2,387	2,488	2,482	2,825
Hospitals per system	8.1	8.6	7.6	7.5	6.9	7.3
Proportion of hospitals in systems	41%	49%	52%	55%	57%	65%
Independent hospitals—*not* in a system	2,991	2,389	2,195	2,053	1,906	1,505
Proportion of hospitals not in systems	59%	51%	48%	45%	43%	35%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 4: Ownership of Hospital Systems

	1995	2000	2005	2008	2013	2016
Non-profit systems						
Community 501(c)(3) and governmental	162	195	244	264	297	324
Faith-based	71	56	55	51	50	47
Catholic	57	45	42	39	35	33
Other	14	11	13	12	15	14
Total non-profit systems	**233**	**251**	**299**	**315**	**347**	**371**
Total investor-owned companies	**20**	**15**	**15**	**15**	**15**	**15**
Total non-profit and investor-owned systems	**253**	**266**	**314**	**330**	**362**	**386**

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

future as struggling hospitals might have difficulty finding partners. Despite much commentary to the contrary, the number of announced M&A transactions increased only slightly during the 2008–2016 period. The size of transactions, measured by the number of hospitals involved, has also been consistently small over this period, averaging approximately one-and-one-half hospitals per transaction. The only exceptions were during years when the data were impacted by large transactions amongst investor-owned companies.

Hospital Systems

Table 3 reviews the development of multi-hospital systems. These include non-profit and investor-owned general acute care systems.

This is the first data that can be used to assess the overall level of *business concentration* in the industry. The proportion of hospitals that are part of systems is one measure of such concentration. During the 2008–2016 period there was gradual concentration of the hospital industry. The proportion of hospitals that are part of systems increased from 55 percent in 2008 to 65 percent in 2016. This increase in concentration has been occurring at a relatively consistent pace over the past 20 years. The business entities, themselves, have not become larger. In fact, as measured by the number of hospital systems, they have become slightly smaller.

Table 4 describes the development of multi-hospital systems by ownership type.

In continuing to assess the development of multi-hospital systems between 2008 and 2016, we consider which types of non-profit hospitals have been most inclined to consolidate (i.e., by either forming or becoming part of multi-hospital systems). Over this period, the number of community 501(c)(3) systems grew by 15 percent. The number of Catholic-sponsored systems shrank by 15 percent, primarily as a result of intra-Catholic mergers. These resulted in fewer, but larger Catholic systems. The number of investor-owned companies remained constant. However, there has been considerable

consolidation amongst large publically held investor-owned companies.

Tables 5–9 describe the development of multi-hospital systems by *ownership type.*

Table 5 describes the development of community 501(c)(3) systems.

During the 2008–2016 period, the number of multi-hospital systems increased by 23 percent and the proportion of all acute care hospitals in systems increased to 35 percent. However, the size of these systems, as measured by number of hospitals, shrank slightly.

Next we consider the development of Catholic-sponsored systems since 1995 (see **Table 6**). Non-Catholic faith-based systems are not a significant group from a national point of view.

During the 2008–2016 period, smaller Catholic systems continued to merge into large Catholic systems. The proportion of total systems that are Catholic declined in the 2000s. The proportion of total hospitals that are sponsored by the Catholic Church increased slightly. The size of Catholic systems, as measured by numbers of hospitals, continued to increase. We suspect that this is attributable to a strong sense of ownership and commonality of purpose that is present in Catholic systems.

We summarize the development of *all non-profit systems* in **Table 7**.

Between 2008 and 2016, the number of all non-profit systems increased by 18 percent, although the number of hospitals that were part of these systems grew by only 2 percent. The proportion of all hospitals that are part of a non-profit system increased from 43 percent to 51 percent. However, the number of hospitals per system shrank from 6.3 to 5.9.

Table 8 reviews the development of *investor-owned systems.*

The investor-owned sector has not been growing. Investor-owned companies are, however, much larger, measured by number of hospitals, than any of the non-profit system groupings. The investor-owned companies average 40.3 hospitals per system versus 5.9 hospitals per system for all non-profits. Again, one would attribute this to board decisions that reflect the fact that ownership nominates board members of investor-owned companies.

Table 9 (on the next page) reviews the development of *all systems*, both non-profit and investor-owned.

Table 5: Community Systems

	1995	2000	2005	2008	2013	2016
Community 501(c)(3) and governmental systems	162	195	244	264	297	324
Hospitals in community systems	866	1,115	1,210	1,317	1,270	1,506
Hospitals per community system	5.3	5.7	5.0	5.0	4.3	4.6
Proportion of all systems that are community systems	64%	73%	78%	80%	82%	84%
Proportion of all hospitals in community systems	17%	24%	26%	29%	29%	35%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 6: Catholic Systems

	1995	2000	2005	2008	2013	2016
Catholic systems	57	45	42	39	35	33
Hospitals in Catholic systems	488	560	555	556	521	588
Hospitals per Catholic system	8.6	12.4	13.2	14.3	14.9	17.8
Proportion of all systems that are Catholic systems	23%	17%	13%	12%	10%	9%
Proportion of all hospitals in Catholic systems	10%	12%	12%	12%	12%	14%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 7: All Non-Profit Systems

	1995	2000	2005	2008	2013	2016
Non-profit systems	233	251	299	315	347	371
Hospitals in non-profit systems	1,451	1,777	1,873	1,975	1,908	2,207
Hospitals per non-profit system	6.2	7.1	6.3	6.3	5.5	5.9
Proportion of all systems that are non-profit	92%	94%	95%	95%	96%	96%
Proportion of all hospitals in non-profit systems	29%	38%	41%	43%	43%	51%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 8: Investor-Owned Companies

	1995	2000	2005	2008	2013	2016
Investor-owned companies	20	15	15	15	15	15
Hospitals in investor-owned companies	589	514	514	513	574	605
Hospitals per investor-owned company	29.5	34.3	34.3	34.2	38.3	40.3
Proportion of all systems that are investor-owned companies	8%	6%	5%	5%	4%	4%
Proportion of hospitals in investor-owned companies	12%	11%	11%	11%	13%	14%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 9: All Systems Combined

	1995	2000	2005	2008	2013	2016
Hospital systems	253	266	314	330	362	386
Hospitals in systems	2,040	2,291	2,387	2,488	2,482	2,825
Hospitals per system	8.1	8.6	7.6	7.5	6.9	7.3
Proportion of all hospitals in systems	41%	49%	52%	55%	57%	65%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 10: Hospital Companies

	1995	2000	2005	2008	2013	2016
Hospital systems	253	266	314	330	362	386
Independent hospitals	2,991	2,389	2,195	2,053	1,906	1,505
Total hospital *companies*	3,244	2,655	2,509	2,383	2,268	1,891

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 11: Largest Hospital Systems—2015

10 Largest Hospital Systems	Total Revenues in Billions	Market Share	Tax Status	Debt Rating
HCA	$39.7	4.0%	IO	Ba2
Ascension Health	$20.5	2.1%	NP	Aa2
Community Health Systems	$19.4	2.0%	IO	B2
Tenet Healthcare	$18.6	1.9%	IO	B2
Catholic Health Initiatives	$15.0	1.5%	NP	Baa1
Trinity Health	$14.7	1.5%	NP	Aa2
Providence Health	$14.4	1.4%	NP	Aa3
UPMC	$12.8	1.3%	NP	Aa3
Dignity Health	$12.6	1.3%	NP	A2
Sutter Health	$11.0	1.1%	NP	Aa3
Total, 10 Largest Hospital Systems	**$178.7**	**18.0%**	-	-
Hospital industry, aggregate	$994.0			

Sources: Company Web sites, audited financial statements, credit rating agencies, Juniper estimates.
IO = investor-owned, NP = non-profit

The total number of hospital systems and their proportion of all hospitals has increased since the late 1995. However, the number of hospitals per system is stagnant, indicating that hospital systems, on average, remain relatively small businesses.

Hospital Companies

In order to better understand the extent to which control has become more centralized, we next consider changes to the number of business entities or *companies* in the hospital industry (see **Table 10**). By combining the number of independent hospitals with the total number of systems, we approximate the number of businesses (i.e., entities under discrete ownership and governance control). Between 2008 and 2016, the number of companies continued to decline through consolidation; however, there are still nearly 1,900 companies with distinct boards of directors and managements making up the general acute care industry.

Table 11 lists the 10 largest hospital companies by size, as measured by revenues, and market share. Consolidation has caused the share of market occupied by the 10 largest companies to increase from 15 percent in 2008 to 18 percent in 2015.

The hospital industry has one market leader, in terms of size, which commands only 4 percent of industry revenue. By comparison, the leaders in the airline and banking industries occupy 22 percent and 23 percent of their industries, respectively. Frequently, more than half of the top 10 competitors in any given industry are of relatively comparable size. However, Ascension, HCA's largest competitor, is only one-half the size of HCA in terms of revenues. Historically, such comparisons have been viewed to be less important in the hospital industry due to local and regional, rather than national market characteristics, and lack of international markets.

Market leaders of most major industries have access to capital, which is significantly better than that experienced by even the leading hospital companies. In every mature major industry except the hospital industry, the leading companies have access to both equity and debt markets. Access to debt is characterized by strong investment grade ratings and the ability to issue debt in most of the major global markets and, also, be able to issue commercial paper and medium-term notes.

There are no hospital companies, non-profit or investor-owned, with this sort of access to capital. Approximately 40 percent of non-profits have strong credit ratings and good access to debt, although limited to municipal bond, private institutional, and bank markets. None, of course, have access to equity. Currently, *no* investor-owned companies have investment-grade ratings, and only five are publically held.

Observations

As noted in our 2010 review, there was only modest change in the ownership and concentration of the hospital industry from 1995 to 2008. This article describes the impact of the first six years of the ACA, through 2016, on consolidation. Some notable findings include:

- Despite references to enormous levels of merger activity among hospitals, the pace of announced combinations was only moderate during the entire period, and well below levels experienced in the mid-1990s.
- However, there has been an increase in the systemization of hospitals. More hospitals are now part of multi-hospital systems (65 percent in 2016, versus 55 percent in 2008). The size of these systems has not increased since 2008 and, on average, they remain small businesses.
- An increasing proportion of hospital M&A transactions feature non-profit buyers. As a result, there have been more

mergers and fewer asset acquisitions during the first years of the ACA.
- Only Catholic-sponsored and investor-owned hospital systems have combined into significantly larger companies. We believe this is due to the presence of, and accountability to, "owners" for these two groups.
- There have been no large interstate combinations between non-profit systems.
- Academic hospitals are beginning to expand by acquiring non-profit hospitals in their region.
- Despite some consolidation, there remain nearly 1,900 separate business entities, and the largest companies are small compared to their peers in other industries.

Despite references to enormous levels of merger activity among hospitals, the pace of announced combinations was only moderate during 2008–2016, and well below levels experienced in the mid-1990s. However, there has been an increase in the systemization of hospitals.

The nature and tone of the merger market has been impacted as hospital companies struggle with the implications of healthcare reform and the ACA:
- Increasingly, boards of hospitals are considering independence. Approximately 80 percent of independent hospitals and small systems were doing this in 2016, up from 15 percent in 2008. As a result, it has become much more acceptable for boards to acknowledge, often publically, that they are considering the topic.
- There has been a very significant increase in the number of affiliations and alliances. These are contractual arrangements in which no ownership or control is exchanged. They have been occurring at the rate of several hundred per year recently.
- The significant growth in acquisitiveness by larger non-profits has resulted in many new participants in merger transactions.
- Transactions are taking considerably more time to complete and are more fragile.
- Mergers involving government-owned hospitals have been burdened with political disputes. As a result, this sector of the industry is changing very slowly.
- We sense that there is a bias towards combining through pre-packaged bankruptcies as hospitals approach the "zone of insolvency."
- The health insurance industry has continued to consolidate. Fewer than 10 companies comprise the majority of the health insurance market.

The ACA had two primary objectives: lowering the cost of healthcare and improving coverage and protection. Little progress has been made on the first objective; the cost of healthcare continues to consume more than 16 percent of GDP.

The ACA has made significant progress on the second objective as 20 million additional people have health insurance coverage and improved protections are in place. Regardless of what happens to the ACA itself, the industry continues to move towards value-based care and reimbursement. As a result, new ways and structures will need to be found that will enable it to deliver care more efficiently.

The negative impact of the industry's fragmented structure on efficiency and effectiveness has been well-documented. Other major industries with characteristics similar to the hospital industry (i.e., commercial complexity, capital intensity, and heavy regulation) have fewer and larger companies. Only a few urban markets (e.g., Cleveland, Denver, and Dallas) benefit from strong larger companies. Many continue to ask why the industry remains so fragmented.

The hospital industry, uniquely, has evolved from a complex and interrelated set of mission and commercial objectives, but the determinants of success have changed enormously. In the past, the hospital industry's local approach and fragmented structure fitted the needs of the market and were consistent with its transportation, commercial, and reimbursement characteristics. This evolution along with the governance structure of the community non-profit hospital industry plays a large role in its resistance to structural change. **In our view, the conflict between the exigencies of reform versus the governance preference for independence is the largest factor facing the industry today.**

In addition, the lack of structural change in the past six years was partially the result of strict antitrust enforcement by the FTC, and strong demand from the municipal bond market. In 2010, many observers thought that the municipal bond market would be less willing to buy small issues of small hospital companies. Surprisingly, this was not the case. Also, historically low interest rates during the period enabled many hospital companies to remain independent.

Given all of the factors described above, it is hard to predicate the future pace of consolidation. We believe it is likely that business combinations will continue at a moderate level and that they will likely continue to be hard to complete. Should any of several things happen, however, the potential for *disruption* of the industry exists. First, significant change in the capital markets could cause an increase in consolidation. This would most likely be in the form of dramatically higher interest rates or a substantial decrease in demand from the municipal market due to changes in income tax policy. Also, potential repeal-and-postpone scenarios could cause significant economic stress on hospital financial performance with the same result. Should insurance companies be granted the ability to sell policies across state lines, large community non-profits might actively consider interstate business combinations. This sort of growth might be less likely to meet with FTC resistance than has been the case with mergers in contiguous markets.

We are optimistic that the industry will encourage innovative thinking and pave the way for the strong organizations that can provide healthcare in new and unique ways, regardless of ownership, location, size, or other factors addressed in this article. We hope this updated review is of help to industry participants as they consider industry trends, strategic responses, and market positions in order to reach the best conclusions for their communities and patients.

The Governance Institute thanks James Burgdorfer, Principal with Juniper Advisory, for contributing this article. *He can be reached at jburgdorfer@juniperadvisory.com.*

Minimum Director Independence Requirements: The Next Trend in Hospital Governance?

BY ANJANA D. PATEL AND ANJALI N.C. DOWNS, EPSTEIN, BECKER & GREEN, P.C.

The trend in having more independent directors on boards has been rising in recent years, especially in the for-profit arena after the enactment of the Sarbanes-Oxley Act in 2002.

Key Board Takeaways

The IRS does not mandate a particular board structure, but it will review an organization's board structure and conflict-of-interest disclosures to ensure that the board is not dominated by non-independent directors. The trend in having more independent directors on boards has been rising in recent years. Some of the factors driving decisions around director independence include:

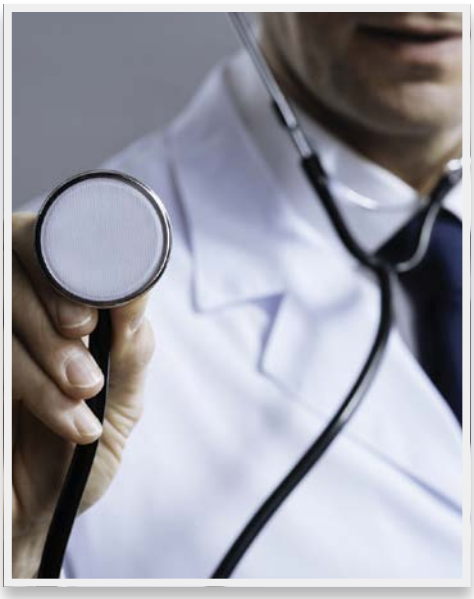
- The highly regulated healthcare industry requires awareness of changing regulations and recent guidance from the government about individual accountability under the "Yates Memo."
- The government's focus on individual accountability is not new—the "Holder Memo" (1999) also dealt with holding executives responsible for corporate misconduct.

In healthcare, many hospitals and health systems are tax-exempt organizations under section 501(c)(3) of the Internal Revenue Code. Although the IRS does not mandate a particular board structure, it will review an organization's board structure, conflict-of-interest policy, and disclosures to ensure that the board is not dominated by non-independent directors.[1] Further, given the dynamic nature of the healthcare industry, many hospitals and health systems continue to consider changes to their board structures in an effort to improve their governance practices, including imposing a requirement for a minimum number of independent directors.

This article discusses some of the factors driving decisions around director independence, including recent changes in government enforcement guidance that may also impact board composition.

Defining "Independent Director"

As a threshold matter, the term "independent director" is generally not defined under the corporate laws in most states, and thus, hospitals and health systems have discretion to develop their own definition for purposes of identifying conflicts of interest. Healthcare organizations may use the requirements imposed on for-profits by the Sarbanes-Oxley Act as a starting point. Commonly, an "independent director" definition ensures that the director and his/her immediate family members—or a business owned by such individuals—do not have an ownership, investment, or compensation arrangement with the hospital. The ultimate goal is to ensure that the definition is broad enough to make sure that directors who have "skin in the game" in any particular arrangement are not a part of the board's decision making on any matters in which they are an interested party.



The Impact of Industry Changes on Scope of Fiduciary Duties

While most directors understand their basic fiduciary duties to the organization, directors need to be cognizant of how to exercise these duties in the ever-changing landscape of the highly regulated healthcare industry. In addition to new regulations, it has been a longstanding expectation of the federal government that boards of healthcare organizations exercise compliance oversight to assess both the organization's compliance infrastructure and the manner in which it is operationalized. In the last few years, the government has reinforced its interest in individual accountability through the issuance of guidance and the increased number of enforcement actions against senior leadership of healthcare organizations.

The government's focus on individual accountability is not new. For a number of years, the government has shown an interest in investigating—and taking legal action against—healthcare executives believed to be involved in corporate wrongdoing. This focus on individual accountability was outlined in 1999 by Attorney General Holder, when he issued a memorandum focused on developing a framework for prosecutors to use in assessing whether to charge a corporation with wrongdoing (the "Holder Memo").[2] The Holder Memo also emphasized that just because a corporation is charged does not mean that individual officers and/or employees should also not be charged. Since the issuance of the Holder Memo there have been numerous revisions, updates, and policy statements to advance the government's perspective.

Most recently, on September 9, 2015, Deputy Attorney General Sally Yates issued a memorandum outlining six policy statements to guide Department of Justice attorneys to focus on individuals when investigating civil or criminal corporate misconduct (the "Yates Memo").[3] As a result, the Yates Memo incentivizes corporations and their governing officials to remain compliant with existing regulations and statutes. Failing to do so could result in personal liability, as demonstrated by

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1 See Internal Revenue Service, "Governance and Related Topics–501(c)(3) Organizations" (available at www.irs.gov/pub/irs-tege/governance_practices.pdf).

2 "Bringing Criminal Charges Against Corporations," Department of Justice, June 16, 1999 (available at www.justice.gov/sites/default/files/criminal-fraud/legacy/2010/04/11/charging-corps.PDF).

3 Sally Yates, "Individual Accountability for Corporate Wrongdoing," Department of Justice, September 9, 2015 (available at www.justice.gov/dag/file/769036/download).

Minimum Director Independence Requirements…

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recent cases involving corporate officials facing monetary penalties, exclusion from federal healthcare programs, indictments, and jail time.

The need for directors to be well-versed in changing regulations and the threat of individual accountability from the government could be significant deterrents to recruiting and retaining directors. This may make it difficult to maintain minimum independence requirements. Further, independent directors may face larger obstacles in this respect, because they may need to spend extra time to learn the corporate culture and the organizational operations in order to fully exercise good business judgment in these instances. In other words, independent directors may need to put in extra effort in order to avoid a government investigation. This leaves healthcare organizations in a precarious position, forcing the organization to balance between appointing independent directors while also ensuring that the board is well equipped to lead the organization.

Below are some recommendations for the board to consider in determining whether to establish minimum independence requirements:

- **Establish the definition of "independent director."** Once this has been determined, the board can consider whether there should be a minimum number of independent directors.
- **Each hospital should customize any minimum director independence requirements to their organization.** The decision to establish a minimum number of independent directors will be influenced by other factors relating to governance, such as:
  - » The size of the board: A larger board may be better able to support minimum independence requirements than a smaller board.
  - » The board's need for certain types of expertise: Board members with certain backgrounds and expertise (e.g., legal, financial, etc.) will obviously enhance the board's oversight function, but setting minimum independence requirements may impede the ability of the board to obtain such expertise.

  - » The hospital's success with recruiting and retaining directors: A hospital with a strong director recruitment and retention track record may be in a stronger position to support higher independence requirements.
  - » The hospital's policy on board diversity: A hospital's desire to ensure the board includes minorities and women may also factor into the decision to impose a minimum independence requirement.
  - » The hospital's board refreshment and term limits policies: If the board composition changes frequently and recruiting independent directors is challenging for the hospital, setting a minimum independence requirement may present additional challenges for the hospital.
  - » The juxtaposition of independence and community representation: While independent directors may bring a fresh view to governance issues, a non-profit hospital's board oftentimes will have representatives from its community that are likely to have relationships with the hospital. Setting a high threshold requirement for independent directors may thus not be feasible for some hospitals.

Even if the board doesn't set minimum independence requirements, The Governance Institute does recommend that a majority of board members are independent. Boards should consider what works best for their organization while making sure that enough directors are free of relationships that may impair their ability to exercise independent judgment in the boardroom.

The Governance Institute thanks Anjana D. Patel, Member, and Anjali N.C. Downs, Member, Epstein, Becker & Green, P.C., for contributing this article. They can be reached at adpatel@ebglaw.com and adowns@ebglaw.com.

Governance Restructuring after a Merger

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from our Waterbury marketplace that sit on the regional board who previously served on Saint Mary's board, and people from our area that serve on the regional board so our community is well represented.

Role of the Regional Board

The regional board is responsible for strategic planning across the region and building Trinity Health—New England. It is also fiscally responsible for each of our five hospitals—how to maintain a fiscally responsible health system and regionally contribute to a national system. Strategy and finance represent a meaningful portion of our discussions right now, especially in light of the overall system's People-Centered 2020 strategic plan.

> All these changes will help us streamline and focus governance around what is most important. At the local level, we can focus on health, and at the regional level the board's primary concern is healthcare, but with both groups consigned to a similar, united approach.

The decision-making process has changed and is good for the local health system. The appropriate decisions are now at the appropriate level organizationally. Decisions are made with line of sight across the region with the collective best and brightest minds at work interfacing and ensuring support from Trinity Health. The operating budget and capital budget are approved by Trinity Health—New England, along with compliance and audits, which is controlled by Trinity Health. The committee structure also rests at the regional level, which includes committees on finance, governance, and mission. Given the change in focus and need to move certain decision rights to the regional board, the sensitivities around governance-by-representation become very important. The regional board has an astute and diverse membership from all of the markets that are part of our region; however, their job is to act on behalf of the best interest of Trinity Health—New England. Two board members at the regional level do come from the Saint Mary's area, but they represent the region's interests, not Saint Mary's. In addition, we are moving away from the hospital being at the center of care toward a population health approach, which will help us move away from the notion of governance-by-representation.

Taken together, all these changes will help us streamline and focus governance around what is most important. At the local level, we can focus on health, and at the regional level the board's primary concern is healthcare, but with both groups consigned to a similar, united approach. Decision rights are well-defined and decisions are made at the most appropriate level—either local or regional depending upon the subject.

One important aspect to consider with serving on a board that reports to a larger system board is to make sure you have people who understand and appreciate system thinking. It is important to resist governance-by-representation as the board turns over. The local board focuses on the mission with primary focus on quality and patient safety, community health, and building a consumer-driven, patient-centered organization. Board members should possess an approach that is unified across these various different constituencies so that everyone is remaining focused on what is important to the regional organization as a whole, through a similar mission, vision, values, purpose statement, or standards. You can approach it in different ways, with different paths to get there, but having consistency and focus that is well understood is important.

The Governance Institute thanks Chad W. Wable, FACHE, President and CEO of Saint Mary's Hospital and Senior Vice President, Operations and Chief Transformation Officer of Trinity Health—New England for contributing this article. He can be reached at cwable@stmh.org.

Why Your Nurses Should Serve...

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The power of nurses to improve community health is echoed by Susan Orsega, M.S.N., FNP-BC, FAANP, FAAN, Rear Admiral, United States Public Health Service (USPHS), Assistant Surgeon General, and USPHS Chief Nurse Officer, who leads a team of 1,500 nurse commissioned officers. "Commissioned Corps nurses play a vital role in reaching the population where they work, play, and pray," said Orsega. "Population health is a staple of what we do in our varied assignments across the country. The Commissioned Corps nurses fulfill critical roles in clinics, hospitals, and public health outreach programs and policies that are vital to the health of families and communities across the nation."

> "The involvement of their nurse executives in high-profile community boards builds credibility and enhances the reputation for the organizations that employ them. Serving on community boards, nurses are extending the reach and reputation of the hospital beyond the clinical environment in helping shape policy and strategy decisions that impact these critical areas of patient care across the continuum of care."
>
> *–Lawrence W. Vernaglia, Foley & Lardner LLP*

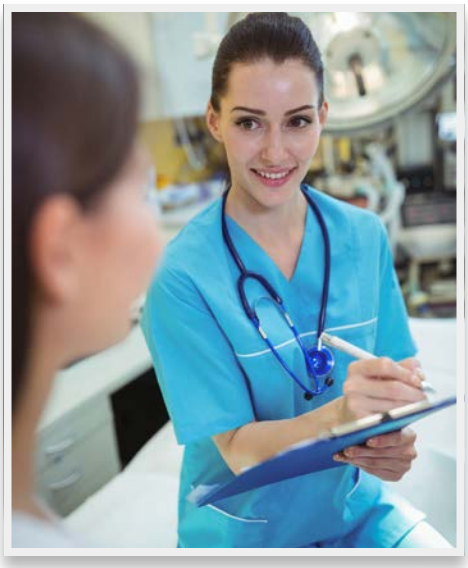
"The Commissioned Corps community outreach, as an outside activity, to support a culture of health is ever present," Orsega continued. "Our nurses lead community events that bring together several organizations to organizing community runs to serving on church boards and school activity boards. We also bridge federal resources to the community, whether state, local, or tribal, providing an exceptional opportunity for the promotion and support of the Surgeon General's priorities, calls to action, or public health initiatives. My nurse team impacts the health of every American using a model of care centered on population health, wellness, and prevention. We want to create a culture and world where good health is in the reach of every person."

Benefits for Nurses

Nurses gain a valuable professional development opportunity when they serve on community and non-profit boards. The Center for Creative Leadership's 70-20-10 rule for leadership development states that leaders need to have three types of experience, using a 70-20-10 ratio: challenging assignments (70 percent), developmental relationships (20 percent), and coursework and training (10 percent).[6] Board service is an excellent way for employers to expose nurse leaders to developmental relationships and thus foster the leadership of its nursing workforce. Additionally, serving on community boards often has a positive impact on job satisfaction.

Benefits for Healthcare Organizations

Healthcare organizations stand to gain when they promote nurses participating in community service. As Lawrence W. Vernaglia, Partner and Chair, Healthcare Practice, Foley & Lardner LLP, states: "The involvement of their nurse executives in high-profile community boards builds credibility and enhances the reputation for the organizations that employ them. Serving on community boards, nurses are extending the reach and reputation of the hospital beyond the clinical environment in helping shape policy and strategy decisions that impact these critical areas of patient care across the continuum of care."



Nurses' service in community governance roles also helps them bring back new ideas, best practices, and even professional connections gained through board service to their places of employment. "The experiences gained by the nurses on community boards is often reflected back through the evidence-based learning that they apply within their own hospitals as a result of their community board roles," Vernaglia adds.

Finally, by remaining "in touch" with the community, nurses can also conduct environmental scans, alerting hospitals and health systems to new and emerging healthcare issues.

It is increasingly beneficial—to communities, nurses, and healthcare organizations—when hospitals and health systems support the volunteer efforts of their nurse executives serving in board and other leadership roles in their communities.

The Governance Institute thanks Laurie Benson, B.S.N., Executive Director, Nurses on Boards Coalition, and Kimberly J. Harper, M.S., RN, Chief Executive Officer, Indiana Center for Nursing, Nursing Lead, Indiana Action Coalition—National Future of Nursing Campaign for Action, and National Co-Chair, Nurses on Boards Coalition, for contributing this article. They can be reached at laurie.benson@ana.org and kharper@ic4n.org.

6 Ron Rabin, *Blended Learning for Leadership: The CCL Approach,* Center for Creative Leadership, 2014.

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or employed physician base will be critical moving forward. If you do not already have alignment with clinicians, consider alignment with clinicians to form an accountable care organization (ACO) (or partner with an existing ACO or Medicare Shared Savings Program) as a mechanism to improve quality and contain costs. Partnering with a Medicare Advantage health plan could be a good option as well.

Power shift to insurance companies: Deregulation of provisions of the ACA related to insurers, such as the elimination of the medical loss ratio (MLR) target, rate regulation, and standard benefit design, coupled with allowing plans to be sold across state lines will likely provide additional power to the insurance industry. Deregulation combined with the current trend of insurers partnering with physicians in an effort to commoditize hospitals will force them to find ways to maintain essentiality and demonstrate value.

What to watch: Ensure that your hospital or health system is actively developing and implementing high-value provider networks with economic alignment (incentives) that will ensure collaboration, relevance, and competitive advantage in negotiations with payers. Simply said "be relevant" in the market. In addition, providers with employed physicians should attempt to use MACRA as a motivator to align with clinicians. Seek out health plans to partner with that are interested in moving toward value-based shared savings arrangements.

Shift to physician-led delivery and payment reform models: Between MACRA and Representative Price's criticism of mandatory bundled payment programs and preference for physician-focused models, expect to see the development of additional models available for clinicians. MACRA will lead to even more focus on value-based care and APMs. These models will likely have similar designs and characteristics to the Comprehensive Primary Care Plus (CPC+) model, which is designed to facilitate a more comprehensive and coordinated approach to primary care services and patient care (provide enhanced value).

What to watch: MACRA provides hospitals and health systems with significant opportunities for further integration (economic alignment) with physicians. It will be important to evaluate appropriate ways to assist clinicians with reporting, strategic direction, benchmarking data, care models, and other vehicles to boost income in either the Merit-Based Incentive Payment System (MIPS) option or through participating in APMs. Monitor Trump policy and market activity of competitors developing APMs that exclude your organization. Examine broader partnership opportunities in these areas to accelerate your ability to participate in new models. Continue developing and implementing other integration strategies with clinicians.

Reduced revenue per service to providers: Regardless of the Congressional approach to repeal and replace the ACA, there is still a major challenge with federal spending on healthcare and we expect that the continued trend of holding Medicare and Medicaid spending in line will continue. As a part of this dynamic, federal and state budgets will continue payment increases below expense increases and will move toward value-based payment models.

What to watch: To address reduced Medicare and Medicaid reimbursement, hospitals and health systems should evaluate the potential for alternative arrangements utilizing ACOs, Medicare Shared Savings Program organizations, clinically integrated networks, participation in APMs, and direct-to-employer agreements. This will create opportunities to integrate and align incentives with physicians and be rewarded for reducing costs and improving quality. Additionally, providers should seek annual productivity increases in reimbursement and shared savings agreements from commercial and risk payer agreements.

Final Word

Predicting the future accurately is difficult at this time due to the change in administration and healthcare policies (recognizing many other "new directions/approaches" will also have a major impact on healthcare). However, it is the responsibility of governing boards to not be distracted by short-term turbulence, and to look through the lens of a longer-term vision. Each wave of disruptive change brings with it opportunities for innovation, new approaches, new partnerships, and different ways of thinking. Make this wave a catalyst for ensuring that your organization becomes stronger, more sustainable, and serving the communities within the reach of your organization. Don't panic, change of this magnitude will take time to implement and there will be much debate in public about the impact.

The Governance Institute thanks Guy Masters (Principal), Seth Edwards (Principal), and Steve Valentine (Vice President), Premier, Inc., for contributing this article. *They can be reached at guy_masters@premierinc.com, seth_edwards@premierinc.com, and steve_valentine@premierinc.com.*

Governance Forecast: Strategic Considerations under a New Administration's Policies

BY GUY M. MASTERS, PREMIER, INC.

With the new administration pursuing major shifts in the approach to healthcare reform, governing boards must understand the context and direction of expected policy changes, trends, and shifts in power that are likely to occur.

Following is a succinct synopsis of who and what to watch, and the potential strategic impacts and opportunities this change will create for hospitals and health systems.

Leadership Perspectives: Clues to Healthcare Policy Shifts

Representative Tom Price and Seema Verma were nominated to lead the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS), respectively. Representative Price is a former orthopedic surgeon who serves as a Congressman from Georgia. He has been very engaged in healthcare policy as the Chairman of the House Budget Committee and as a member of the powerful House Ways and Means Committee. Representative Price supported the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation, which transforms clinician reimbursement to a value-based model. However, upon CMS's issuing of the associated regulations, he articulated concerns with MACRA's implementation, particularly physician reporting requirements. A staunch critic of the Affordable Care Act (ACA), Dr. Price has criticized the Center for Medicare & Medicaid Innovation, as well as the former administration's approach to mandatory bundled payment programs, such as the Comprehensive Care for Joint Replacement (CJR) model.

Ms. Seema Verma's healthcare background has been as the Founder and President of SVC, Inc., a national health policy consulting firm. She was the architect of the nation's first consumer-directed Medicaid program, Healthy Indiana Plan (HIP), under Indiana Governor Mitch Daniels, and designer of Governor Mike Pence's HIP 2.0 waiver proposal. She has assisted a number of other states with 1115 waiver applications, including Iowa, Ohio, and Michigan.

What to Watch: Implications for Governing Boards

In light of the backgrounds of Representative Price and Ms. Verma, as well as the policies articulated by President Trump, expect full steam ahead to repeal and replace the ACA (likely a two- to three-year implementation). In anticipation of these reforms, governing boards of hospitals and health systems can expect to see the following trends and shifts in healthcare policy and payment direction.

Increased flexibility for states: Given Ms. Verma's background, it is likely that the new administration will work with states to reform Medicaid delivery and payment models. This trend will shift decision making from CMS to governors and state legislatures. As part of this shift, a potential movement to state block grant funding will likely signal payment cuts to providers.

What to watch: Longer term, hospitals and health systems should prepare for the possible increase of underinsured beneficiaries and greater levels of bad debt. There will be an increased focus on care management and patient coordination strategies by providers. Expect states to move away from fee-for-service reimbursement toward alternative payment models (APMs) (case rates or capitation). Pay attention to your state's approach to restructuring its Medicaid program—benefits to be provided, eligibility, funding, payment models, etc.

Medicare reform: Both Representative Price and Representative Paul Ryan have proposed reforms to Medicare that couple entitlement reform with payment changes (possible use of vouchers with health plan choice and competition). Congress and the administration may pursue a similar approach, which will lead to a stronger health plan marketplace (choice) coupled with restructuring of co-pays and deductibles through a shift toward defined contribution/premium support (vouchers, means testing, etc.). There should be continued support for Medicare Advantage health plan offerings (Medicare HMO).

What to watch: Assess your payer (health plan) alignment and contracting strategies relative to Medicare Advantage enrollees, as there will likely be an increased emphasis to move away from fee-for-service Medicare, through the pursuit of value-driven health plan options. Having a partnership or close working relationship with a medical group, independent practice association (IPA),

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Key Board Takeaways

Boards must not be distracted by short-term uncertainty resulting from a new administration. A longer-term vision and orientation is essential to see opportunities for innovation and different approaches to healthcare delivery. A few considerations for boards include:

- "Repeal and replace" intentions for the ACA will be more difficult to do than to talk about. Expect change to occur over a two- to three-year implementation period.
- Prepare for increases in underinsured beneficiaries and higher bad debt for hospitals and health systems.
- Expect to see more support for Medicare Advantage programs, and a move away from fee-for-service Medicare with emphasis on value-driven health plan options.
- Physician alignment will be essential. Develop high-value provider networks and relationships with aligned financial and clinical incentives.