Provider scale strategies: The evolving landscape

Scott Lichtenberger, MD; Rupal Malani, MD; Neha Patel; and Saum Sutaria, MD
Provider scale strategies:
The evolving landscape

*M&A remains an important option for health systems, but targets and strategies are shifting. While traditional economies of scale will continue to be a strong stimulus for M&A, providers will likely seek and achieve value creation much differently in the future.*

Although merger announcements from several large health insurers garnered most of the headlines last year, provider M&A deal volume remains strong. On average, in the past five years, more than 70 deals were struck annually (Exhibit 1), up from 40 per year in the previous five years.

Deal value also has increased (Exhibit 2). Average annual revenues per transaction, which were $136 million in nominal dollars between 2005 and 2010, rose to $250 million in the subsequent five years.\(^1\) Average annual revenues per acquired hospital also grew, from $90 million to $150 million. The growth in deal value reflects the overall increase in provider consolidation, not just the impact of a few especially large deals. The three provider megamergers that occurred in 2012 and 2013 accounted for less than 20% of the aggregate revenues ($107 billion) of all health systems targeted for M&A between 2010 and 2015.\(^2\)

In the past several years, health systems have also been growing through non-M&A deals such as joint ventures and partnerships. These capital-light deals are often struck not only to achieve scale benefits but also to improve care coordination, attract and retain physicians, or better position the organization for value-based contractual arrangements (e.g., accountable care organizations).

The increase in provider deal activity has been prompted by a range of industry changes, including payor consolidation, the emergence of narrow networks, rising regulatory pressures and compliance costs, and shifts in where care is delivered. Today’s health systems recognize a growing need for network adequacy if they are to capture greater share in a risk-based world, and are beginning to appreciate that they cannot rely solely on traditional economies of scale if they are to withstand the pressures on their profitability and balance sheets.

However, a comprehensive analysis of recent provider deals reveals that the landscape is evolving in several important ways, with important implications for the future of health system M&A. In particular, three trends have emerged from the most recent wave of consolidation:

- **Midsize systems**—those with $1 billion to $5 billion in revenues—are now in the lead as both buyers and targets, and they are focusing significantly on in-market scale.

- The number of small health systems (those with less than $1 billion in revenues) is dwindling, and most that remain are not ideal acquisition targets.

- Health systems are becoming increasingly deliberate about what they hope to achieve through M&A and have pursued strategic and opportunistic acquisition patterns that go beyond just adding more acute care beds.

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Part of the reason the provider industry remains fragmented is that most deals in recent years—especially since 2013—have involved small or midsize health systems. Between 2007 and 2014, the number of midsize systems increased by about 20%, and these systems now account for about 35% of all US health systems. Although some midsize systems have expanded their geographic reach, much of the consolidation has been within existing and adjacent markets. Midsize systems were either the first- or second-largest care provider in 183 metropolitan statistical areas in 2007 but in 226 MSAs in 2014 (Exhibit 4). On average,

In this article, we discuss these trends, their implications for health systems, and key issues provider executives should consider.

Rise of the midsize systems

Despite the increase in deal activity, the provider landscape remains comparatively fragmented. If the three announced payor deals go through, the top five payors’ share of the commercial market will likely increase from 54% to 61% (Exhibit 3). In comparison, the top 20 health systems’ share of overall healthcare spending rose only from 26% to 28% between 2010 and 2014.

EXHIBIT 1 M&A hospital deal volumes have surged in the past five years

<table>
<thead>
<tr>
<th>Number of deals</th>
<th>Strategic deals (acquirer is hospital or health system)</th>
<th>Private equity deals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>43</td>
<td>3</td>
</tr>
<tr>
<td>2006</td>
<td>40</td>
<td>11</td>
</tr>
<tr>
<td>2007</td>
<td>48</td>
<td>4</td>
</tr>
<tr>
<td>2008</td>
<td>40</td>
<td>9</td>
</tr>
<tr>
<td>2009</td>
<td>34</td>
<td>11</td>
</tr>
<tr>
<td>2010</td>
<td>51</td>
<td>9</td>
</tr>
<tr>
<td>2011</td>
<td>62</td>
<td>9</td>
</tr>
<tr>
<td>2012</td>
<td>70</td>
<td>11</td>
</tr>
<tr>
<td>2013</td>
<td>84</td>
<td>12</td>
</tr>
<tr>
<td>2014</td>
<td>69</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>78</td>
<td>11</td>
</tr>
<tr>
<td>2015</td>
<td>74</td>
<td>4</td>
</tr>
</tbody>
</table>

Analysis does not include independent hospitals (those not part of a health system). Data for 2015 are not yet available. Midsize systems covered 270 metropolitan statistical areas in 2013, compared with 248 MSAs in 2007.

1 Only deals involving the acquisition of a hospital or health system target are included. The acquirer was either a hospital/health system or private-equity investor (the private-equity investments were either buy-outs or add-on investments). The counts do not include joint ventures, partnerships, or deals involving specialty hospitals (e.g., behavioral, rehabilitation, or inpatient cancer facilities).

Source: McKinsey analysis of Levin data
midsize systems today operate in three markets and have a 37% share of inpatient admissions within those markets; the comparable figures for large systems are 19 markets and 28% share.

In the past five years, midsize systems have been more active as buyers than large systems, and have been acquisition targets more often than small systems (Exhibit 5). The shift may reflect a change in strategy at some mid-

### EXHIBIT 2 Aggregate M&A hospital deal value has tripled

<table>
<thead>
<tr>
<th>Aggregate revenues of M&amp;A targets</th>
<th>Total number of hospitals acquired</th>
<th>Average revenue/hospital acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ billions</td>
<td>Number</td>
<td>$ millions</td>
</tr>
<tr>
<td>107</td>
<td>740</td>
<td>150</td>
</tr>
<tr>
<td>380</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

1 Does not include specialty hospitals (e.g., behavioral, rehabilitation, inpatient cancer facilities). Revenue numbers are in nominal dollars. Medical cost inflation rose by a compound annual growth rate of 3% during the ten years evaluated.

Source: McKinsey analysis of Levin data

### EXHIBIT 3 Segments across the healthcare continuum are consolidating at varied rates

**Urgent care**
- Top 4 urgent care players had a 1% market share between 2010 and 2015

**Hospitals**
- Top 20 health systems’ share of spending increased from 26% to 28% between 2010 and 2014

**Payors**
- Top 5 payors’ commercial market share is currently 54%

**Dialysis**
- Top 2 providers’ market share increased from 65% to 85% between 2010 and 2015

Source: HealthLeaders InterStudy (2010, 2015); Modern Healthcare (2010 and 2015)
size systems. Rather than acquiring relatively underperforming smaller assets as a way to add acute care beds, some midsize systems may be pursuing M&A with similarly sized players to improve their scale and performance. The midsize systems acquired during the past three years had an average operating margin of 3.8%, close to the average of nonacquired peers of similar size. By contrast, the average operating margin was –2.1% among the small systems acquired by midsize players and 1.8% among their nonacquired peers.

**Dwindling number of attractive small systems**

Fewer small health systems remain, and those that do cover fewer geographic areas and are less likely to be market leaders (Exhibit 4). In 2007, about 350 systems with revenue below $1 billion operated independently. By 2014, that number had dropped to 232. Small systems provided care in 277 markets in 2007 but only 231 markets in 2014. Furthermore, in 2014, small systems were the number-one or number-two provider in only 60% of the markets they served, compared with 83% for midsize systems. Revenue share for small systems fell from 30% in 2007 to 16% in 2014.

The small systems acquired by another system of any size had worse financial performance than nonacquired peers of similar size (operating margins of –0.6% and 1.8%, respectively), suggesting that the acquired systems may not have been strong enough to support the larger systems.

### EXHIBIT 4  Systems with revenues over $1 billion are expanding geographically and gaining market share

<table>
<thead>
<tr>
<th>Compound annual growth rate, 2007–2014, %</th>
<th>Systems with over $5 billion in revenues</th>
<th>Systems with $1–5 billion in revenues</th>
<th>Systems with &lt;$1 billion in revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average system revenues</strong> &lt;sup&gt;1&lt;/sup&gt; $ billions</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Average system admissions</strong> Thousands</td>
<td>–6</td>
<td>–4</td>
<td>–2</td>
</tr>
<tr>
<td><strong>Average number of MSAs</strong></td>
<td>2</td>
<td>1</td>
<td>–3</td>
</tr>
<tr>
<td><strong>Growth in top market share</strong> &lt;sup&gt;2&lt;/sup&gt; Number of MSAs where #1 or #2</td>
<td>2</td>
<td>3</td>
<td>–6</td>
</tr>
</tbody>
</table>

<sup>1</sup>Historical five-year operating-margin data are not available.

<sup>2</sup>This statement applies to health systems, not to individual facilities.

<sup>3</sup>American Hospital Association data for 2015 were not available for this analysis.

<sup>4</sup>These numbers are based on all health systems with less than $1 billion in revenues acquired between 2012 and 2015, regardless of the size of the acquirer. Historical data for 2010 and 2011 were not available for this analysis.

<sup>5</sup>Systems with zero or negative revenue reported, as well as systems with zero acute beds reported, are excluded. Analysis also excludes independent hospitals.

<sup>6</sup>Top market share is determined by the number of admissions. The number of systems in each size category is held constant at 2014 levels to accurately show change in market share within each category.

Source: American Hospital Association annual hospital database 2007 and 2014

MSA, metropolitan statistical area.
Midsize systems are increasingly becoming both acquirers and targets of M&A

**Number of deals by buyer size, %**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Over $5 billion</td>
<td>244</td>
<td>412</td>
</tr>
<tr>
<td>$1–5 billion</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>&lt;$1 billion</td>
<td>42</td>
<td>37</td>
</tr>
</tbody>
</table>

**Aggregate target revenues, %**

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Over $5 billion</td>
<td>35 billion</td>
<td>107 billion</td>
</tr>
<tr>
<td>$1–5 billion</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>&lt;$1 billion</td>
<td>79</td>
<td>58</td>
</tr>
</tbody>
</table>

1 Acquirers are quantified by the number of deals instead of aggregate target revenues because the latter skews the analysis in favor of larger systems (on average, they make larger acquisitions).

2 Targets are quantified by their revenues to maintain consistency with all other exhibits and analyses in this article. Targets include health systems as well as independent hospitals.

Source: McKinsey analysis of Levin data

Financially to remain resilient in the face of acquisition interest. It may also suggest that the small systems remaining today may be too expensive to purchase.

**Expanding acquisition strategies**

In the past few years, health systems appear to have pursued M&A for a variety of reasons, not simply to achieve traditional economies of scale. When the deals are analyzed carefully, several strategic and opportunistic patterns emerge. Among the most important of these are differences in geographic preferences and increased activity by academic medical centers (AMCs) and faith-based systems.

**Geographic preferences**

Proximity has been a focus for many systems (presumably, to build or maintain local relevance). Not-for-profit systems, in particular, have favored deals within their existing areas. Between 2013 and 2015, 66% of the targets acquired by not-for-profit systems operated in MSAs where the acquirers had existing facilities; 93% of the targets were in states where the acquirers had a presence. For example, OSF HealthCare, Novant Health, and Piedmont Healthcare all made acquisitions in which there was overlap between MSAs where they already owned at least one facility and where the target had a presence.

Investor-owned systems appear to be more willing to pursue deals across regions. Between 2013 and 2015, only 52% of the deals undertaken by these systems were in MSAs where both the acquirer and target had at least one facility; 64% were in states where both were already present. In the Tenet/Vanguard deal, there were no shared MSAs;
AMCs and faith-based systems have recently become more acquisitive

**Acquisitions by system/hospital type, %**

<table>
<thead>
<tr>
<th>System/Hospital Type</th>
<th>2005–2010 Aggregate target revenue</th>
<th>2010–2015 Aggregate target revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMC</td>
<td>12%</td>
<td>28%</td>
</tr>
<tr>
<td>Faith-based</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>70%</td>
<td>47%</td>
</tr>
</tbody>
</table>

AMCs, academic medical centers.
' Targets include health systems and independent hospitals.
Source: McKinsey analysis of Levin data

the two companies did share one state, however. CHS gained 20 new MSAs when it acquired HMA in 2013.

**Academic medical centers**

AMCs are making an increasing number of acquisitions—from zero in 2005 to four in 2010 and 20 in 2015. Acquisitions by AMCs accounted for more than 25% of aggregate target revenues over the past five years (Exhibit 6).

In most cases, AMCs have focused on building in-market scale via hub-and-spoke arrangements with community hospitals or, in larger markets, “hub-and-hub” relationships with other tertiary providers. About two-thirds of the 86 AMC acquisitions between 2010 and 2015 involved community hospitals, and about 70% of the acquisitions operated within 50 miles of their acquirers, which suggests the AMCs are making a network and referral management play. Recent examples of AMCs creating in-market scale through acquisitions include the Northwestern/Cadence deal in Illinois, the Penn Medicine/Lancaster General Health deal in the Philadelphia area, and Jefferson Health’s multiple acquisitions in that area. In 13 cases, AMCs targeted other AMCs.

**Faith-based systems**

Faith-based systems, too, are showing growing interest in M&A. Acquisitions by faith-based systems accounted for 25% of aggregate target revenues from hospital M&A deals between 2010 and 2015, up from 18% in the previous five years.

Although most faith-based systems are Catholic, they often acquire secular targets. In 2015, for example, ten of the 14 acquisitions made by these systems were secular. Recent examples of faith-based/secular deals include the St. Mary’s Health Care System acquisition of Ty Cobb Regional Medical Center in Georgia and Mercy Medical Center’s acquisition of Skiff Medical Center in Iowa. A recent example of a deal involving two faith-based systems is Trinity Health System’s acquisition of St. Joseph’s Hospital Health Center in New York.

**Implications for providers**

Evolution of the M&A landscape has important implications for provider executives. Here, we describe the four decisions that are most important for them to make, as well as the rationale for each recommendation. Once these decisions are made, provider executives should be well positioned to identify appropriate targets for acquisition.
Define your role in the midmarket battleground
Consolidation will likely continue, but the players will change

Although the regulatory environment may become increasingly challenging (as the Federal Trade Commission’s objections to the North-Shore/Advocate merger suggest), deal activity will likely continue. We believe three major acquirer archetypes are emerging:

Super-regionals (e.g., Carolinas, Baylor Scott & White) will continue to expand within existing and adjacent markets to increase local relevance. Much of the deal activity in the past few years supports this hypothesis. A number of midsize systems began to pursue M&A only recently and have yet to unlock the full benefit of scale. As a result, a growing number of super-regionals could emerge.

Academic aggregators (e.g., Partners) will continue to build on their hub-and-spoke models. In some cases, the expansion will come in the form of partnerships, but many AMCs appear to have a clear preference for full integration to achieve economies of scale across a larger set of assets and to gain other benefits. About 100 US AMCs have revenues between $1 billion and $5 billion. Of these, about 60 currently have limited networks (zero to two hospitals) beyond their main teaching hospital. In all but a single case, these AMCs have at least one community hospital within 50 miles they could potentially target.

Nationals (e.g., Tenet, HCA, Ascension, CHI) will likely continue to make acquisitions within their existing markets and expand into new markets when it makes sense to do so. However, these organizations may be more cautious in pursuing M&A now than they were in the past, given the existing debt on their balance sheets (they have three times or more the level of debt of a typical midsize system), as well as their need to protect cash reserves and, in some cases, continue integrating existing assets.

Be bolder in realizing synergies
The imperative to realize value will become increasingly important

The targets’ size and multiples (enterprise value to revenue) are rising: between 2012 and 2015, the average hospital acquisition’s multiple increased from 0.6 to 0.8. Because the need to achieve greater value creation has become more pressing, provider executives will be increasingly compelled to identify potential synergies, articulate a deal’s rationale to justify the purchase price, and then realize the synergies once the deal is completed. Two factors may hamper their efforts, though. As health systems grow larger, there are fewer traditional synergies to capture and more organizational complexities to deal with.

- Fewer traditional synergies. Many health systems have realized value from acquisitions through traditional synergies (e.g., back-office administration). Once a health system reaches scale, however, traditional synergies will deliver at best only marginal returns, and the remaining value-creation opportunities will be in areas more difficult to capture—in particular, those more clinical in nature. Greater emphasis will thus need to be placed on clinical integration of assets to improve care coordination, physician alignment, and growth, as well as to decrease variability in clinical decision making.
Define your portfolio of scale

Scale continues to be relevant, but the type of scale will matter

Regardless of what further changes occur in the healthcare industry over the next several years, scale will continue to be important for health systems. Our analysis shows that greater size correlates with stronger performance and a better ability to withstand growing pressures on profitability, balance sheets, and market structure (Exhibit 7). On average, operating costs are more than

EXHIBIT 7  On average, health systems with greater geographic scale and market concentration are more efficient

<table>
<thead>
<tr>
<th>Operating expenses per case mix index-adjusted admission, by system type¹</th>
<th>Operating expenses per case mix index-adjusted admission, by market share</th>
</tr>
</thead>
<tbody>
<tr>
<td>System type, $ thousands</td>
<td>Average share in top 50 MSAs, $ thousands</td>
</tr>
<tr>
<td>National</td>
<td>High per-MSA share</td>
</tr>
<tr>
<td></td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>8.4</td>
</tr>
<tr>
<td>Super-regional</td>
<td>Moderate per-MSA share</td>
</tr>
<tr>
<td></td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>7.8</td>
</tr>
<tr>
<td>Local</td>
<td>Low per-MSA share</td>
</tr>
<tr>
<td></td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>10.3</td>
</tr>
<tr>
<td>Sub-scale</td>
<td>Non-AMC providers</td>
</tr>
<tr>
<td></td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>AMC providers</td>
</tr>
<tr>
<td></td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>7.0</td>
</tr>
</tbody>
</table>

¹Includes AMCs; systems with zero or negative revenue reported, systems with zero acute beds reported, are excluded; top market share is determined by the number of admissions. Analysis does not include independent hospitals.
²Health systems were defined as follows: national if at scale in 6 or more MSAs; super-regional if at scale in 3–5 MSAs; local if at scale in 1–2 MSAs; sub-scale if not at scale in any MSAs. “At scale” is defined as having >15% share of inpatient admissions in a given MSA.
³Weighted average share of inpatient admissions across MSAs in which system provides care; define as high if weighted average share is >30%; moderate if weighted average share is 15–30%; low if weighted average share is 2–15%.

Source: AHA hospitals report 2013; Medicare cost report 2013

Organizational complexities. A multitude of challenges are inherent in all large integrations, but the challenges are especially acute when the integration involves a health system, rather than a single hospital. Among the difficulties the acquirer will face are the need to manage a range of multifaceted organizations, many of which may have different cultures, and to employ more complicated value-capture levers. As a result, the acquirer will have to establish clarity on organizational structure, decision-making rights, and expectations during the deal phase; it should not count on settling those issues after the close.

Nevertheless, it is crucial that provider executives be able to accurately assess the true value-creation opportunity before executing a deal and put in place plans that can achieve savings or growth.
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11% higher at smaller, “local” systems than at national systems. Super-regional systems with more than $5 billion in revenues are, on average, 7% more efficient than super-regionals with revenues below $3 billion.

In the future, however, traditional economies of scale such as improved cost management will not be sufficient to enable health systems to compete effectively, so health systems must seek other advantages that scale can bring. For example, greater size can provide better access for patients and broader networks of coordinated care that lead to improved outcomes. Scale can also help build brand value and consumer loyalty. Employers also gain value from scale: they can develop agreements with a health system to reduce costs, but only if the system has a network large enough to cover all of their employees.

Although many health systems have already achieved scale, they may want to consider new consolidation opportunities. As they do so, they should be thoughtful about where to invest. Acquiring facilities in disparate markets provides limited additional value once minimum effective scale has been reached. It is often wiser to focus on gaining local market leadership (i.e., first or second position in share) and integrating care delivery more effectively. Our analysis of 50 MSAs shows that health systems

Key insights about provider M&A

- The total volume and value of provider deals remain high—and not just because of a few megadeals.

- Midsize systems, which now account for more than one-third of all US health systems, are playing an increasingly prominent role in deal activity. These systems are currently more active as buyers than large systems, and are acquisition targets more often than small systems. We expect this trend to continue, especially because the number of high-performing small systems is dwindling.

- Many acquirers, especially not-for-profit health systems, are focusing on geographic proximity, not expansion to new markets. However, investor-owned systems appear to be more willing to pursue deals across regions.

- Academic medical centers and faith-based health systems are making an increasing number of acquisitions. Together, they now account for more than half of aggregate target revenues.

- Scale matters. Our analyses show that systems with higher local market concentration are more cost-efficient. Furthermore, the imperative to achieve cost synergies will only increase, given the size, complexity, and multiples of likely future deals.

- When contemplating acquisitions, provider executives need to think beyond the traditional economies of scale. They should carefully define their strategic approach to M&A (especially in the midmarket battleground), be bolder and more aggressive in realizing synergies, consider the other advantages scale can bring, and use consolidation to build or obtain the advanced capabilities needed to compete in the future.
with high market share are, on average, about 17% more efficient on a cost basis than those with low share. Interestingly, the majority of the high-market-share systems are midsize.

For health systems that have not yet reach minimum effective scale, aggregating facilities in existing or adjacent markets is likely to be another wise move. Aggregation will not only enable the systems to reach sufficient scale, but also allow them to afford the corporate capability building required to succeed in a value-based environment.

The health systems operating on a national scale appear to have grasped this point. Their actions suggest they believe that success within markets requires share leadership; they focus on building local market scale and exit a market when this is not possible. If they continue on this path, they will likely make additional investments in existing markets—for example, to acquire ambulatory facilities.

Enhance capabilities along the way
Economies of scope and skill become more relevant

Consolidation can also allow health systems to acquire or develop economies of scope and skill. Greater scale can help them avoid what would otherwise be duplicate investments, such as spending on patient engagement platforms. Perhaps more important, it can establish a more robust asset base to support next-generation strategies. For instance, greater scale can permit health systems to acquire new capabilities that provide a near-term competitive advantage and may become table stakes in the near future. Examples include advanced analytics to identify trends that could influence clinical interventions (e.g., disease prevalence analysis, readmissions prevention tools), precision medicine, digital technology to improve patient engagement and care coordination, and more sophisticated management tools. By using scale to gain these capabilities, health systems put themselves in a better position to succeed in an increasingly complex environment.

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Although provider M&A deal volume remains strong, the nature of the deals and the strategic intentions are evolving. When considering future acquisitions, provider executives should think beyond traditional synergies; they deliver at best only modest returns once minimal efficient scale is reached. Instead, provider executives should ground future deals in a clear strategy and focus on identifying and extracting value from economies of scope and skill. In that way, they can create significant value and compete more effectively in this dynamic healthcare environment.

Scott Lichtenberger, MD (Scott_Lichtenberger@McKinsey.com), is a partner in McKinsey’s Denver office. Rupal Malani, MD (Rupal_Malani@McKinsey.com), is a partner in the Cleveland office. Neha Patel (Neha_Patel@McKinsey.com) is an associate partner in the Washington, DC office. Saum Sutaria, MD (Saumya_Sutaria@McKinsey.com), is a senior partner in the Silicon Valley office.

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For more information, contact McKinsey_on_Healthcare@mckinsey.com

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