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The Governance Institute

Hospital Governance following a Merger or Acquisition: The View from Both Sides

By Larry S. Gage, Senior Counsel, *Alston & Bird LLP*

Despite recent divestiture announcements, merger mania in the hospital industry shows little sign of losing steam. In 2024, together with Alvarez & Marsal, my law firm conducted a survey of governance practices at 17 high-performing non-profit health systems. Since our original 2015 survey, these systems have continued to grow—from 241 hospitals to 375, and from $77 billion to over $155 billion in net revenue.

Our survey sought to identify governance "best practices" of large non-profit systems across a range of domains. One area of particular focus was how mergers and acquisitions impact both system-wide governance and the governance of the individual hospitals or smaller systems being acquired. Often, the governance expectations of the acquiring entity do not match up smoothly with those of the acquisition target. These misalignments can pose significant risks—at times leading to stalled or even abandoned transactions.

The purpose of this article is to identify the governance issues and challenges inherent in the continued growth and consolidation of the hospital industry, from the viewpoint of both acquiring systems and the hospitals being acquired.

The Perspective of the Health System

Most of the multi-hospital systems surveyed placed clear limitations on the powers and decision-making authority of boards at acquired hospitals. In several systems, owned

What's Inside:

hospitals either no longer have their own boards or are part of a governance structure with regional or "market" boards that are responsible for several hospitals.

Across surveyed systems, governance structures varied substantially:

- Nine reported that "some owned hospitals and/or systems have fiduciary boards."
- Six reported that "some owned hospitals and/or systems have advisory boards."
- Three reported that "no owned hospitals or regional systems have boards."

However, the trend is toward eliminating local or regional boards or reducing them to an advisory role.

The three systems without separate subsidiary boards instead deploy mirror boards in which system board members simultaneously serve on boards of other licensed entities. One of these systems also has a local advisory council at each community hospital.

In some cases, acquisitions or mergers (including mergers of equals) have triggered changes in system governance. The most common change has been the addition of board members from the acquired organization to the system board. While often well-intentioned, for some systems this led to constituency representation that was not conducive to effective governance of the entire system.

In other situations, a merger target retained a separate fiduciary board due to unique circumstances. In one system, the acquired organization needed to remain a faith-based entity, while the acquiring system was secular. In another, involving the acquisition of a small community system by a major teaching hospital, a fiduciary board was preserved because of substantial differences in mission and strategic goals between the two organizations.

For systems with both fiduciary and advisory boards, many of these structures persist for historical reasons or because they were required by the acquired hospital as part of the merger agreement. In most cases, however, the acquiring system has imposed a transition plan to narrow local fiduciary authority over time.

> "Having well-intentioned board members is not the same as having a high-functioning board, and the wrong governance can be an anchor to a system."
> *—Wright Lassiter III, CEO, CommonSpirit Health*

Governance Responsibility of Subsidiaries

Local/Subsidiary Committees	Count
Patient Care Quality and Safety	12
Governance / Nominating	10
Other	8
Executive	7
Finance and Investments	5
Executive Compensation	2
Community Benefit Finance	2
Strategic Planning	1
Board Education and Development	1
System Strategy and Planning	1

Note: A majority of systems reported that the Patient Care Quality and Safety (71%) and Governance/Nominating (59%) committees are committees of local or subsidiary boards. Only one system indicated that strategic planning was a committee at the local or subsidiary level. Systems that responded "Other" included local or subsidiary committees for Credentialing, Physician Compensation, Medical Executive Staff, Development, Community Benefit (no financial component), and Community Relations.

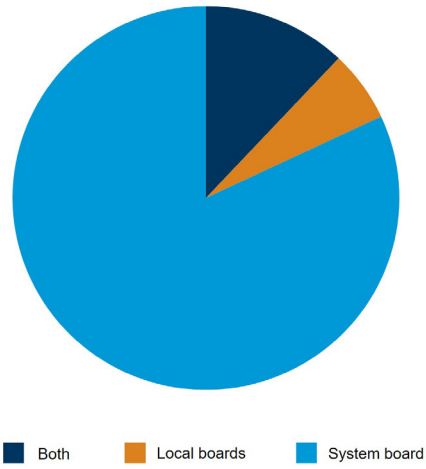
System boards continue to assume more fiscal and strategic responsibilities for owned hospitals. Best practices identified for subsidiary hospital boards include:

- Making local boards primarily advisory, with fiduciary duties (if any) limited to certain matters.
- Streamlining local boards by minimizing the use of committees and reducing the number of board meetings.
- Where appropriate, implementing "mirror" boards for subsidiaries, which meet concurrently with the system board.

In those systems that do have local hospital boards, the role of those boards has been redefined in recent years. Localized duties and responsibilities typically focus on:

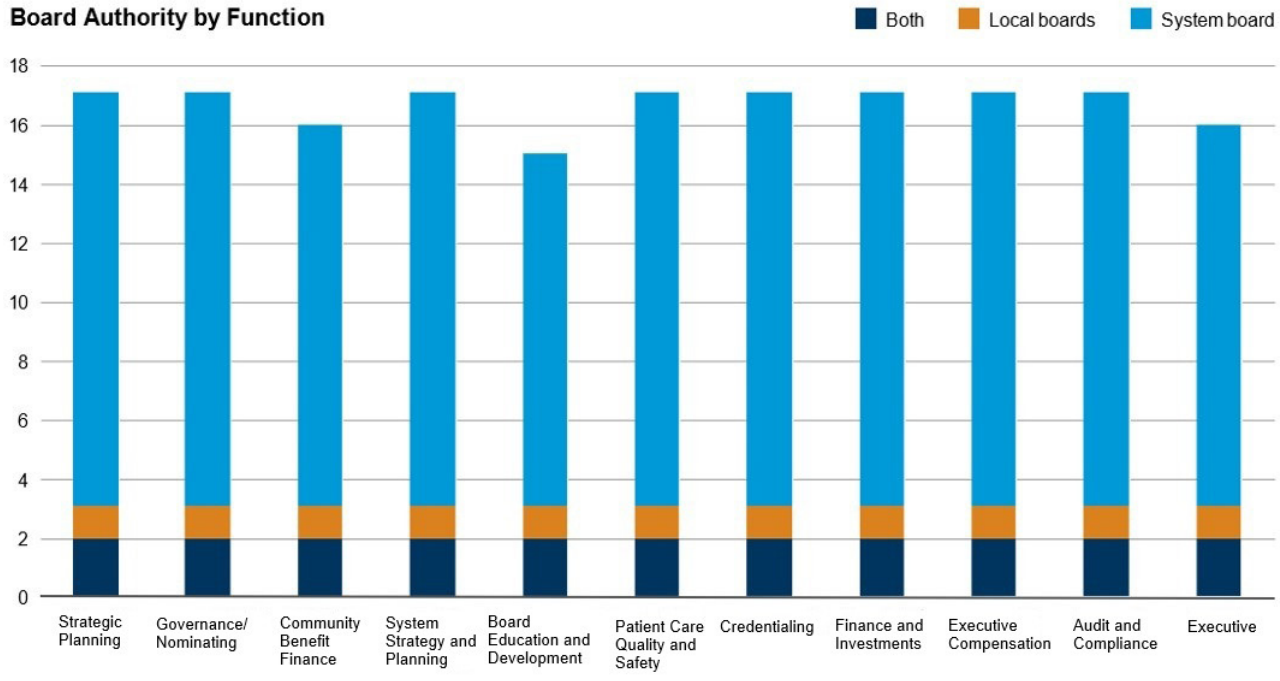
- Maintaining and improving linkages to their communities
- Monitoring quality of care
- Patient and employee experience
- Credentialing medical staff

Authority of Boards



Note: Aggregate of Responses on Authority by Function, System, vs. Local Board

Board Authority by Function



Note: A majority of systems reported that authority by function lies with the system board.

The Perspective of the Hospitals Being Acquired

Many of the hospitals being acquired by large systems today are stand-alone hospitals or part of small regional systems. Historically, such hospitals have faced a wide range of challenges. Many smaller stand-alone hospitals have struggled to meet the average operating margins that are expected by most not-for-profit hospitals. This is due to a variety of factors, including lack of scale, poor payer mix, high overhead costs, fewer high-margin specialty service lines, lower revenue base, and difficulty recruiting physicians. Events of the last year have dramatically increased the stakes for stand-alone hospitals, and a toxic combination of federal budget cuts, soaring labor and supply chain costs, reimbursement pressures, and a rising tide of uninsured patients have exacerbated these pressures.

The challenges are particularly daunting for rural hospitals. **A February 10, 2026 report** estimated that as many as 417 rural hospitals across the country are at risk of closure. For many of these hospitals, a merger with or acquisition by a larger system may be the only viable path forward.

For acquisition targets, it is important to consider governance implications at the outset—not as an afterthought. The governance models of large systems should by now be fairly well known or can be evaluated through "reverse due diligence." While some systems have done away with fiduciary governance at the subsidiary level, others have permitted some measure of local responsibility. Hospital boards considering affiliation should proactively assess whether a potential partner's approach aligns with their expectations before entering into serious negotiations.

Survey Interview Insights: "Following a major merger five years ago, we now only have two members left of the legacy boards."

Specific circumstances can also influence governance outcomes. A hospital that is attractive financially, has a good payer mix, makes a margin, and dominates its local area, may be able to drive a more attractive arrangement than one that lacks those attributes. On the other hand, a hospital that does not measure up to those standards may have little leverage or not even find any interested partners in today's health market.

Among systems with local hospital boards:

- Nine indicated that those boards are appointed by and directly report to the system board.
- Four stated that they are organized locally or regionally but report to the system board.
- One reported that they are appointed locally and do not report to the system board.
- One said that local boards are appointed by, but do not report to, the system board.

Acquired hospitals should not assume they will receive a seat on the system board. This is no longer viewed as a governance best practice, unless the transaction is a merger of equals or there is some other extenuating circumstance.

When considering a potential transaction, acquisition targets should conduct a clear and candid assessment of their strengths and weaknesses before engaging in negotiations and consider all realistic options for a strong partner. If maintenance of some form of local governance is important, they should be prepared to emphasize why it matters—to the community, and to the success of the affiliation.

Interview Insights

We followed up on our 2024 survey with interviews of leadership at each of the surveyed systems. Across interviews with system leaders, a consistent message emerged: systems are restructuring governance to reduce duplication, streamline decision making, and reinforce enterprise-wide alignment:

- "By restructuring our hospital boards to just local advisory boards and doing away with fiduciary boards, we have a sense of system thinking across all hospitals. Our relationship between management and board governance is stronger than ever."
- "We have recently reduced our [local] hospital board by half (nine to 11 members) and have eliminated all committees. We want to streamline and minimize duplication across the system."
- "Our system board is no longer a constituent board. There is no fiduciary board over anything in the health system. Each hospital has a community advisory board. We have a disciplined management structure. We have a reverse hub-and-spoke model. The board members realized the most important thing they could do to serve their community was to relinquish their independence to join the system board. Once they joined, they realized the benefit their hospital would have if they adopted a system-wide mindset instead of focusing their attention only on the individual hospital that they represent."
- "We are collapsing our regions and turning these into divisions. It has gotten too confusing with having secular hospitals with fiduciary boards that operate independently. We also have different states that operate differently than others too. [State] is actually our first group of regional boards that will be collapsing this structure and putting up one regional board for [the entire State]."

Survey Interview Insights:
"We have about 250+ subsidiary companies and over 50 percent of our revenue is earned outside of hospitals. As a consequence, we have had to balance fiduciary oversight with agility in decision making and execution of strategy."

Case Study

In 2025, we worked closely with a multi-hospital system centered around a major academic medical center. In just two decades, this system grew from a single major

teaching hospital to nearly two dozen hospitals. A majority of the hospitals are owned outright, while several are operated under management agreements. The system also developed or acquired approximately 100 other subsidiaries, affiliations, partnerships, and joint ventures during this period.

Both owned and managed hospitals have retained their local governing boards. As a result, governance structures across the system vary widely in size, composition, committees, and meeting cadence. While the system's board and CEO are responsible for appointing the members of the individual hospital boards under the terms of the acquisition agreements, each local board manages its own succession planning policies and practices.

System leadership valued local boards for maintaining and enhancing community engagement, but they were concerned that the lack of a cohesive and coordinated system-wide approach to governance was impeding the ability to generate a culture of "systemness" that would enable all components of the system to work together toward common strategic goals. For example, the system brand was strong throughout its geographic area, but different governance responsibilities were impeding the development of "branded" clinical service lines on a statewide and regional basis, which is a major component of their current strategic plan.

Management of the current governance structure also proved to be challenging. With over 100 different board members, and all boards and committees meeting at least every two months, system staff found it difficult to maintain consistent messaging and oversight. On average, a board or committee meeting occurred every three to four days.

In early 2024, the system started the process of streamlining system-wide governance. The system instituted a revised set of bylaws for all owned hospitals, which clarified delegated duties to each board. However, there were remaining ambiguities about the powers and duties of local boards. For example, the revised bylaws gave a range of advisory powers to owned hospital boards in areas such as finance, audits, and planning, but did not provide the boards with decision-making authority in those areas.

Following a 2025 governance assessment, several recommendations emerged:

- Retain streamlined local community boards for owned hospitals, each with the same limited powers and duties, sufficient to satisfy the needs of the various regulatory and accrediting bodies.
- Remove formal advisory authority in areas such as finance, legal, strategic planning, and development of new services. Rather, system leadership would consult as needed with local boards and management about relevant system policies, actions, and decisions.

- Establish consistent standing committees across all community boards, such as medical staff credentialing, quality, and community engagement.

As hospital consolidation accelerates, governance alignment has become one of the most decisive factors in whether transactions succeed or fail. Systems and community hospitals alike will be best positioned for long-term stability when they approach governance not as an afterthought, but as an early, strategic element of partnership design.

Key Board Takeaways

For Potential Acquisition Targets:

- Develop a clear and candid assessment of your strengths and weaknesses before engaging in negotiations.
- Evaluate all realistic options for a strong partner before committing to one entity.
- Conduct "reverse due diligence" on potential acquiring partners.
- Emphasize that a local board is important to retain community support.
- Understand that system board seats for acquired hospitals are no longer standard best practice, unless the transaction is essentially a merger of equals.

For Potential Acquirers:

- Determine early whether local or regional boards will be retained.
- Avoid creating "constituent boards" in which the allegiance of some members may not be to the entire system.
- Maintain clear system board accountability for financial performance.
- Use local boards primarily for advisory purposes.
- If delegating fiduciary duties, limit them to credentialing, community benefit and engagement, and monitoring quality and patient/workforce satisfaction.
- Minimize committee use by local advisory boards.

TGI thanks Larry S. Gage, Senior Counsel, Alston & Bird LLP, for contributing this article. He can be reached at ***larry.gage@alston.com****. The author would also like to thank Jamal Brown and Sheridan Kelly, Associates at Alvarez and Marsal, and Grace Nelms, Associate at Alston & Bird, for their work on the 2024 survey and 2025 engagement that serve as the basis for this article.*

Recent Developments Prompt a New Approach to Board Diversity Decisions

By Michael W. Peregrine

A series of significant recent developments signal the need for boards to reassess how they approach traditional diversity factors in the recruitment, evaluation, and retention of corporate board members.

This should come as no surprise to board governance and nominating committees that have been monitoring the policy headwinds and the resulting decline in board composition practices grounded in race, gender, ethnicity, and sexual orientation.

Indeed, these new developments are likely to accelerate this decline, in favor of director selection criteria more clearly tied to selecting the best possible candidates for board membership given the strategic direction of the company. However, this may offer boards a promising opportunity to revisit and strengthen their composition strategies.

One notable development is President Trump's recent State of the Union address, in which he included amongst his administration's achievements that, "[W]e ended DE&I in America." While there may be some debate on the accuracy of that statement, it is nevertheless a very clear expression of government policy that governance and nominating committees should factor into their deliberations.

Another development is the February 16th announcement that the prominent investment bank **Goldman Sachs has decided to eliminate race, gender identity, sexual orientation**, and other elements of diversity from the factors applied by its governing board when evaluating director candidates. Previously, the Goldman board considered a broad definition of diversity that included viewpoints, background, work and military service, and "other demographics" encompassing traditional DE&I factors. **The updated framework eliminates those demographic considerations**.

Additionally, ***The Wall Street Journal*** reported on February 20th that many companies have swiftly retreated from prior DE&I-related commitments with the change in national political perspectives. The overall message of this particular story is that traditional diversity-driven board and workforce composition policies have been dramatically de-emphasized over the past several years and can no longer be described as a widely accepted practice.

Critical Questions for Boards:

- Does our current approach to board diversity create legal, regulatory, or reputational risk under today's enforcement environment?
- Are our director selection criteria truly aligned with the strategic direction, customer base, and future competencies needed by the organization?

Navigating Legal, Compliance, and Enterprise Risk

None of this suggests that corporate leaders should ignore the importance of demographic diversity in the workplace or the boardroom. For example, the latest McKinsey/LeanIn.org ***Women in the Workplace*** study describes a decline in organizational commitment to gender diversity and equality that threatens to roll back recent progress made for women. Recent reporting has also raised concerns about a potential reversion to less inclusive boardrooms.

However, these developments make it clear that board composition strategies designed to address diversity issues should now be approached with greater diligence and awareness. In the current environment, such strategies raise clear corporate compliance and enterprise risks. Indeed, any proposed board diversity-focused strategies considered by leadership should be balanced with the realities of government policies and the rigor of their enforcement, as well as third-party litigation risks. Board diversity policies that were widely adopted in prior years may now conflict with law and regulation.

This risk is most acute for board composition strategies that are not director-neutral in their impact. The same extends to related initiatives that appear to involve mandates, quotas, or are otherwise suggestive of disparate treatment in the terms, conditions, and privileges of board service. For these and other reasons, organizational leadership should work closely with experienced legal counsel before proceeding with board composition strategies involving diversity features. With the appropriate guidance, it may be possible to identify alternative composition approaches that support board effectiveness without exposing the organization to unnecessary legal and reputational risk.

Board composition strategies with diversity components must now be approached with greater diligence and awareness. In the current environment, such strategies raise clear corporate compliance and enterprise risks.

Broadening the Lens on Board Composition

A possible path forward is suggested by the well-known CEO Betsy Atkins. In a recent edition of ***Fortune***, she argues against a retreat from the basic goal of boardroom diversity, which she describes as "bringing the best minds from the broadest backgrounds" to achieve true diversity of thought and maximize governance effectiveness. She encourages board composition strategies to focus on obtaining the broadest and most relevant set of experiences in the boardroom. The aim is to avoid a narrowing of boardroom perspective that can arise when candidates are drawn primarily from professional and educational networks familiar to sitting directors.

Atkins notes that this might require expanding board skills matrices to consider "attributes [that] may not fit neatly into traditional demographic categories, but [they] can meaningfully affect strategic judgment." Depending on the company, those attributes

might include a "generational cohort, frontline operating experience, entrepreneurial background, international market leadership, digital-native fluency, and non-elite educational pathways." The overall goal is to enhance the board's ability to relate to future customers and anticipate market trends.

Thus, as one board diversity strategy fades, another may be emerging. The increasing barriers to the use of race, gender identity, ethnicity, and sexual orientation in board composition creates an opportunity for boards to revisit diversity and inclusion through the lens of a broader, strategically aligned talent pool—one that focuses more directly on expertise driven by the evolution and complexity of the company's marketplace and its consumer base. That would seem to be a worthy discussion item for the governance and nominating committee.

Key Board Takeaways

- **Review current board diversity policies through a legal and compliance lens.** Ensure they align with the current regulatory environment and do not advantage or disadvantage any individual director.
- **Reevaluate director selection criteria to ensure they are clearly tied to strategic needs.** Confirm that your skills matrix reflects the competencies required for the company's future direction.
- **Broaden the talent pipeline.** Incorporate experience-based attributes—such as digital fluency, international leadership, or frontline operational expertise—that support diversity of thought.
- **Engage legal counsel early.** Before implementing or updating board composition strategies with diversity implications, obtain clear guidance on potential risks.
- **Strengthen governance committee oversight.** Charge the governance or nominating committee with periodically reviewing board composition practices and market expectations.

TGI thanks Michael W. Peregrine, a Fellow of the American Health Law Association and of the American College of Governance Counsel.

A Question of Scale: Insights from Agriculture to Inform Hospital Strategy

By Chris Benson, Managing Director, and Adam Davis, Executive Director, *Juniper Advisory*

In both farming and healthcare, the question of scale is not simply about efficiency—it often determines whether an organization can thrive. A small farm considering the purchase of a combine harvester faces a decision much like that of a community hospital debating an investment in an MRI, a CT scanner, an electronic medical record system, or a new AI-driven clinical decision support tool. All are large capital commitments that require adequate volume to justify. Balancing those costs with utilization separates sustainable operations from those that slowly erode under financial pressure.

This comparison is more than a metaphor. It also frames a governance question for hospital boards: **when is it prudent to remain independent, and when does the scale imperative make partnership a fiduciary responsibility?**

Farming: Survival and Size

In agriculture, combine harvesters and other equipment are indispensable but expensive. A single combine can cost $500,000 or more, and its value depends entirely on how much land it covers during harvest. For most operators, the economics work only at around 2,000 acres or more, where fixed costs can be spread across enough volume to make the investment pay off.

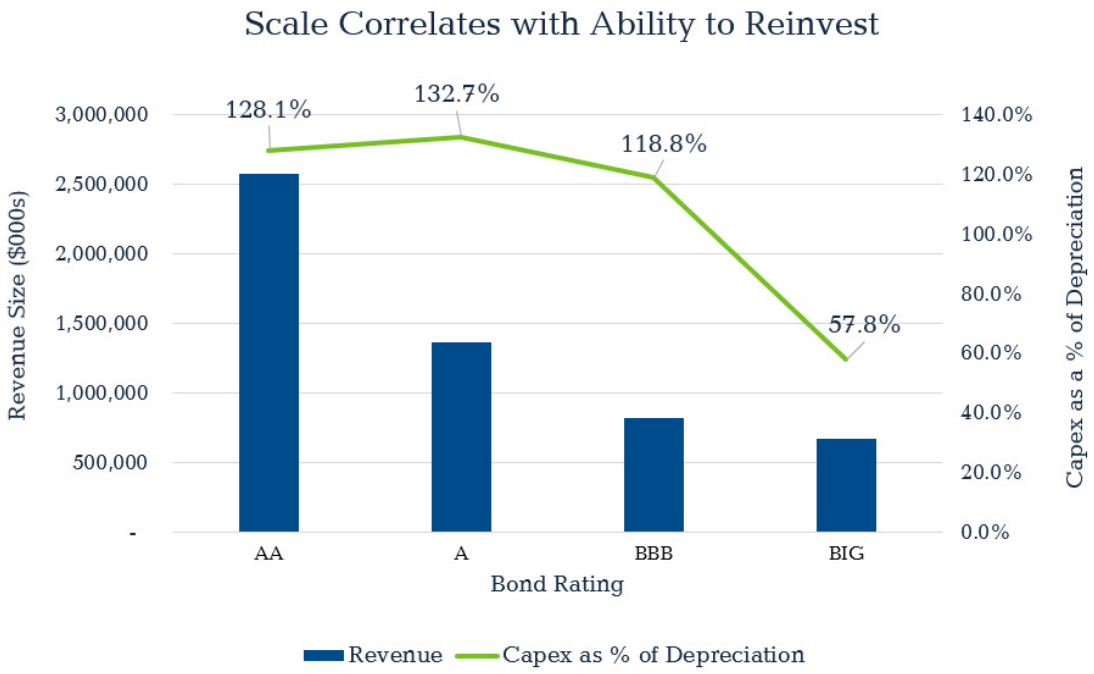
Smaller farms often cannot keep combines running long enough to justify the expense. Idle equipment raises the cost per acre and puts smaller operators at a disadvantage compared to larger competitors. Many turn to sharing equipment, joining cooperatives, or outsourcing. These steps help preserve autonomy while still gaining access to the scale benefits necessary to compete.

Hospitals: Parallel Pressures from Capital Intensity

Hospitals face remarkably similar economics, and in healthcare we have a lot of "combines." For example, advanced diagnostic equipment like MRIs and CT scanners are essential to modern care but costly. Beyond the initial purchase, hospitals must also fund installation, annual maintenance, and appropriate staffing. These same fixed-cost dynamics apply to less visible infrastructure too, such as information technology, analytics,

cybersecurity, and care-management capabilities, which are all increasingly required for both quality and reimbursement.

Like farms, hospitals with size and scale are generally better positioned to achieve operating margins to fund capital reinvestment for the future. Management teams should assess capital needs on an ongoing basis to ensure they are keeping up. Analysts and rating agencies often evaluate this through capital expenditures relative to depreciation expense. Sustained levels below 100 percent can indicate underinvestment over time. Larger organizations with debt capacity and strong reserves can more nimbly address capital requirements than smaller organizations with tight cash positions and relatively high leverage. In fact, there is a direct correlation between a hospital's revenue size, capital spending levels, and bond ratings as shown below:



Scale is a fundamental characteristic of well-capitalized hospitals. These organizations not only have the internal ability to reinvest in their physical assets, but by virtue of their bond ratings, also have access to external capital sources at a lower cost.

Small or rural hospitals rarely reach that threshold. The result is predictable: less robust systems, higher costs for services, thinner margins, and tighter budgets. Underutilized technology can drag on financial performance in the same way an underused combine does for a small farm. But unlike agricultural equipment, hospital technology cannot

simply be parked until volume materializes. Clinical expectations, regulatory standards, and quality metrics require these assets to remain fully operational for care regardless of utilization.

Integration, Quality, and Reimbursement

The financial pressures around equipment are part of a broader trend. Hospitals are increasingly expected to integrate clinically, coordinate across service lines, and manage population health under value-based reimbursement models. Large systems tend to have the centralized resources to do this well—standardized electronic records, coordinated care teams, and fewer redundancies.

Independent hospitals often lack that capacity. Analyses from the American Hospital Association (AHA) highlight consistent structural pressures for rural hospitals, including low patient volume, workforce shortages, and reimbursement constraints. These factors make it harder for smaller facilities to cover fixed costs. Without the ability to maintain state-of-the-art clinical services, patients may choose to leave the community for care, only causing further financial erosion.

Governance and the Board's Fiduciary Imperative

For hospital boards, the scale challenge is fundamentally a governance issue. Board members are fiduciaries, responsible for ensuring the long-term stability of their institutions. That duty extends far beyond balancing this year's budget. It involves evaluating whether the organization can remain viable under shifting reimbursement, workforce, and capital conditions.

Sound governance requires directors to test the assumption that independence is synonymous with strength. Boards must regularly assess whether their hospitals have the volume, integration, and capital access needed to sustain mission and quality. Failing to do so risks breaching the duty of care, which includes overseeing strategy and anticipating material risks.

Proactive boards examine partnership models and explore the potential benefits and trade-offs of affiliations before urgency limits their options. Periodically exploring partnership options does not represent giving up on local control; it is an exercise in stewardship. By initiating strategic evaluations early, boards maintain leverage to negotiate from a position of strength, preserving core values while securing a durable future.

Well before making big investments, boards should thoughtfully assess their competitive position to ensure their hospital will be there for the community over the long run.

Key Governance Insight:
Maintaining independence is not a strategy. Boards must determine whether independence supports mission or places it at risk.

Critical Questions for Boards:

- Are we large enough to sustain the capital reinvestment necessary for modern care?
- Does our current scale allow us to meet future clinical, technology, and workforce expectations?
- What partnership models should we proactively evaluate before urgency limits our options?

Key Board Takeaways

- **Ensure capital budgeting aligns with strategic realities.** Boards should confirm that major capital allocation decisions are grounded in accurate projections of future volume, reimbursement, and workforce capacity.
- **Act early.** Boards that confront scale, integration, and partnership questions before financial pressure escalates uphold their governance responsibilities, protect community access to care, and position their organizations to thrive in a consolidated environment.
- **Evaluate a range of structural options.** Shared-service models, clinical affiliations, and regional partnerships can deliver scale benefits—shared technology, group purchasing, and specialized staffing—without requiring ownership transfer. Boards should balance relationships to keep future options open.
- **Reassess independence as part of fiduciary duty.** Governance responsibility includes determining whether independence remains in the community's best interest. The duty of care requires assessing strategic options, ensuring mission continuity, and anticipating market and regulatory shifts before they create crisis conditions.

TGI thanks Chris Benson, Managing Director, and Adam Davis, Executive Director, Juniper Advisory, for contributing this article. *They can be reached at* ***cbenson@juniperadvisory.com*** *and* ***adavis@juniperadvisory.com****.*