E-Briefings

VOLUME 23 • NO. 2 • MARCH 2026

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

© The Governance Institute | GovernanceInstitute.com

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.

© The Governance Institute | **GovernanceInstitute.com**

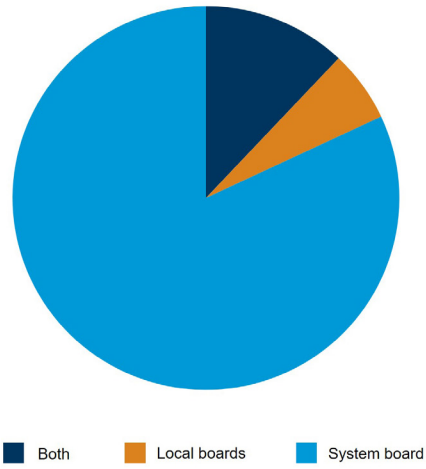
System boards continue to assume more fiscal and strategic responsibilities for owned hospitals. Best practices identified for subsidiary hospital boards include:

- 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:

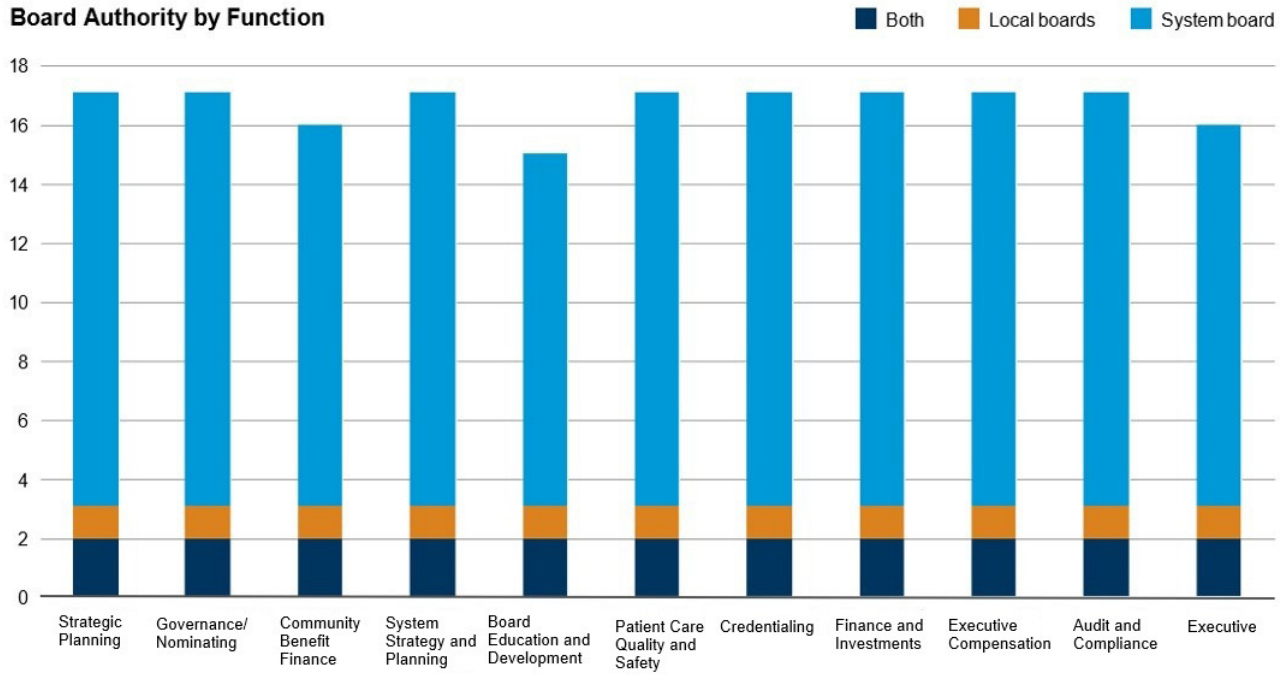
- Maintaining and improving linkages to their communities
- Monitoring quality of care
- Patient and employee experience
- Credentialing medical staff

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 Governance Institute | **GovernanceInstitute.com**

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.

© The Governance Institute | **GovernanceInstitute.com**

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

© The Governance Institute | **GovernanceInstitute.com**

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.

© The Governance Institute | **GovernanceInstitute.com**

- 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.*