Rural Hospitals' Perspectives On Health System Affiliation

The Rural Policy Research Institute (RUPRI) Health Panel

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Purpose

This brief explores the current trend in hospital affiliation from a rural perspective and offers guidance to rural hospital leaders in navigating a potential affiliation. With an understanding of the rural context and challenges facing rural hospitals, risks and opportunities across key areas for consideration are presented, including costs, quality, service delivery and system finances. The brief offers an overview of the affiliation process and how to assess success.

Introduction: Trends in Health System Affiliation

Over the last two decades, hospital systems have consolidated significantly through horizontal mergers. This has resulted in many US healthcare markets having one to three large health systems accounting for a majority of the market share [1]. Roughly 80% of US hospital markets are considered highly concentrated according to criteria set by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) [1]. According to the American Hospital Association's *Fast Facts on U.S. Hospitals, 2024,* a health system is defined as two or more hospitals owned, leased, sponsored, or contract-managed by a central organization [3]. Trends in hospital system affiliation show that from 2007 to 2016, hospital system affiliation increased across all categories of hospital size, metropolitan/non-metropolitan location, and Critical Access Hospital (CAH) status [16].

We are particularly interested in systems in an eight-state region: Iowa, Minnesota, Montana, North Dakota, Nebraska, Nevada, South Dakota, and Wyoming. Between 2018 and 2021, 10 of the 54 hospital systems in the region gained one or two hospitals, but seven of the systems lost between one and three hospitals. Among all the hospitals in the region, 55.6% were independently owned and governed, while 44.4% were part of a regional system [17].

Challenges Facing Rural Hospitals

Rural Context

Over one-third of US community hospitals are found in rural areas, providing inpatient care and other services to 60 million people, nearly 20% of the US population [2]. Those hospitals are anchor institutions in their communities and are the hubs for a host of healthcare services such as emergency care (including ambulance service), outpatient care, long term care (via swing beds), and primary care in provider-based rural health clinics [15]. They are also leaders in securing or arranging for services not delivered directly by the hospital (e.g., visiting specialty clinics, helping establish referrals). Rural hospitals are often among the top three employers in their communities [15]. Community hospitals can be the source of innovation in local health care and participants in new approaches to organizing and financing health care (e.g., the global budget model in Pennsylvania, the clinically integrated network in North Dakota). They also face headwinds that affect their ability to function effectively in a challenging fiscal environment, such as shortages of clinical and nonclinical workforce, changes in payer mix (e.g., increased percentage of revenue from public payers), and financing new infrastructure (including hardware and software for new information systems).

The RUPRI Health Panel summarizes challenges facing rural hospitals that could lead to consideration of affiliation or other strategies to ameliorate these challenges as follows:

- Patient and service volumes lack critical mass for value-based contracting
- Too few covered lives impede positive value-based performance
- Payer-designed value-based programs that are not practical in all rural settings
- Lack of purchasing power and inefficient resource utilization
- Underdeveloped clinical and financial data systems
- Difficulty providing isolated physicians with peer-to-peer support
- Inadequate training and support for leaders and managers
- Limited regulatory and payment policy voice and influence

Rural hospitals cannot remain a going concern if consistently negative operating margins threaten organizational financial viability. Pathways to solid operation require addressing the challenges just listed to operate efficiently and function effectively, sustain essential services, and implement policies and programs to succeed in a challenging fiscal environment. Multiple strategic options may be available, including network alliances with other rural hospitals, agreements with regional hospitals specific to certain functions (e.g., electronic health records, specialty clinics), and conversion to different configurations (e.g., rural emergency hospitals). This paper will focus on one strategic option – affiliation with a larger, typically urban-based, hospital system.

Affiliation should be considered as one part of strategic planning for dealing with the challenges facing rural hospitals. But that approach should be considered long before there the onset of fiscal crisis. Negotiations with systems should occur while the rural hospital organization is still in a relatively strong financial position and holds maximum negotiating power (7).

Assessing Potential Impacts of Affiliation

Researchers and policymakers have considered the potential negative impacts of health system mergers. Concerns about increased market concentration have made hospital mergers a well-represented topic in Federal Trade Commission investigations [4]. As rural hospital leaders consider mergers and affiliations, the financial impacts of the affiliation (rural hospital and the health system impacts) must be carefully explored. Additionally, community effects should be considered including changes in service costs (including out-of-pocket costs), access to high-quality services, and community members' perspectives regarding healthcare delivery (including breadth of services available in their communities).

Changes in Cost of Services

Reports on the effects of hospital mergers or acquisitions consistently show higher prices for consumers/patients stemming both from price increases in merged hospitals as well as in competing hospitals [19, 22, 18]. However, these findings were largely drawn from merging hospitals located in the same geographic market. Of perhaps more relevance for rural hospitals, a

recent spate of work has sought to understand how mergers and acquisitions across geographic markets, referred to as "cross-market mergers", affect prices. Lewis and Pflum (2017) found that relative prices increase 17% at hospitals acquired by out-of-market systems, defined as at least 45 miles away [23]. Dafny et al. (2019) suggest cross-market, within-state mergers increase prices 7-9% for acquiring hospitals [20]. The primary mechanism for cross-market, post-merger increases in price is leverage in contract negotiations with insurers, in some instance by tying hospitals together in contracting [21]. Brand et al. (2023) evaluated hospital mergers between 2009 and 2016 and found economically significant price increases, even in mergers involving hospitals up to 400 miles apart, though price effects decreased as distance between merging hospitals increased and were smaller when a small hospital distant from the merging system joined a large system [6].

Impact on Quality of Care

Quality of care for community residents could be affected in multiple ways post-merger. For instance, quality might improve with more direct access to specialty care through the system (both with telemedicine and rotating clinics) and more timely referrals. Conversely, quality could be adversely affected if merger and consolidation results in loss of local services through centralization, perhaps resulting in local residents not seeking that care. Mergers may provide increased investments from the system, sustain local care and service offerings, and improve quality of care. A recent article published in *JAMA Network Open*, provided evidence showing improved quality of care post-merger [2]. The case-control analysis compared merged hospitals to independent hospitals and controlled for patient, hospital, and community characteristics. The researchers found significant decreases in inpatient mortality for several conditions including heart failure, acute myocardial infarction, stroke, and pneumonia among patients admitted to acquired and merged hospitals, as compared to independent hospitals. The potential to increase quality of care was in part due to improvements in hospital clinical services, clinical expertise, and increased use of services [2]. Other studies have also shown that mergers and acquisitions are associated with a statistically significant reduction in inpatient readmission rates and improvements in certain outcomes and performance measures, including mortality measures [17].

Changes in Health Care Service Delivery

A critical impact of affiliation is how subsequent changes in services offered locally affect service utilization and satisfaction. Affiliation may provide investment in local services, including some that were not previously sustainable, but it also may result in loss of local community service as a result of system decisions to consolidate services elsewhere. Patient satisfaction with health care delivery is one measure of the impact of affiliation. A qualitative study on patient satisfaction of rural health systems post-merger, showed that 88% of community members believed the merger resulted in larger facilities and more services, 72% believed that healthcare quality was better, and 46% believed there was now better staffing [14].

Impact on System Finances

Health system mergers have contributed to cost savings for health systems. Acquisitions and mergers help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Analysis conducted by the American Hospital Association (AHA) showed that hospital acquisitions are associated with a statistically

significant 3.3% reduction in annual operating expenses per admission at acquired hospitals, along with a 3.7% decrease in net patient revenue per adjusted admission [17].

Rural hospitals that are less profitable, larger, for-profit, and less able to cover debt have the highest odds of merging. Thus, financial improvement opportunities are a fundamental rural hospital consideration when seeking affiliation [13]. A study of a sample of hospitals from 2009-2015 found that cost savings resulted from lower prices paid for medical and surgical supplies, particularly on the purchase of physician preference items [4]. However, savings were to local hospitals, and not necessarily to the total system. Another study of rural health systems pre- and post-affiliation found higher profitability (total margin, operating margin, cash flow margin), better ability to cover debt payments, and higher revenues from outpatient services when compared to inpatient services and higher patient deductions [5].

Actions to Support Decision Process for Affiliation

Deciding When to Affiliate

Affiliation should be considered as one part of strategic planning for dealing with the challenges facing rural hospitals. But that approach should be considered long before there the onset of fiscal crisis. Negotiations with systems should occur while the rural hospital organization is still in a relatively strong financial position and holds maximum negotiating power [7].

Rural hospital systems should consider several key factors when deciding whether to affiliate, including newly realized efficiencies resulting in lower prices, improved quality of care, and enhanced products and services [4]. They may also address operational and financial factors of concern such as 1) decreased inpatient utilization of services, 2) constrained ability to recruit clinicians, 3) lack of access to capital, and 4) diminishing reimbursement [7].

Choosing Advisors

External advisors help the hospital board of directors: 1) understand the organization's goals and needs, 2) evaluate a wide range of potential partners that can be vetted under a competitive process, 3) generate and cultivate support for affiliation among key stakeholders, and 4) maintain oversight on a well-structured comprehensive process and be capable of addressing regulatory concerns [7]. Having a knowledgeable team of advisors familiar with the organization's history, goals, and needs is a critical step for successful affiliation. It is also essential that legal, financial and communication professionals are consulted so that the most ideal negotiation terms can be obtained, and that important information can be properly conveyed to the stakeholders [7].

Engaging all Key Decision Makers in the Healthcare Organization –Organization Executives, Board of Trustees

Prior to the affiliation process, board members should be familiar with relevant state laws defining fiduciary duties regulating their actions in transactions conducted on behalf of their hospital or health system. They should investigate all pertinent details of a proposed transaction and ensure that the organization receives fair market value. The Board should also comprehensively evaluate other competing offers and alternative proposals [7]. They must detect any conflicts of interest and maintain confidentiality within the scope of the transaction. Board

members of non-profit hospitals and health systems must act in accordance with furthering their organization's charitable goals. Consultation with legal counsel may be necessary to properly understand these duties, to guide directors to fulfill their fiduciary obligations, and protect them from any potential liability during the transaction [7].

Process for Developing Agreements

Overview

Once affiliation is deemed necessary, hospital leadership (both administrative and the Boards) must develop comprehensive criteria on which to assess the success of potential partnerships. Criteria should include attracting clinical and administrative staff, increasing access to capital, maintaining essential services, adding services as appropriate, and adapting to changes in payment policies [11]. These criteria will present a clear picture of expectations to potential partners of the rural hospital and can be used to determine goodness of merger fit [7]. In addition, this will ensure that the board is aligned and united based on the criteria outlined, and these criteria will serve to expedite the partner selection process. Established criteria should be included in the marketing plan to potential partners. Optimizing operational and financial standing are important when evaluating mergers, but rural hospitals should take actions consistent with their core missions, values, and their place in the communities that they serve. Leadership should consider the impact of mergers on key stakeholders such as employees, physicians, and community groups as well as other parties not involved in preliminary planning [8].

A communication strategy is needed to share important information with key stakeholders including, but not limited to, physicians, staff members and the community. Communication with physicians should occur throughout the entire process, including having a physician representative on the affiliation board.

Assessing Affiliation Models

There is a variety of affiliation models: 1) asset sale or membership substitution, 2) merger, 3) joint venture, 4) joint operating agreement, and 5) maintain independence [7]. Under a membership substitution or asset sale agreement, the local hospital relinquishes its control in exchange for the most potential in increased efficiency. In an asset purchase, the buyer acquires a portion or all the assets of the local hospital. These are often 'cash out' deals that allow the merged hospital to distribute cash to its owners and eventually dissolve operations. In this case, the buyer is able to acquire select assets and liabilities. The downside to this model is that parties may incur added costs related to taxes, and asset purchases may be more labor intensive because of having to create asset schedules [12].

Joint ventures and joint operating agreements are closely structured transactions, but they are not always easy to negotiate because both parties must agree to terms of governance and operations of the merged hospital [7]. Under a merger, the two entities legally combine into a single surviving business that owns the assets and is responsible for the transaction liabilities of both entities pre- and post-merger. A merger may be more straightforward to execute because all

the assets and liabilities of both entities are involved. However, liability considerations require substantial due diligence, and the new combined entity may have unlimited exposure for pre-transaction liabilities [12]. Overall, the model a system chooses determines where the focus of control in the system will lie.

Engaging Key Stakeholders

A communication strategy is needed to share important information with key stakeholders including, but not limited to, physicians, staff members and the community. Communication with physicians should occur throughout the entire process, including having a physician representative on the affiliation board. The physician representative will share information with and solicit input from other clinicians (including the medical staff) during the affiliation process [7].

Partners in affiliation discussions should also meet directly with physician representatives to enhance buy-in. Negotiators should monitor success working with physicians, goals for affiliation, alternative payment strategies, new technology innovations, and service-line solutions [7]. The communication of the affiliation process to physicians, staff, and the community should be as transparent as possible while maintaining sufficient confidentiality to avoid compromising the process. Hiring a public relations team to assist with communication to community representatives may be necessary, especially if the hospital is publicly-owned. Community stakeholders should have a basic understanding of the rationale for affiliation to garner their support during the process.

Recognizing Hurdles and Liabilities

Developing a current and accurate inventory of systems and interfaces will help smooth the process for integration of operations and prevent future setbacks [10]. This inventory should include: 1) malpractice and insurance relationships, 2) real estate restrictions, and 3) restrictions on licenses, regulatory and compliance matters [7]. Throughout affiliation deliberations the advisors and boards selected to steer the process must ensure that the planning and documentation of procedures are standardized and properly recorded so that a unified exposition can be given to partners during the process and to government regulators after finalization.

Top Considerations for Health Care Mergers and Acquisitions

Affiliation partners must comply with federal and state regulations, including the Physician Self-Referral Law (Stark Law), federal and state anti-kickback statutes, and the False Claims Act [7]. Partners should require self-disclosure from sellers, regarding any cases of non-compliance with statues, to government regulators. In addition, it may be necessary to hire experienced experts to assist the affiliation advisory board in tasks such as comprehensive review of physician service arrangements, contract agreements, and interactions with other regulatory agencies.

Assessing Affiliations: Suboptimal and Optimal

Markers of Suboptimal Affiliations

Affiliations that are suboptimal are often marked by the following conditions: issues in relationships between parties, trouble embarking on new programs, insufficient capitalization of market opportunities, duplication of efforts during the process, and insufficient strategic planning.

Issues in relationships between parties are often tied to an inadequate or poor understanding of the bidirectional value of the relationship - the intrinsic interdependency of the parties and financial commitments [8]. A merged system's ability to fund new programs and business development opportunities is dependent on how well a formalized process is developed for determining funding sources. Having a mutually understood process will assist with alignment of core values and maintenance of objectives.

Affiliations that fail to produce intended outcomes are often identified by the following markers: 1) a mismatch of initial expectations, 2) overestimation of partner capabilities, 3) lack of buy-in from key stakeholders such as medical staff and community members, 4) agreements borne of desperation when the system being acquired is in financial turmoil, 5) ownership change after the affiliation is completed, 6) trusting the partner's leaders rather than closely reviewing contractual agreements, and 7) misunderstood governance agreements [9].

Markers of Optimal Affiliation

Having a process that is transparent, strategic, and engages parties from the rural hospital and community makes it easier to build stakeholder consensus on objectives. Through all points of the process – from the search, to negotiations, to the transaction agreement – the objectives of the rural hospital must guide discussion and action. This is often best accomplished when there is alignment and overlap of the core values, strategies, and missions of both parties in the negotiations. Affiliations often strike a balance between securing resources and maintaining local prerogatives. This balance will allow for good faith that will strengthen contractual agreements and retain local governance power [9].

Conclusion

Rural hospitals are affected by an amalgam of factors which may lead them to consider alternative organizational structures such as reconfiguring to a rural emergency hospital, participating in local rural health networks, and affiliating with large regional health systems. These factors include decreasing operating margins, workforce shortages, and low patient volume [5]. This document has focused on affiliations as one strategic response. The process to affiliate requires comprehensive and strategic planning that incorporates the core values, missions, and business strategies of the acquired, the acquirer, and community stakeholders.

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