NC RHRP

Findings Brief
NC Rural Health Research Program

August 2018

Rural Hospital Mergers from 2005 through 2016

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BACKGROUND

Hospital mergers and acquisitions[1] are changing the face of health care in both rural and urban communities across the country. There are many factors driving expansion of organizational size and scale through mergers, including "intellectual capital, brand and presence, network infrastructure, risk-bearing capabilities, care continuum, clinical and business intelligence, consumerism, capital resources, and diversified operations."[2]

As hospitals consolidate, rural hospitals remain a common acquisition target for three primary reasons. First, under value-based-purchasing payment schemes and regulations,[3] hospitals may face Medicare reimbursement cuts if they are unable to meet quality and technological standards. Small, rural hospitals may not have the capital necessary to implement such infrastructure improvements, and merging with another hospital or system may be the only way to meet these demands.[4]

Second, larger hospitals are absorbing smaller hospitals and local physician practices in an attempt to gain market share and control costs.[5] Hospitals have high fixed costs, and mergers may allow consolidation of services and reduction of duplicative fixed costs. For example, regional consolidation of orthopedic surgery in one large facility may be more cost -effective for a network than having multiple, small-volume orthopedic surgery programs.

Third, many rural hospitals have low patient volumes, workforce shortages, and lack of access to capital. They serve older, poorer, and sicker communities where higher percentages of patients are covered through Medicare and Medicaid, if they are covered at all. These financial realities can result in long-term unprofitability and financial distress. In 2016, urban hospitals were twice as profitable as rural hospitals, and the majority of unprofitable hospitals in the country were rural hospitals.[6] For many rural hospitals, the financial choice may be to merge or go out of business.

Concerns about rural hospital mergers have also been voiced, including reduced negotiating power with insurers, outsourcing of support services, centralized administration, greater use of agency versus full-time local nurses, and other actions to lower expenses and boost margins.[7] Service consolidation (and the potential loss of specific local services) may result in rural residents having to drive longer distances to access care, an issue particularly important in maternity care.[8] Finally, some rural hospitals fear losing local control and independence.[9]

KEY FINDINGS

- From 2005 through 2016, there were 380 rural hospital mergers. The number of rural hospital mergers increased steadily from 2009 through 2014, and then dropped in 2015 and 2016.
- Over half of all rural hospitals that merged (n=173) were in 11 states, most frequently in Oklahoma (n=22), Texas (n=22), and Wisconsin (n=19).
- Some rural hospitals merged more than once – in total, the 326 unique rural hospitals were involved in 380 merger deals. Ten merged rural hospitals subsequently closed without reopening.

Many industry analysts see the pace of mergers continuing, fueled by cost pressures, technological advances, and patient demands.[10] Given the trend toward greater consolidation and the potential impact on rural communities, the purpose of this study is to describe the number and geographic distribution of 380 rural hospital mergers from 2005 through 2016.

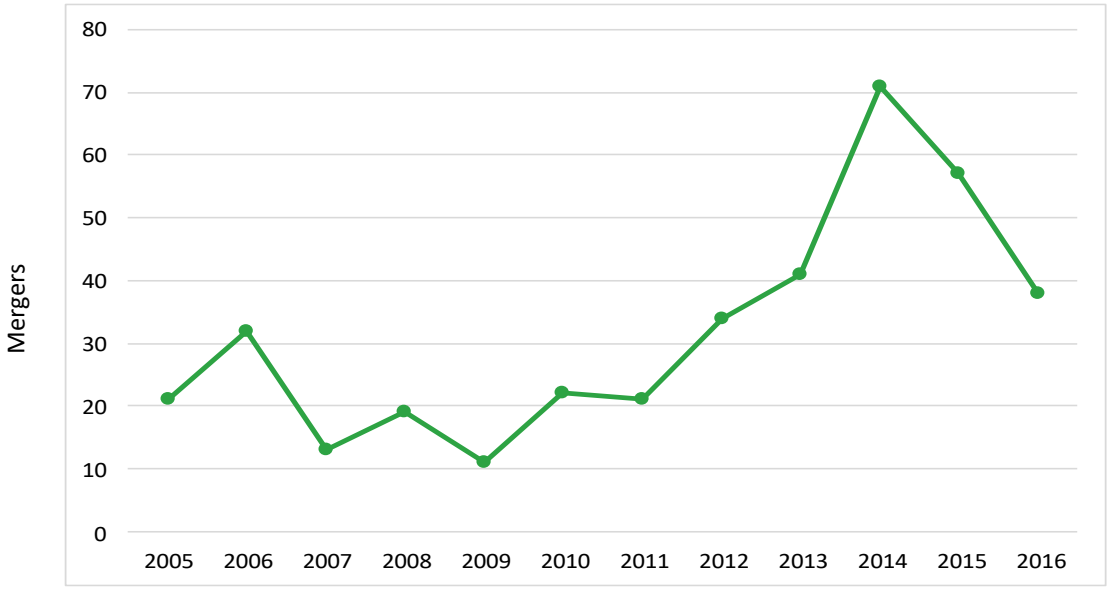
METHOD

A hospital is designated as rural if it is located outside metropolitan Core Based Statistical Areas or within Rural-Urban Commuting Area codes of 4 or greater according to the Federal Office of Rural Health Policy in 2010. Mergers involving rural hospitals from 2005 through 2016 were identified from "The Health Care Services Acquisition Report" produced by Irving Levin Associates. Effective merger dates for each reported rural merger were verified through publicly available online information (for-profit IRS Form 10-Ks, not-for-profit IRS Form 990s, and annual reports from hospital websites).

Number of Rural Hospitals Mergers by Year

Figure 1 shows the trend in annual mergers from 2005 through 2016. There were 380 rural hospital mergers. The number of mergers increased steadily from 2009 through 2014, and then dropped in 2015 and 2016.

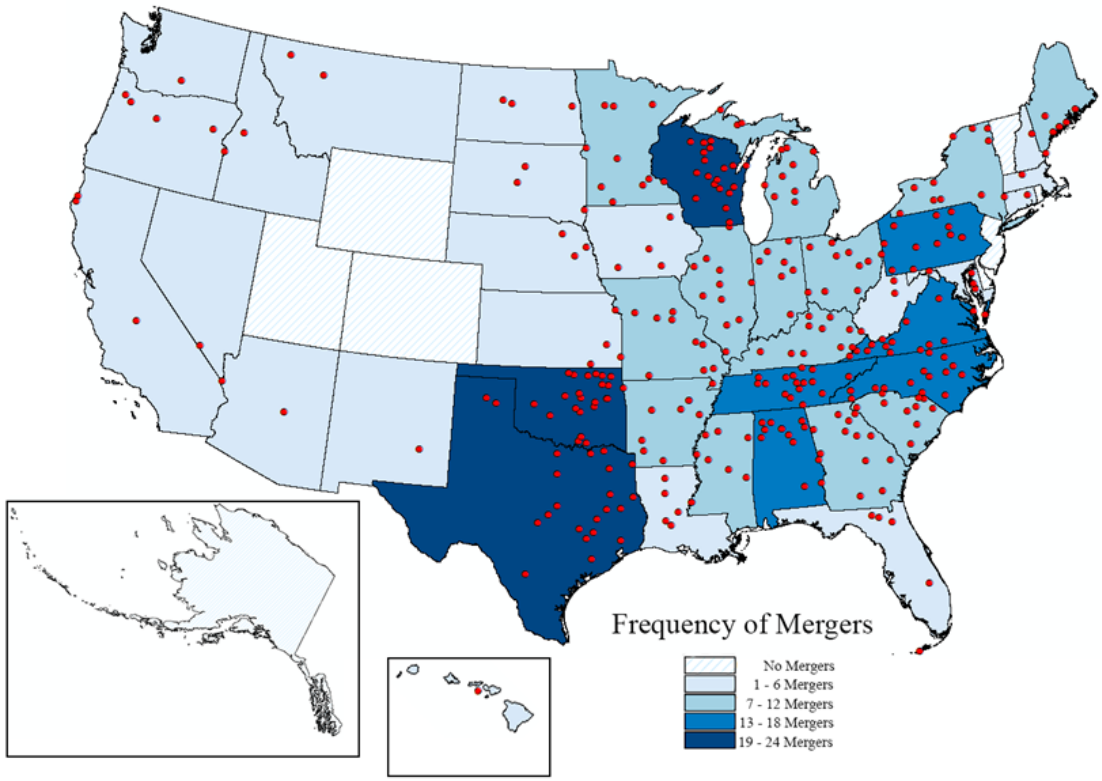
Figure 1: Number of Rural Hospitals Mergers, 2005-2016



Number of Unique Rural Hospitals that Merged by State

Figure 2 shows the number of unique rural hospitals that merged by state from 2005 through 2016. There were 380 mergers in this period that involved 326 hospitals—some merged more than once. Over half of all merged hospitals (n=173) were in 11 states (Oklahoma, Texas, Wisconsin, Tennessee, North Carolina, Virginia, Pennsylvania, Alabama, Michigan, Georgia, and Illinois). The greatest number of hospitals that merged were in Oklahoma (n=22), Texas (n=22), and Wisconsin (n=19). Among states with at least 25 total rural hospitals, Virginia (44%), South Carolina (37%), and Pennsylvania (29%) had the highest proportion of hospitals that merged.

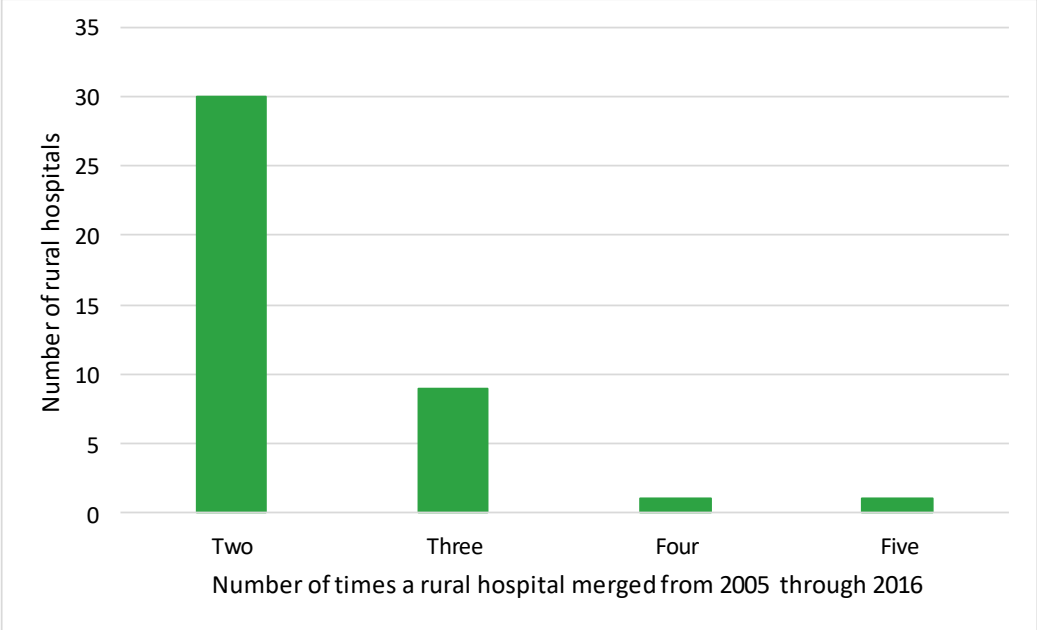
Figure 2: Unique Rural Hospitals that Merged by State, 2005-2016



Post-Merger Closures and Multiple Mergers

Among the 326 unique rural hospitals that merged, 10 hospitals closed after merging, nine of which closed from 2010 through 2016. Figure 3 shows the number of rural hospitals that merged more than once from 2005 through 2016. In total, 41 of 326 rural hospitals merged more than once: 30 merged twice, nine merged three times, one merged four times, and one merged five times. Many of these hospitals were part of multiple-hospital acquisitions by health care systems.

Figure 3: Rural Hospitals that Merged More than Once from 2005 through 2016



DISCUSSION

This study found that mergers have been a common phenomenon among rural hospitals: approximately 12% of all rural hospitals merged from 2005 through 2016. The number of mergers increased steadily from 2009 through 2014, and then dropped in 2015 and 2016. Mergers have been geographically concentrated: over half of all rural hospital mergers occurred in eleven states. More than half of all rural hospital mergers were in the South, but other geographic patterns are not apparent. Kansas and Oklahoma are an interesting contrast in states: they are contiguous and each has a large number of rural hospitals. However, Oklahoma had one of the highest percentages of rural hospitals involved in a merger (27%), while Kansas had one of the lowest percentages (4%).

These findings support the need for further research investigating why so many rural hospitals are merging, the financial impact of merging, and the impact on access to care within rural communities.

Appendix: Rural Hospital Mergers by State, 2005-2016*

Oklahoma	36	Missouri	11	Connecticut	3
Texas	24	New York	11	Maryland	3
Tennessee	20	Mississippi	11	Nebraska	3
Wisconsin	19	Kentucky	10	South Dakota	3
North Carolina	18	Minnesota	10	North Dakota	3
Pennsylvania	17	Indiana	9	Arizona	2
Virginia	16	Florida	9	Montana	2
Georgia	16	Louisiana	7	New Mexico	2
South Carolina	15	Oregon	7	Washington	2
Alabama	14	Maine	6	New Hampshire	1
Illinois	13	Iowa	5	Hawaii	1
Michigan	13	West Virginia	5	Nevada	1
Ohio	12	Kansas	4	Idaho	1
Arkansas	11	California	3	Massachusetts	1

*Table includes the number of 2005-2016 rural hospital mergers (380) in which 326 unique rural hospitals were involved.

REFERENCES AND NOTES

1. A merger occurs when two organizations combine to become a single organization. In most mergers, one organization (the acquirer) initiates action to take over another (the target). A horizontal merger occurs when two organizations in the same line of business combine – for example, when one hospital acquires another. A vertical merger occurs when one type of provider acquires another - for example, when a hospital acquires a medical practice. A conglomerate merger occurs when unrelated businesses combine – for example, when a hedge fund acquires a hospital for investment purposes.
2. Kaufman Hall. 2017 in Review: The year M&A shook the healthcare landscape, 2018. Available at: https://www.kaufmanhall.com/resources/research/2017-review-year-ma-shook-healthcare-landscape.
3. Value-based purchasing (VBP) is a CMS initiative that rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries. The program adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they deliver. The VBP Program encourages hospitals to improve the quality and safety of acute inpatient care for Medicare beneficiaries and all patients by 1) Eliminating or reducing adverse events (health care errors resulting in patient harm); 2) Adopting evidence-based care standards and protocols that make the best outcomes for the most patients; 3) Changing hospital processes to make patients' care experiences better; 4) Increasing care transparency for consumers, and; 5) Recognizing hospitals that give high-quality care at a lower cost to Medicare. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html.
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This study was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement # U1GRH07633. The information, conclusions and opinions expressed in this brief are those of the authors and no endorsement by FORHP, HRSA, HHS, or The University of North Carolina is intended or should be inferred.