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Hospitals and the Proposed Virginia Medicaid Expansion

By Marc D. Joffe and Jason J. Fichtner

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Foreword

Although the expansion of Medicaid has been defeated in the Virginia General Assembly, the advocates of Obamacare and for expansion of Medicaid under this program vow to keep this issue alive.

Last September the Thomas Jefferson Institute published a study that showed the profit and loss and net worth of the acute care hospitals here in Virginia. That report was published because the largest business group supporting Medicaid expansion was the hospitals. They said they needed Medicaid expansion because their financial health required it. This study highlighted the financial health of our hospitals and let the readers draw their own conclusions. This report can be found here: http://www.thomasjeffersoninst.org/files/3/Virginia%20Hospital%20Report.pdf

And today the hospitals continue to be the major advocates outside of government for a major expansion of Medicaid. And that will likely continue to be the case.

The Washington Post on March 16, 2015 ran an article about the shaky financial health of rural hospitals in our country. That is also the case here in Virginia. Most of the hospitals that are in a difficult financial situation here in the Commonwealth are the small, rural hospitals.

This study by Marc Joffe and Jason Fichtner highlights the most current financial standing of Virginia's hospitals as available at the Virginia Hospital Information website. And it shows that, overall, our hospitals are doing very well. And yet, as these authors point out, the smaller rural hospitals are indeed the ones in trouble and they point out that public policy might indeed want to help these health care facilities. The authors maintain that expanding Medicaid is not the best way to help these hospitals. It would be better, these authors argue, for our state to spend more on these hospitals directly rather than expand Medicaid.

This study shows how the for-profit and non-profit hospitals are doing financially. The overall net income for the for-profit hospitals was $243 million in 2013 (see page 4) and for the non-profit hospitals the net income was over $1 billion in 2013 (see page 6). And the authors also highlight the compensation that the top administrators and doctors are making in Virginia's non-profit hospitals (pages 8, 9 and 10).

Medicaid is already the fastest growing part of our state budget. And the way that the law is crafted, it tells the states that if they expand Medicaid, the federal government will pay 90% of the cost for the expansion of this major entitlement program. But it can really do so?

Earlier this year, I attended a briefing with Congressman Paul Ryan who now chairs the United States House of Representatives' Committee on Ways and Means. In that briefing, Congressman Ryan made is very clear that the proposed expansion of Medicaid could not continue at the

promised 90% and that the cost for expansion will have to be reduced to match the current payment structure for the rest of Medicaid. That is basically a 50% federal payment and 50% state payment. This means that any expansion of Medicaid in Virginia will end up being extraordinarily expensive.

This is not the first time the federal government has promised to pay new costs for a federally mandated program. The 1975 Individuals with Disabilities Education Act (IDEA) imposed new conditions on local school systems to provide students with disabilities with a free, appropriate public education. The American Association of School Administrators has pointed out that "the law proposed that federal funds should cover up to 40% of the excess cost of educating students with disabilities." Today, the federal government covers less than 16 percent of those costs. Those who trust promises on Medicaid might consider the record on IDEA.

This study is published by the Thomas Jefferson Institute in order to show that the hospitals in Virginia are, overall, doing pretty well financially. The hospitals that are the main non-government advocates for Medicaid expansion are not in financial difficulty.

This study is provided as a public service so that the debate over health care in general and Medicaid expansion specifically can take place with facts in front of our elected leaders and others interested in this important issue. This study is not meant to support or oppose any specific legislation and does not necessarily reflect the opinions of the Thomas Jefferson Institute or its Board of Directors.

Michael W. Thompson, Chairman and President
Thomas Jefferson Institute for Public Policy
April 2015

Hospitals and the Proposed Virginia Medicaid Expansion

By Marc D. Joffe and Jason J. Fichtner [1]

The debate over Medicaid expansion under the provisions of the Affordable Care Act (ACA) often revolves around its impact on low income, uninsured adults. But Medicaid does not only benefit enrollees; it also benefits various groups of medical providers. Indeed, Medicaid payments are made directly to hospitals and other providers.

Hospitals thus have a financial incentive to support Medicaid expansion in Virginia and elsewhere. After providing some evidence that Virginia hospitals are acting on this incentive, we consider whether they should receive additional taxpayer funds through Medicaid. We find that hospitals have traditionally acted on the belief that they have an obligation to provide care for economically disadvantaged patients and that today's not-for-profit hospitals are expected to fulfill this traditional obligation in return for the benefits that derive from their not-for-profit status. Further, we find that – by and large - hospitals can afford to provide this "charity care" without increased Medicaid subsidies.

Hospital Support for Medicaid Expansion

Of the $7 billion the Virginia Medicaid program pays to providers, about $1.5 billion is remitted to hospitals. It is expected that these facilities would receive a significant share of additional Medicaid payments if the program is expanded. For example, a 2013 Robert Wood Johnson study estimated that Virginia hospitals would receive an additional $600 million in 2016 if the state implemented Medicaid expansion.[2]

For this reason, hospital administrators are major supporters of Virginia Medicaid expansion. In 2013, the Virginia Hospital & Healthcare Association (VHHA) Political Action Committee donated $39,000 to Terry McAuliffe's gubernatorial campaign and only $13,500 to that of Ken Cuccinelli.[3] The PAC's largest House of Delegates beneficiary was Thomas Rust – the only Republican delegate to vote for Medicaid expansion when it was raised in February 2014.[4]

VHHA also commissioned a study from Chmura Economics & Analytics[5] that concluded:

> The Medicaid expansion can inject new money into Virginia's healthcare industry, provide cost savings for Virginia businesses, and increase household spending for those newly insured. Consequently, the Medicaid expansion can generate more Virginia jobs and tax revenue (p. 4).

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[1] The authors wish to thank Anna Mills for her contributions to this research.

[2] Stan Dorn, et. al., *The Financial Benefit to Hospitals from State Expansion of Medicaid* (Robert Wood Johnson Foundation, March 2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf405040.

[3] Author's calculation from Virginia State Board of Elections, *Campaign Finance Reports*, n.d., http://cfreports.sbe.virginia.gov/Committee/Index/f4dcfa71-6b73-e111-86d3-984be103f032. The disparity may be partially explained by the phenomenon of campaign contributors focusing their support on the likely winner, as discussed by Dennis Mueller, *Public Choice III* (New York: Cambridge University Press, 2003).

[4] Michael Laris and Laura Vozzella, "House and Senate in Virginia at Loggerheads over Medicaid Expansion," *Washington Post*, February 20, 2014, http://www.washingtonpost.com/local/virginia-politics/house-and-senate-in-virginia-at-loggerheads-over-medicaid-expansion/2014/02/20/7bdf47f0-9a3d-11e3-b931-0204122c514b_story.html.

[5] Chmura Economics and Analytics, *The Economic Impact of the Medicaid Expansion on Virginia's Economy*, December 7, 2012, http://www.vhha.com/documents.html?id=845.

Hospital association lobbying on behalf of Medicaid expansion can best be understood in terms of Bruce Yandle's "Baptists and Bootleggers" construct.[6] Yandle concluded that new regulations have the strongest chance of succeeding when they are supported by two distinct groups: true believers and interest groups that can profit from the intervention. The colorful name for this theory stems from the Prohibition era when Baptists (who ardently believed in the benefits of temperance) and Bootleggers (who could profit from alcohol prohibition by driving out legal distributors and thereby gaining pricing power) found themselves on the same side.

Although Yandle proposed the theory to explain regulation, it has since been applied to other areas of rent-seeking behavior, such as subsidies. In 2007, Michael Cannon, health care expert at the Cato Institute, described an alliance of healthcare access advocates and healthcare provider lobbies supporting expansion of the State Children's Health Insurance Program (SCHIP).[7] This alliance is once again at play in Virginia, where hospitals and other providers join with advocacy groups such as the labor union supported Virginia Organizing to lobby on behalf of Medicaid expansion.

A possible objection to the Bootleggers and Baptists analogy is that hospital administrators deserve far more respect than liquor smugglers. Health care might be viewed as a necessity and service to the public welfare, while alcohol viewed as a guilty pleasure. But the simple fact that a lobbying group is providing an essential service does not imply that such a group won't attempt to extract rents (excess returns) for its work. And, when a provider group seeks to extract rents for its service, it is reasonable for academic researchers to identify its rent seeking behavior.

A further objection is that most hospitals operate as not-for-profits creating the presumption that management is primarily motivated by non-pecuniary concerns. We will question that presumption below, and offer evidence that many not-for-profit institutions offer their stakeholders opportunities for financial gain.

Charity Care and Medicaid: Some Historical Perspective

Charity care – the provision of medical services to the poor regardless of their ability to pay – has a long tradition. For example, charity care is listed among a physician's professional duties in the American Medical Association's 1847 Code of Medical Ethics.[8] In 1932, the Committee on the Costs of Medical Care found that the very poorest Americans used hospitals as frequently as the wealthiest Americans, because of the availability of charity care. At that time, a combination of pro bono services, philanthropic donations that supported the operations of sectarian hospitals and public hospitals funded by local governments provided the poor with free or reduced cost access to medical facilities.[9]

Federal involvement in hospital finance began after World War II and greatly increased with the 1965 passage of Medicare and Medicaid. But even with federal funding, the expectation that hospitals would provide charity care remained. In 1986, Congress passed the Emergency Medical Treatment and Labor Act (EMTALA) requiring all Medicare-participating hospitals to provide emergency services regardless of ability to pay. Virtually all hospitals in Virginia participate in Medicare.[10]

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[6] Bruce Yandle, "Bootleggers and Baptists in Retrospect," *Regulation* 22, no. 3 (October 1999): 5–7.

[7] Michael F. Cannon, *Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs*, Cato Briefing Papers, September 13, 2007, http://object.cato.org/sites/cato.org/files/pubs/pdf/bp99.pdf.

[8] *Code of Ethics of the American Medical Association: Originally Adopted at the Adjourned Meeting of the National Medical Convention in Philadelphia, May, 1847* (Chicago: American Medical Association Press, 1900).

[9] Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care Since 1965* (Durham, NC: Duke University Press, 2006).

[10] Center for Medicare and Medicaid Services, "Emergency Medical Treatment and Labor Act (EMTALA)," March 2012, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/.

This background suggests that access to hospital care for the economically disadvantaged has not been a matter of debate. Instead, the question is one of whether taxpayers should bear a larger burden of the charitable care historically provided by hospitals. One criterion for making this policy choice is hospitals' ability to pay: when adults earning less than 133 percent of the federal poverty line (the income ceiling for the proposed Medicaid expansion in Virginia) come to the emergency room, can hospitals afford to treat them?

Hospital Income

To assess whether hospitals can afford to provide charity care, we can review their income statements. In Virginia, hospital financial and operating data are collected by Virginia Health Information (VHI), working under contract with the Virginia Department of Health.[11] VHI publishes a Hospital Detail Report and various Industry Reports on an annual basis. These data sets may be purchased from VHI, although some of the information is freely available on VHI's web site at http://www.vhi.org.

VHI's current Industry Review contains 2013 financial data for 101 hospitals. VHI data do not include Veterans' Administration Hospitals, but do include a broad range of facilities including acute care, rehabilitation, psychiatric and children's hospitals. Table 1 provides summary data for the hospitals in the VHI data set.

Table 1: VHI Summary Data

	Number of Hospitals	Number of Admissions (2013)	2013 Net Income	Number with Positive Net Income	Number with Negative Net Income
For Profit	30	162,455	$ 243,150,288	21	9
Not-for-profit	66	541,585	1,027,763,136	47	19
Government	5	76,985	265,338,388	4	1
Totals	**101**	**781,025**	**$ 1,536,251,812**	**72**	**29**

Source: Virginia Hospital Information, Hospital Reports 2013 and Author's calculations.

[11] For more information about VHI, please see Virginia Department of Health, "Virginia Health Information," 2010, http://www.vdh.virginia.gov/Administration/VHI/index.htm and Virginia Health Information, *From Numbers to Knowledge: VHI 2013 Annual Report and Strategic Update*, 2013, http://vhi.org/files/pdfs_to_download_from_web/AR&SPU%202013.pdf.

In aggregate, Virginia hospitals reported strong financial results, with revenues exceeding expenditures by almost $1.5 billion, representing a return on income of roughly 8%. Hospitals in all three ownership categories – for profit, private not-for-profit and government – reported positive net income.[12] That said, some individual hospitals sustained operating losses. Most of these money losing facilities are smaller hospitals with less than 100 staffed beds.

For Profit Hospitals

For profit hospitals account for over 20 percent of admissions in the VHI data set. The biggest private hospital company in Virginia is Hospital Corporation of America, which operates hospitals in several states and trades on the New York Stock Exchange as HCA Holdings, Inc. (symbol HCA). The company reported close to $1.6 billion in net income in 2013. But this number understates the profitability of HCA's hospitals, since some of the profits are distributed to minority interests when HCA owns less than 100 percent of a given hospital. When net income attributable to non-controlling interests is included, HCA hospitals reported aggregate net income of $2.0 billion.[13] Between January 1, 2012 and December 31, 2014, HCA's shares more than tripled, substantially outperforming the S&P 500..[14] HCA has not only performed well for its owners; company executives have also benefited. According to company proxy materials, CEO Richard Bracken received $16.5 million in total 2013 compensation, while the next four highest paid executives received a total in excess of $20 million – averaging $5 million each.[15]

HCA is not the only profitable hospital company operating in Virginia, as shown in Table 2.

Table 2: Virginia For-Profit Hospitals by Corporate Parent

Company (Ticker Symbol)	Number of Virginia Hospitals (2013)	Virginia Hospital 2013 Net Income	Total Corporate Earnings (2013)
Hospital Corporation of America (HCA)	10	$ 206,288,855	$ 1,556,000,000
HealthSouth (HLS)	6	11,791,138	323,600,000
LifePoint (LPNT)	6	27,969,676	127,800,000
Community Health Systems (CYH)	3	(2,138,407)	141,203,000
Universal Health Services (UHS)	3	(78,583)	510,733,000
Other For-Profit	2	(682,391)	
Totals	**30**	**$ 243,150,288**	

Source: Virginia Hospital Information, Company 10-K Filings

[12] The Thomas Jefferson Institute reported Virginia hospital income and net worth in a September 2014 study entitled *The Financial Health of Virginia's Hospitals* available at http://www.thomasjeffersoninst.org/files/3/Virginia%20Hospital%20Report.pdf.

[13] HCA Holdings, Inc., *Annual Report to Stockholders*, 2013, http://hcahealthcare.investorhq.businesswire.com/sites/hcahealthcare.investorhq.businesswire.com/files/report/file/HCA_2013_Annual_Report.pdf.

[14] "Yahoo Finance: HCA Holdings, Inc http://finance.yahoo.com/echarts?s=HCA.

[15] HCA Holdings, Inc., *Proxy Materials*, March 14, 2014, http://quote.morningstar.com/stock-filing/Proxy-Statement/2014/4/23/t.aspx?t=XNYS:HCA&ft=DEF%2014A&d=e8d1d3cb4290605d9895df2e24a0ed2f.

Four other companies operate multiple Virginia hospitals. Two realized subsantial positive net income from their Virginia hospitals, and all of them had substantial profits at the corporate level in both 2012 and 2013. Although earnings declined in 2013, Virginia appears to remain an attractive market to for-profit hospital operators, as evidenced by LifePoint's November 2013 acquisition of a majority stake in Warrenton, VA's Fauquier Hospital.[16]

We have no quarrel with corporate profits per se, nor do we advocate government controlling executive pay. We raise the issues of profits, stock performance and executive compensation to make the simple point that these hospital chains do not need the additional subsidies that Medicaid expansion would provide.

Profiting from Not-for-Profit Hospitals

The term "not-for-profit" evokes a vision of an organization operating for the public good rather than private benefit. But the distinction between "not-for-profit" and "for-profit" corporations is less clear than the terminology suggests. Not-for-profit hospitals can and do run surpluses.[17]

According to VHI financial data, Virginia's 66 private, not-for-profit hospitals had aggregate net income of $1.028 billion in 2013. Many Virginia hospitals are members of large health systems that often operate across state lines. Table 3 (next page) shows the performance of the eight not-for-profit health systems that operated at least three hospitals in Virginia in 2013. All eight of the not-for-profits recorded revenues greater than expenditures on their Virginia hospitals in 2013; and they all reported revenues greater than expenditures system-wide on their most recently published financial statements.

Despite the lack of Medicaid expansion thus far, two systems have expanded operations in Virginia recently. In March 2014, Novant Health opened Haymarket Medical Center, a 60-bed community hospital in northern Virginia. Novant Health operates a total of 15 hospitals in four states including Prince William Medical Center in Manassas, VA.[18] Meanwhile, in February 2014, Bon Secours Health System announced plans to take over Rappahannock General Hospital in Kilmarnock, VA.[19]

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[16] Fauquier Health, "Fauquier Health / LifePoint Hospitals Partnership: Building a Healthier Future Together.," 2013, http://www.fauquierhealth.org/Partnership.

[17] The literature contains a number of studies that explore the convergence of not-for-profit and for-profit hospitals and question whether not-for-profits provide community benefits sufficient to justify their status. See, for example, Guy David, "The Convergence between for-Profit and Nonprofit Hospitals in the United States," *International Journal of Health Care Finance and Economics* 9, no. 4 (December 2009): 403–28; David P. Gehant, *Are Non-Profit Hospitals Doing Enough to Justify Their Exemptions? A Comparative Analysis.*, Doctoral Project (Medical University of South Carolina, 2008), http://lcdl.library.cofc.edu/lcdl/catalog/lcdl:32516; and Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf.

[18] Novant Healthcare, "Novant Health Announces Opening of Haymarket Medical Center," *Potomac Local News*, March 28, 2014, http://potomaclocal.com/2014/03/28/novant-health-announces-opening-of-haymarket-medical-center/.

[19] Tammie Smith, "Bon Secours to Acquire Rappahannock General in Kilmarnock," *Richmond Times Dispatch*, February 12, 2014, http://www.timesdispatch.com/business/health/bon-secours-to-acquire-rappahannock-general-in-kilmarnock/article_ad2fda53-bb95-58d1-956d-f489af304daf.html.

Table 3: Not-For-Profit Hospital Groups in Virginia

	Number of Virginia Hospitals (2013)	Virginia Hospital 2013 Net Income	Group-Wide Excess of Revenue over Expenses (2013)
Sentara Healthcare	12	$ 211,636,360	$ 606,412,000
Bon Secours Health System	7	122,209,540	170,850,000
Carilion Clinic and Subsidiaries	7	170,251,781	142,984,000
Riverside Health Care Association	8	50,713,000	5,360,000
Inova Health System	5	160,435,032	662,468,000
Mountain States Health Alliance	5	5,687,794	59,567,000
Valley Health System	4	19,896,120	18,597,000
Centra Health	3	46,425,139	59,963,787
Other Private Not-for-Profit	15	240,508,370	
Total	**66**	**$ 1,027,763,136**	

Sources: Virginia Health Information, Form 990 Filings and Audited Financial Statements.

From an economic standpoint, the distinction between for profit and not-for-profit organizations is that the latter do not have an obvious residual claimant. When a for-profit firm realizes profits, these residuals belong to the company's shareholders. Management, acting as an agent for shareholders, may decide to retain and reinvest the earnings, rather than distribute them as dividends – but the profits clearly belong to the company's owners. In the case of a privately owned, not-for-profit hospital group, excess revenues are not the property of any individual or set of individuals.

However, the fact that excess income at non-profit hospitals does not legally belong to anyone, does not mean that they cannot be used for individual benefit. For several decades, economists have studied residual claimants at not-for-profit hospitals. In a 1973 *American Economic Review* article, Mark Pauly and Michael Redisch theorized that physicians enjoy *de facto* control of not-for-profit hospitals and they use their power to maximize their practice incomes. Pauly and Redisch conclude that physician control will result in hospitals of smaller than optimal size, because incumbent physicians have an incentive to restrict the number of new doctors permitted to admit patients to the facility.[20]

[20] Mark Pauly and Michael Redisch, "The Not-for-Profit Hospital as a Physicians' Cooperative," *The American Economic Review* 63, no. 1 (March 1973): 87–99.

The emergence of multi-facility health systems has given rise to a class of hospital administrators who may have supplanted physicians since Pauly and Redisch published their findings in 1973. A Compdata salary survey reported in the *New York Times* found that the average hospital administrator earned more than the average general practitioner, while the average hospital CEO received $386,000 in cash compensation plus substantial non-cash benefits.[21] The story quotes Cathy Schoen of the Commonwealth Club (in New York City) as follows: "At large hospitals there are senior V.P.s, V.P.s of this, that and the other … each one of them is paid more than before, and more than in any other country." While we urge caution in criticizing the organizational and compensation policies of not-for-profit hospital groups, we question whether further taxpayer subsidies are required to support these practices.

Not-for-profit organizations are required to list executive compensation in their annual IRS reports using IRS tax Form 990, which is roughly analogous to Form 1040 but requires much more information. The IRS publishes scanned images of these reports and several organizations display them on the internet.[22] We collected the most recently available Forms 990 – mostly reflecting 2012 data - from these web sites and reviewed executive compensation levels. These highly compensated executives are listed in Table 4. Over 100 additional not-for-profit hospital executives with Virginia connections were awarded between $500,000 and $1,000,000 in total compensation according to the latest available reports (which are mostly from 2012 and 2013).

High compensation is not objectionable per se. Firms operating in a competitive environment without taxpayer subsidies may determine that highly paid executives add sufficient value to justify their compensation. But Virginia hospitals and health systems operate in a highly regulated environment and receive a substantial portion of their revenue from governmental sources. Thus, it is possible that high executive compensation levels include economic rents as well as residual claims on the excess income of their institutions. It is also appropriate for the public and policymakers to consider these compensation levels when taxpayers – both in Virginia and across the nation – are being asked to increase the support they provide to these institutions.

With respect to subsidies, it is also worth noting that not-for-profit hospitals receive benefits from their status as charitable organizations. Among these benefits are the ability to receive tax deductible contributions, exemptions from income, property and sales taxes, and the access to tax-exempt bond financing (tax-exempt bonds pay lower interest rates than taxable bonds with similar risk and maturity dates).[23] Until 1969, not-for-profit hospitals were explicitly required to provide charity care to be eligible for tax exemption. This conditionality was weakened by IRS Revenue Ruling 69-545, which allowed non-profits to retain their tax exemptions if they provided any of a broader set of "community benefits".[24]

[21] Elisabeth Rosenthal, "Medicine's Top Earners Are Not the M.D.s," *New York Times*, May 17, 2014, http://nyti.ms/1jpkhLo.

[22] Form 990 internet repositories are available from Guidestar, Propublica, PublicResource.org, CitizenAudit.org and the National Center for Charitable Statistics.

[23] See William Gentry and John Penrod, *The Tax Benefits of Not-for-Profit Hospitals* (National Bureau of Economic Research, February 1998), http://www.nber.org/papers/w6435. and Virginia Department of Taxation, "Retail Sales and Use Tax Exemptions for Nonprofit Organizations," July 2014, http://www.tax.virginia.gov/site.cfm?alias=SUTExemption.

[24] Helen Schneider, "Paying Their Way? Do Nonprofit Hospitals Justify Their Favorable Tax Treatment?" *Inquiry* 44, no. 2 (Summer 2007): 187–99.

Table 4: Not-For-Profit Hospital Executives with Total Compensation in Excess of $1,000,000						
Employer	**Name**	**Title**	**Reportable Compensation from the Organization**	**Reportable Compensation from Related Organizations**	**Other Compensation from Organization and Related Organizations**	**Total Compensation**
Novant Health Inc.	Paul M. Wiles	Former CEO	$11,115,042	$0	$27,210	$11,142,252
Sentara Healthcare	David L. Bernd	CEO/Director/Trustee	4,981,854	0	326,749	5,308,603
Sentara Healthcare	Howard P. Kern	COO/President	3,731,697	0	722,594	4,454,291
Inova Alexandria Hospital	J. Knox Singleton	President	0	3,538,107	644,863	4,182,970
Mountain States Health Alliance	Dennis Vonderfecht	CEO	3,163,747	0	42,698	3,206,445
Novant Health Inc.	Carl Steven Amato	CEO & President	1,665,294	0	1,133,054	2,798,348
Inova Health Care Services	Mark Stauder	COO	0	1,949,318	553,322	2,502,640
Novant Health Inc.	Stephen L. Wallenhaupt	EVP Chief Medical Officer	1,678,522	0	764,557	2,443,079
Bon Secours Health System	Richard Statuto	CEO/President	2,187,270	0	171,522	2,358,792
Novant Health Inc.	Gregory Beier	Former EVP & President Novant Ops	1,968,280	0	31,704	1,999,984
Carilion Services, Inc.	Nancy Howell Agee	President/CEO/Director	1,124,997	837,490		1,962,487
Centra Health	George W. Dawson	Former CEO	1,873,346	0	2,669	1,876,015
Inova Health Care Services	John Niederhuber	CEO, ITMI	0	1,748,456	53,427	1,801,883
Children's Hospital of the King's Daughters	James D. Dahling	President/Director	0	919,968	844,712	1,764,680
Novant Health Inc.	Fred McDowell Hargett	EVP & Chief Financial Officer	1,072,470	0	631,816	1,704,286
Novant Health Inc.	Jacqueune Rene Daniels	EVP & Chief Administrative Officer	1,072,630	0	581,604	1,654,234
Bon Secours Health System	Peter Bernard	EVP - CEO VA Health System	1,438,081	0	192,966	1,631,047
Novant Health Inc.	Lawrence Upchurch McGee	Senior VP & General Counsel	1,074,617	0	501,213	1,575,830
Sentara Healthcare	Michael M. Dudley	Sr VP	905,211	0	660,683	1,565,894
Carilion Medical Center	Gary Simonds MD	Physician	1,376,853	0	81,789	1,458,642
Sentara Healthcare	Gary R. Yates MD	Sr VP/CMO	1,281,743	0	172,648	1,454,391
Novant Health Inc.	Ann Unersallye	EVP & Chief Clinical Officer	1,090,005	0	309,277	1,399,282

Table 4: Not-For-Profit Hospital Executives with Total Compensation in Excess of $1,000,000						
Employer	**Name**	**Title**	**Reportable Compensation from the Organization**	**Reportable Compensation from Related Organizations**	**Other Compensation from Organization and Related Organizations**	**Total Compensation**
Sentara Healthcare	Robert A. Broermann	CFO/Treasurer	1,203,319	0	186,076	1,389,395
Novant Health Inc.	Diana Lee Best	Senior VP	921,415	0	464,295	1,385,710
University of Virginia Physician's Network	Mark A. Stoler MD	Physician	1,213,392	123,983	39,322	1,376,697
Carilion Medical Center	Jonathan Carmouche MD	Physician	1,339,609	0	28,203	1,367,812
Riverside Healthcare Associaton	William McAllister	Physician	1,309,680	0	32,947	1,342,627
Riverside Healthcare Associaton	Dean Kostov	Physician	1,299,757	0	13,871	1,313,628
Novant Health Inc.	Derrick Mark Billings	President, NH Shared Services	265,992	672,531	351,889	1,290,412
Inova Alexandria Hospital	Richard Magenheimer	Treasurer	0	980,061	300,965	1,281,026
Inova Health Care Services	James Eklund	Physician	1,188,645	0	71,625	1,260,270
Bon Secours Health System	Timothy Davis	EVP-CHRAO	1,122,284	0	134,895	1,257,179
Carilion Medical Center	Joseph Moskal MD	Physician	1,202,806	0	46,126	1,248,932
Carilion Medical Center	Nicholas Qandah MD	Physician	1,222,179	0	20,900	1,243,079
Novant Health Inc.	Tony W Johnson	Senior VP	845,963	0	388,180	1,234,143
Bon Secours Health System	Markon Prest, MD	EVP-CMO	1,039,465	0	158,468	1,197,933
University of Virginia Physicians Group	Irving L. Kron MD	Co-Vice Chair of the Board	544,677	576,488	67,906	1,189,071
Maryview Hospital	Mark B. Kerner MD	Physician	1,148,006	0	36,611	1,184,617
Mary Washington Healthcare Group	Glen I Poffenbarger MD	Neurosurgeon	1,138,490	0	40,260	1,178,750
Sentara Medical Group	Bill W. Berry Jr. MD	Physician	1,119,300	0	58,787	1,178,087
Novant Health Inc.	David G. Park	Senior VP	816,329	0	351,856	1,168,185
The Fauquier Hospital Incorporated	Rodger Baker	President/CEO	1,087,052	0	72,527	1,159,579
Riverside Healthcare Association	Richard Pearce	Exec Vice Chairman	1,108,596	0	33,592	1,142,188
Bon Secours Health System	Matthew Toddy	EVP & General Counsel	1,014,148	0	116,512	1,130,660

Table 4: Not-For-Profit Hospital Executives with Total Compensation in Excess of $1,000,000						
Employer	**Name**	**Title**	**Reportable Compensation from the Organization**	**Reportable Compensation from Related Organizations**	**Other Compensation from Organization and Related Organizations**	**Total Compensation**
Carilion Services, Inc.	Donald Lorton	Assistant Treasurer	0	756,751	353,047	1,109,798
Riverside Healthcare Association	William Downey	President, CEO RHS	1,068,287	0	38,496	1,106,783
Bon Secours, DePaul Medical Center	John R. Baker, MD	Physician	1,067,907	0	37,334	1,105,241
Rockingham Memorial Hospital	James D. Krauss	President	950,446	0	146,048	1,096,494
Wellmont Health System	Margaret Denarvaez	President	1,031,881	0	47,176	1,079,057
Bon Secours Health System	Michael Kerner	CEO-BS Hampton Roads Health System	936,925	0	132,770	1,069,695
Martha Jefferson Hospital	Kenneth H. Karkaur	Board Member	0	979,254	84,563	1,063,817
Sentara Healthcare	Kenneth M. Krakaur	Sr VP	979,254	0	84,563	1,063,817
Carilion Medical Center	Cay Mierisch MD	Physician	1,001,548	0	57,129	1,058,677
Novant Health Inc.	Robert H. Seehausen Jr.	Senior VP	629,942	0	407,521	1,037,463
Bon Secours Health System	Mark Nantz	CEO - St. Francis Health System	952,104	0	80,530	1,032,634
Novant Health Inc.	Jim George Tobalski	Sr VP Mkting/Comm & Gov Affairs	984,577	0	43,775	1,028,352
Sentara Healthcare	Mary L. Blunt	Corp VP	0	848,417	174,487	1,022,904
Inova Health Care Services	Marshall Ruffin	Chief Technology Officer	0	854,237	162,975	1,017,212
Inova Health Care Services	Loring Flint	Chief Medical Officer	0	834,890	180,304	1,015,194
Bon Secours Health System	Samuel Ross, MD	CEO-BS Baltimore Health System	938,123	0	76,328	1,014,451
Mary Washington Healthcare Group	Glenn J. Poffenbarger MD	Physician	975,578	0	38,786	1,014,364
Riverside Healthcare Association	Robert Cullom	Physician	1,004,836	0	1,062	1,005,898
University of Virginia Physicians Group	John A. Kern MD	Physician/Professor	793,315	169,426	38,614	1,001,355
Source: IRS Form 990 Filings						

Government (Public) Hospitals

Medical centers operated by governmental entities are not a major component of the Virginia hospital scene. Of the six facilities in this category, four are operated by public universities: University of Virginia and Virginia Commonwealth University. The largest of these facilities are teaching hospitals with substantial operating margins and the ability to leverage the services of interns and residents at low cost. As appendages of large universities, these hospitals may be expected to have more in common with private not-for-profit medical centers. In fact, the physicians at UVA and VCU are employed by private, 501(c)3 physician groups. Two UVA physicians are on the list of not-for-profit hospital employees earning over $1 million annually in Table 4.

Virginia does not have large urban public hospitals like Bellevue Hospital in New York or Grady Memorial Hospital in Atlanta that would normally be expected to have unusually high concentrations of uninsured and Medicaid patients. That said, patients in these categories are not distributed uniformly across Virginia hospitals, as we discuss below.

Disproportionate Share Hospitals and Hospital Closures

Although privately-owned Virginia hospitals are performing well in the aggregate, individual results vary. Hospitals in less affluent areas admit a greater proportion of uninsured patients and Medicaid beneficiaries. Uninsured patients often do not pay their hospital bills, while Medicaid provider payments are generally lower than rates paid by Medicare and private insurers. In 1981, Congress authorized special payments to so-called Disproportionate Share Hospitals (DSH) – those that care for an unusually large share of uninsured and Medicaid patients.[25]

Nationally, a number of rural hospitals have shut down since the beginning of 2013. In Georgia, four such hospitals closed,[26] while Vidant Pungo Hospital in Belhaven, North Carolina closed in July 2014 after a planned takeover by the city of Belhaven failed to materialize.[27] Finally, in Pennington Gap, Virginia, Lee Regional Hospital – a recipient of Medicaid DSH funding - closed on October 1, 2013.[28]

Some ACA supporters have attributed recent hospital closures to the states' failure to participate in Medicaid expansion. Their premise is that the Affordable Care Act reduced DSH payments as an offset to the additional Medicaid reimbursements hospitals would receive from expansion. When certain states, including Virginia, declined to expand Medicaid they put their marginal hospitals at risk. As Tara Culp-Ressler wrote at ThinkProgress:

> Providers that serve a high number of poor and uninsured Americans, technically called "Disproportionate Share Hospitals," often operate on a loss because their patients can't always pay for their care. To compensate, the federal government offers reimbursements for those hospitals — but the Affordable Care Act changes the way the payments are structured. Because the health law intended every state to expand Medicaid, and therefore reduce the number of uninsured people who

[25] Alison Mitchell, *Medicaid Disproportionate Share Hospital Payments* (Congressional Research Service, 2013), http://fas.org/sgp/crs/misc/R42865.pdf.
[26] Andy Miller, "Another Rural Hospital Closed," *Albany Herald*, February 15, 2014, http://www.albanyherald.com/news/2014/feb/15/another-rural-hospital-closed/.
[27] "Even with Pungo Hospital Closed, Town Looks at Options," *WITN 7 News*, July 1, 2014, http://www.witn.com/home/headlines/Possible-Roadblock-For-Vidant-Pungo-Hospital-Transfer-263355711.html.
[28] "Wellmont to Close Virginia Hospital, Points to Obamacare, Patient Loss," September 11, 2013, http://www.johnsoncitypress.com/article/110933/wellmont-to-close-virginia-community-hospital.

> can't pay their bills, the reimbursements for DSH hospitals have been reduced. But if hospitals are located in states that continue to refuse Obamacare's Medicaid expansion, that puts them in a difficult spot. They're losing out on some of the federal government's funding without making up the difference with an influx of insured patients.[29]

When Wellmont Health System announced the closure of Lee Regional Medical Center it cited "reimbursement cuts associated with the Affordable Care Act" as one of the reasons for shutting down the facility[30] - echoing Culp-Ressler's narrative.

However, these statements do not comport with the facts. The original Affordable Care Act legislation phased in DSH reductions starting in FY 2014. The cut for that year was supposed to be $500 million nationally[31] – about 4.4 percent of the $11.4 billion of DSH allotments in FY 2012. So, Lee Regional had not been impacted by DSH reductions when Wellmont decided to close it.[32] Further, Congress has subsequently passed two bills that delay the Medicaid DSH reductions, and they are now not scheduled to begin until FY 2017.[33] Consequently, no recent hospital closures can be accurately attributed to state's failure to offset DSH reductions – since none have occurred.[34]

It is also worth noting that Virginia receives a relatively small amount of Medicaid DSH funds. In FY 2012, the state's hospitals were allotted only $90 million of the $11.4 billion apportioned nationally.[35] Thus, Virginia was allotted 0.8 percent of the national total, although the state accounted for 2.6 percent of US population in 2012.[36] Finally, DSH allotment cuts – if and when they occur - will not be proportional across states. The law directs the Secretary of HHS to make greater cuts in states that have the "lowest percentages of uninsured individuals".[37] These states are unlikely to include those that have declined the Medicaid expansion.

If DSH reductions fail to explain the closure of Lee Regional and several out-of-state hospitals, what does? It is more likely that the closures are part of a long-term decline in rural hospitals – rather than a new phenomenon. According to the HHS Inspector General, 208 rural hospitals closed between 1990 and 2000. Most of the closures were the result of consolidations or failure of low utilization facilities. On

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[29] Tara Culp-Ressler, "A Rural Hospital Is Closing In Tennessee Because The State Refuses To Expand Medicaid," *ThinkProgress*, April 30, 2014, http://thinkprogress.org/health/2014/04/30/3432599/tennessee-medicaid-hospital/.

[30] "Wellmont to Close Virginia Hospital, Points to Obamacare, Patient Loss."

[31] Mitchell, *Medicaid Disproportionate Share Hospital Payments*.

[32] Further, VHI data indicates that Lee Regional did not receive a Disproportionate Share Hospital payment in 2012.

[33] Public Law 113-67 delayed the DSH reductions to FY 2016, and Public Law 113-93 further delayed the reductions to FY 2017. The latest version of the affected statute, Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)), can be found at http://www.law.cornell.edu/uscode/text/42/1396r-4.

[34] In addition to Medicaid DSH, CMS also operates a Medicare DSH program. Hospital reimbursements under this program are also being reduced in accordance with Section 3133 of PL 111-148, The Patient Protection and Affordable Care Act. However, according to the HHS Actuary, this provision had no impact through FY 2013 and only $110 million nationally in FY 2014. See Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Center for Medicare and Medicaid Services, April 22, 2010), http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

[35] "Medicaid Program; Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FY 2012, and Preliminary FY 2013 Disproportionate Share Hospital Allotments and Limits," *Federal Register*, July 26, 2013.

[36] U.S. Census Bureau, "State & County QuickFacts: Virginia," 2014, http://quickfacts.census.gov/qfd/states/51000.html.

[37] 42 U.S. Code § 1396r–4(f)(7)(A)(i)(I)

average, the hospitals that closed had a daily census of ten patients of which five were Medicare beneficiaries and only one was a Medicaid beneficiary.[38]

Low utilization is also a factor in the more recent closures.[39] A 2009 analysis of 32 Georgia Critical Access Hospitals (CAH) found an average occupancy rate of only 25 percent.[40] The four Georgia hospitals that closed since early 2013 were all CAHs – which are eligible for special federal subsidies and must be limited to 25 acute beds. In 2011, Kaiser Health News profiled a Louisiana CAH in which fewer than four of the hospital's 25 beds were occupied on an average day.[41]

According to Virginia Health Information[42], Lee Regional Medical Center had a 33.90 percent staffed bed occupancy rate in 2012. This rate was the fourth lowest among the 73 general hospitals[43] in VHI's 2012 acute hospital data set, which had a median occupancy of 63.32 percent. So it is fair to conclude that low occupancy was also a major factor in Wellmont's decision to close this facility.

More generally, the VHI data set shows a statistically significant correlation ($p < .01$) between hospital utilization rates and their total margin (i.e., net income as a fraction of total revenue). In other words, more highly utilized hospitals tend to be more profitable. There is also a statistically significant correlation (again at $p < .01$) between the number of staffed beds and total margin. This is an intuitive outcome since hospitals have some level of fixed costs. The bigger the hospital, the more beds across which these costs may be divided.[44]

Policy Options

In free, competitive markets, suppliers that attract fewer customers are more likely to fail. Even though the hospital industry is highly regulated and subsidized, we see much the same outcome. Small, low utilization hospitals struggle and are sometimes obliged to shut down.

It is possible to avoid this phenomenon by increasing subsidies to Critical Access Hospitals and other small medical facilities. Policymakers may choose this option – despite its apparent inefficiency – in response to a belief in universal service availability. Just as the nation has many under-utilized post offices in small towns owing to a common belief in the importance of universal access to mail service, it may be deemed appropriate to have small, uneconomic hospitals in rural areas in the belief that everyone should be near a hospital.

Medicaid expansion is an inefficient way to achieve the goal of keeping small, rural hospitals open, because most of the additional funding will go to larger, profitable hospitals that can readily afford to

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[38] Janet Rehnquist, *Trends in Rural Hospital Closure 1990-2000* (Office of Inspector General, Department of Health and Human Services, May 2003), http://oig.hhs.gov/oei/reports/oei-04-02-00610.pdf.

[39] In theory, Medicaid expansion could expand utilization, but the more likely affect would be to shift some charity care admissions to Medicaid-eligible admissions. The core problem of low utilization would thus remain.

[40] Draffin & Tucker, LLP, *Critiical Access Hospital Financial Analyses - 2009*, June 2010, http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/12/16/163203500CAH%20Fiscal%20Analysis%20-%20Phase%20III.pdf.

[41] Jenny Gold, "When 'Critical Access' Hospitals Are Not So Critical," *Kaiser Health News*, December 8, 2011, http://www.kaiserhealthnews.org/stories/2011/december/08/medicare-critical-access-rural-hospitals.aspx.

[42] Virginia Health Information, *Hospital 2012 Worksheet*, Industry Reports (Richmond, VA, 2013).

[43] The overall VHI data set includes a total of 89 facilities: 73 general hospitals, 7 critical access hospitals, 6 long term acute care hospitals and 3 children's hospitals. Three of the 16 specialized facilities had lower occupancy rates than Lee Regional in 2012.

[44] Regression analysis was performed on the 2012 VHI data set. The 2013 data we reviewed did not include the number of staffed beds.

provide charity care. Instead of further expanding the margins of these larger facilities, policymakers should consider focusing incremental expenditures on those hospitals most at risk of closing. This could best be done outside the context of the Medicaid program.

Conclusion

Most Virginia hospitals are profitable, and many can afford to provide their executives with generous compensation packages. They thus do not require Medicaid expansion to provide care to economically disadvantaged Virginians. The voluntary provision of charity care has deep roots in medical ethics and hospital development. Further government involvement in charity care involves subsidizing profitable investor-owned hospital companies as well as many large not-for-profit hospitals and health systems that earn revenues well in excess of their costs.

Some Virginia hospitals are experiencing financial distress most often because they have insufficient volume to cover their fixed costs. If policymakers prefer to avoid mergers and closures among these low utilization facilities, they can support these hospitals directly rather than providing untargeted hospital subsidies through Medicaid expansion.

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"… a wise and frugal government, which shall restrain men from injuring one another, shall leave them otherwise free to regulate their own pursuits of industry and improvement, and shall not take from the mouth of labor the bread it has earned. This is the sum of good government, and this is necessary to close the circle of our felicities."

Thomas Jefferson, 1801

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