

## Vidant Medical Center

Vidant Medical Center (VMC) in Greenville, North Carolina is a large non-profit hospital; it is part of a larger health system that is the sole provider for many rural communities in eastern North Carolina. Because of its affiliation with a state university, the hospital receives cost-based reimbursement from Medicaid and uses Medicaid disproportionate share hospital (DSH) payments to cover its remaining uncompensated care costs for uninsured patients.

### Hospital and Market Characteristics

VMC is a non-profit hospital and the flagship facility of the Vidant Health System, a regional system that serves 29 counties in eastern North Carolina. VMC is the only hospital in Greenville and provides acute, intermediate, rehabilitation, and outpatient services. It serves as the tertiary referral facility for 29 counties.

VMC is also the primary teaching hospital for East Carolina University's Brody School of Medicine. VMC received \$22 million in Medicaid DSH payments in 2012, which represented 8 percent of its total Medicaid revenue (\$291 million) and 2 percent of its total operating revenue (\$1.1 billion).

### Role in the safety net

Although currently part of a private non-profit health system, VMC had been a county hospital until 1998. According to executives, VMC is the safety-net hospital in the community. Executives reported that about 8 percent of VMC's patients are uninsured and about 18 percent are enrolled in Medicaid. In 2014, the share of VMC's inpatient population who were low-income or enrolled in Medicaid was higher than the average share for hospitals in the Greenville hospital referral region (HRR) or in North Carolina (Table 1).

**TABLE 1.** Medicaid and Low-Income Utilization Statistics for Vidant Medical Center and Other Hospitals, 2014

Comparison region	Medicaid inpatient utilization rate	Low-income utilization rate
Vidant Medical Center (Greenville, NC)	30%	18%
Greenville, NC, hospital referral region average	17	12
North Carolina average	19	14
National average	18	13

**Notes:** The Medicaid inpatient utilization rate is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid. The low-income utilization rate is a measure of Medicaid and charity care utilization.

**Source:** MACPAC, 2017 analysis of 2014 Medicare cost reports.



## Types of services provided

VMC is a 909-bed hospital. It plans to add more beds in the near future, and is currently building a 96-bed cancer center. The hospital's physicians are employees of the Vidant Medical Group, which employs about 400 providers system-wide (approximately 250 physicians and 150 mid-level providers). The Vidant Health System also has an affiliation agreement with East Carolina University that includes a network of approximately 400 additional physicians. As the only tertiary care provider and Level I Trauma Center in a rural region that, in the words of one executive, is "the size of Maryland," VMC maintains four helicopters and two mobile intensive care units located throughout their region to help provide this dispersed population with emergency care and transport them to the hospital.

Executives reported that the hospital works with partners such as local health departments, churches, and schools on efforts to increase access and promote health and wellness among the communities they serve. For example, one executive described a partnership to improve child health: "Before . . . we had a huge problem with asthma. Our ED was always full with [children with] asthma and diabetes. And we have almost eliminated the need for that by putting nurses in the school, [which] we fund."

## Market characteristics

VMC executives reported that roughly 98 percent of Greenville's inpatient hospital admissions are to their hospital. They also estimated that about 60 percent of its admissions are from outside Greenville, primarily from its 29-county service area, which includes 7 other hospitals (mostly small county hospitals or critical access hospitals). They said that VMC, as the only tertiary care provider in the large geographic area, has the third largest number of patients transferred to their hospital in the nation. Executives said that in the part of VMC's coverage region located closer to the city of Raleigh, they compete for patients with Duke University, WakeMed Health & Hospitals, and University of North Carolina hospitals, especially for tertiary care. One executive suggested that VMC might be losing some business in that region because "in some instances the road system is a little better going that way than it is coming here."

Executives said that VMC is the largest employer in eastern North Carolina, with the next largest employers being East Carolina University and the Pitt County government and school system. Executives described this as a financial challenge for VMC because, "In some other large urban areas where you have large employers . . . [they] can bring [covered] employees to you on a larger scale; we don't have the luxury of that kind of business." Commercial business was reported to account for about 22 percent of VMC's patient revenues, with many of those commercially insured patients being employees of the hospital.

## State Context

North Carolina has not expanded Medicaid coverage to adults under age 65 with incomes at or below 138 percent of the federal poverty level, and in 2014, the state's uninsured rate was 13.1 percent.



North Carolina pays for Medicaid mainly through a fee-for-service (FFS) delivery system and makes relatively large DSH and non-DSH supplemental payments; these payments accounted for 15 percent of Medicaid benefit spending in 2014.

## Effects of the Affordable Care Act

VMC executives reported little change in the level of uncompensated care since 2014 because of North Carolina's decision not to adopt the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). They said that VMC had experienced some increase in bad debt due to people with high deductible plans. The hospital was unable to sign up many patients for health insurance exchange plans despite having patient navigators available to assist them because "once [patients] found out a lot of them didn't qualify for a full subsidy, they weren't interested."

Executives also noted that the Medicare hospital readmission penalties added under the ACA have resulted in the hospital receiving some reductions in payment and "reputational hits." They expressed the belief that these penalties disproportionately affect safety-net institutions like VMC because of the socioeconomic challenges that their patients face. On the positive side, executives reported that the focus on readmissions "causes us to look [for] and find partners that we wouldn't have had. We talk to people who can help change that metric, which could have good impact."

## State policy changes affecting Medicaid supplemental payments

VMC executives reported few recent changes in state policy pertaining to DSH payments. North Carolina distributes DSH dollars through its Medicaid Reimbursement Initiative (MRI) plan, which spreads funding across qualifying public and private hospitals. The MRI is designed to help cover hospital Medicaid shortfall for both outpatient and inpatient services, with some additional payments going to teaching hospitals for uninsured patients. Public hospitals cover the non-federal share of DSH payments through IGTs. The extent to which the shortfall is covered under the MRI plan varies by whether a hospital is a public or private facility.

North Carolina began making upper payment limit (UPL) payments for Medicaid outpatient and inpatient services in 2012 through a program referred to as the Hospital GAP/UPL plan.<sup>1</sup> The state share of UPL payments is funded by a hospital provider tax.

One policy change that has the potential to affect VMC's Medicaid supplemental payments is North Carolina's planned transition to capitated Medicaid managed care. Executives were worried about this change. One executive said that this shift "may disrupt the current relationship we have [with the state]. I'm more scared of what that is going to do to [the hospital] than I am of anything." Executives were particularly concerned about having the resources to build a system of care to adequately serve their population in a managed care environment, especially in a rural setting where getting access to primary care is a challenge. Executives were anticipating a major reduction in hospital admissions because that is what they observed in other states with Medicaid managed care, and reported that they were working to prepare for this shift while still surviving in the current payment environment. As one executive said, "I think most of us are out here trying to create new models of care, build systems of care, close hospitals



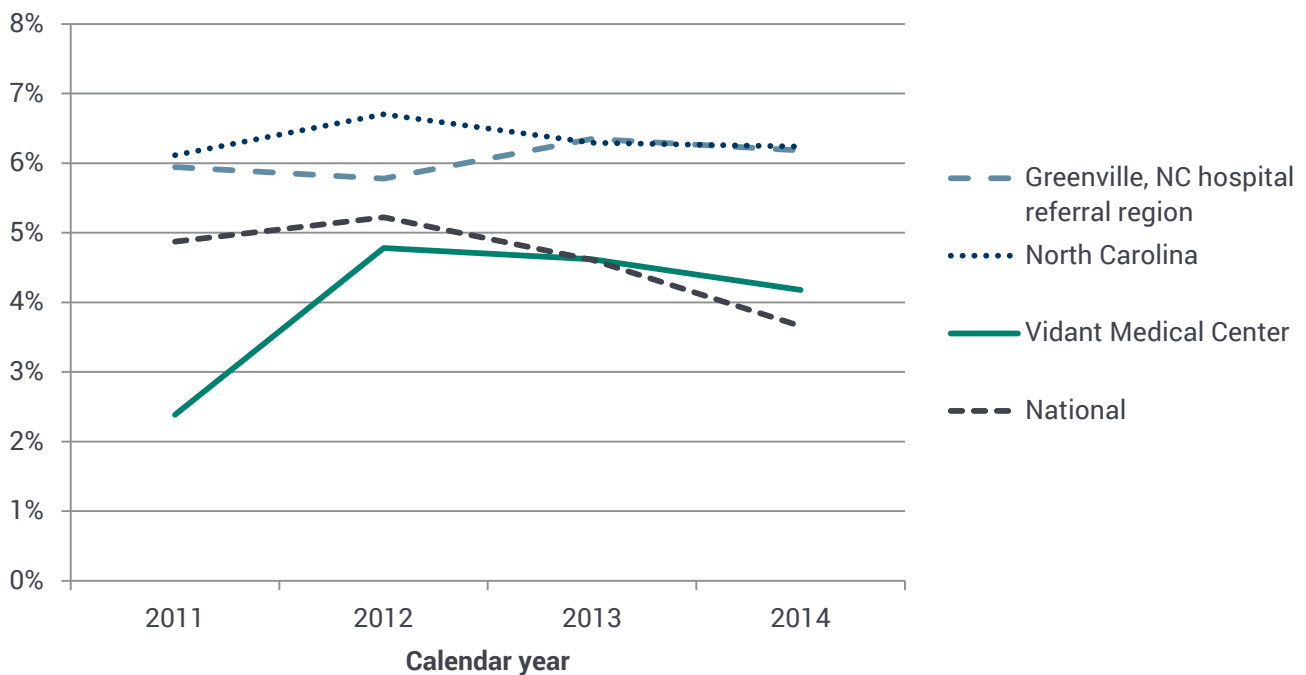
that need to be closed and put other access point in, and actually do that hard work, but it's very hard to do and it takes time to do it, and you have to survive that transition.”

## Hospital Financial Information

### Uncompensated care

Medicare cost reports show that bad debt and charity care as a share of operating expenses more than doubled for VMC between 2011 and 2012, although it remained below reported state and HRR levels (Figure 1). Hospital executives did not have an explanation for this increase. Between 2012 and 2014, VMC's bad debt and charity care declined slightly.

**FIGURE 1.** Uncompensated Care as a Share of Hospital Operating Expenses, Vidant Medical Center versus Other Hospitals, 2011–2014



**Note:** Medicare cost reports define uncompensated care as charity care and bad debt.

**Source:** MACPAC, 2017, analysis of Medicare cost reports.

### Medicaid payment shortfall

VMC is a non-profit hospital, but because of its medical affiliation with Eastern Carolina University, it is considered a public hospital under North Carolina Medicaid guidelines and receives 100 percent cost-based reimbursement for Medicaid inpatient and outpatient services. As a result, the hospital does not have a Medicaid shortfall.



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Executives said that although cost-based payments have been fairly stable, in 2015, North Carolina reduced coverage of Medicaid shortfall for outpatient services. This change reduced VMC's payments for outpatient services from 100 percent of cost to 70 percent of costs. In 2016, this reduction was restored and VMC is again paid full cost-based payment for all Medicaid services it provides.

## Medicaid DSH payments

Executives reported receiving about \$70 million DSH payments in 2016 through the MRI plan. VMC does not help finance the state share of these payments, so the full \$70 million is realized by the hospital.

## Other Medicaid supplemental payments

Non-DSH Medicaid supplemental payments represented about 8 percent of VMC's Medicaid payments in 2012. The supplemental payments are primarily made through the state's UPL program.

Because of its status as a teaching hospital for a state medical school, VMC is exempt from paying the provider tax used to finance UPL payments. (In North Carolina, critical access hospitals are also exempt from the provider tax.) VMC executives said they received \$32 million in UPL payments in 2015. Executives said that the infusion of UPL payments that began in 2012 "have helped solidify our ability to continue the services we do have." However, executives went on to say that they expected VMC's UPL payments to drop to \$25 million in 2016 because of a decline in overall Medicaid inpatient admissions in North Carolina, which they attributed to delivery system reforms and improvements in care management.

## Role of DSH Funding

Executives said that they use DSH and other Medicaid supplemental payments to build and maintain a system of care that helps VMC's patient population stay healthy and out of the hospital, and that this is particularly important because the rural, low-income population that VMC cares for has high rates of chronic disease. As one executive said, DSH payments "make up some of the costs that we bear. . . . We can't track the DSH dollar . . . but it helps us carry . . . [the] burden of providing care to the population we serve."

Executives said that if DSH payments were reduced, "it would be really traumatic. We would lay [off] people and cut services. . . . We would either cut or limit capacity on trauma, emergency room, or behavioral health." In addition, executives explained that because VMC is the largest employer and the main health care provider in the area, any reductions in DSH funding would have broad repercussions in the community. According to one executive, it would be major: "It's a 909-bed hospital in a town of 100,000 people. There aren't very many towns like that. So just the economic impact of losing DSH funding—the jobs, the lives, the services that wouldn't be provided . . . ."

Executives expressed concern about planned federal cuts to Medicaid DSH funding based on the assumption that a hospital's need for those payments would be reduced due to increased coverage for patients under the ACA. One executive said, "So if you're a state that didn't [expand Medicaid] and DSH



cuts still happened, that really affects our capabilities. That's the biggest threat." Executives also thought outpatient services should be considered in DSH payment allocation to support hospital preparation for payment models that emphasize value over volume, citing VMC's work to develop new systems of care and increase emphasis on keeping patients out of the hospital.

## Data and Methods

The information in this profile comes from interviews with hospital executives during the summer and fall of 2016 and MACPAC's analysis of Medicare cost reports, DSH audits, and other publicly available data. For a summary of the findings from all seven DSH hospitals that we profiled and more information about our methods, please see MACPAC's issue brief, *Profiles of Disproportionate Share Hospitals*.

*MACPAC would like to thank Teresa Coughlin and Christal Ramos at Urban Institute for designing and conducting the interview with Vidant Medical Center that was the basis for this profile. The interview was one of seven interviews with executives from safety-net hospitals across the country that occurred between June and October of 2016.*

### Endnote

<sup>1</sup> An upper payment limit (UPL) is the maximum aggregate amount of Medicaid fee-for-service payments that a state may make to a class of institutional providers. A UPL payment is a supplemental payment to a Medicaid provider based on the difference between the amount paid in standard payment rates and the UPL.

