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FOR WEST VIRGINIA POLICY

The Payer Mix Narrative

What Hospital Financials Show in West Virginia

Authored by
Jessica Dobrinsky

ABOUT US

The Cardinal Institute is a West Virginia-based research and education organization committed to improving life in the Mountain State. Through policy research, public education, and community engagement, we provide practical, evidence-informed ideas to expand opportunity and support stronger, safer communities.

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Jessica Dobrinsky is the Chief of Staff at the Cardinal Institute for West Virginia Policy, where she leads internal operations, supports development strategy, and advances the organization's health policy research agenda. She is a nationally recognized expert on Certificate of Need laws, with broader expertise in healthcare regulation, Medicaid policy, and state-level health reform.

Previously, Jessica served as a Policy Analyst and Staff Writer, producing research and commentary on healthcare policy and regulatory barriers to access. Her work has appeared in Forbes, The Washington Examiner, The Spectator, and Real Clear Markets. Earlier in her career, she worked in state government as a Judith A. Herndon Fellow at the West Virginia Department of Health and Human Resources and as a legislative assistant in the West Virginia State Senate.

Jessica holds a Bachelor's degree in Criminology from West Virginia University and a Master of Public Administration and Policy from American University.

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INTRODUCTION

As West Virginians continue to face dwindling access to healthcare providers and services, some state healthcare providers have pushed legislative dialogue surrounding the term “payer mix.” I.e., existing hospital networks claim West Virginia’s “~75% Medicare/Medicaid/PEIA payer makeup” forces hospital systems into financial distress. But this assertion leans heavily into a politically motivated narrative.

The payer mix claim is used as a crutch to justify dependence on high commercial prices, high-margin services, opposition to market-based reform, and service closures in our rural communities. Most notably, it has served as the primary defense of the “need” for West Virginia’s Certificate of Need law.

However, as the following paper reveals, hospital finances and decision-making do not support what such “payer mix” narratives would have the general public believe.

Claims by legacy providers function to reinforce existing market structures in West Virginia, rather than serve patients.

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WHAT IS A MEDICARE RATE? WHY DO HOSPITALS DESCRIBE MEDICARE AS "BELOW COST?"

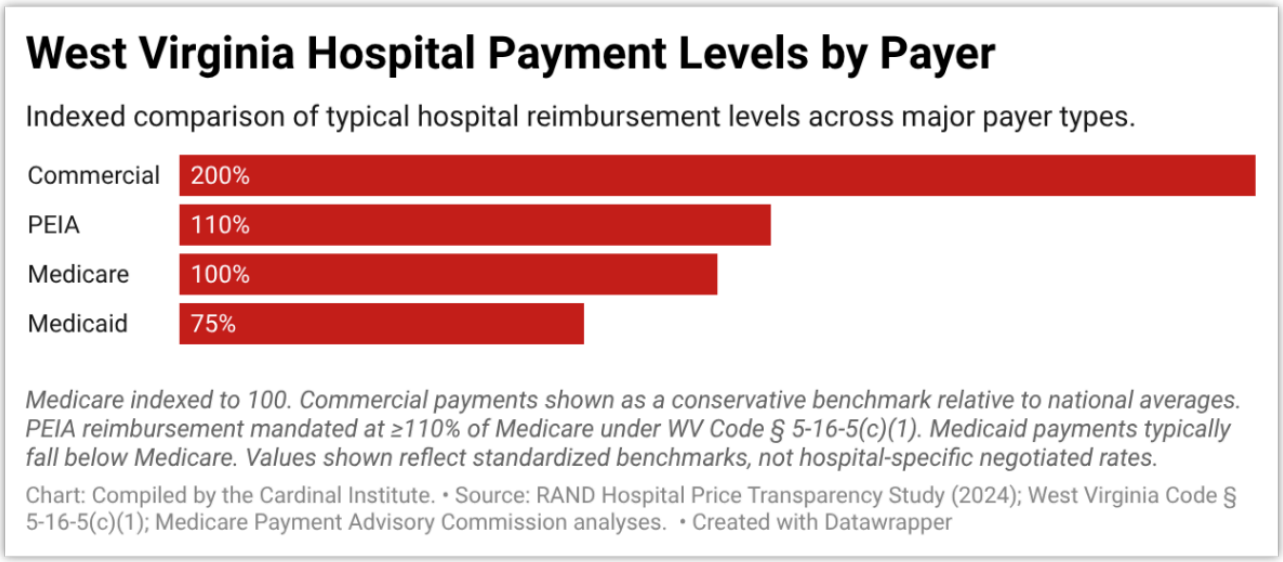
Set by the Inpatient Prospective Payment System (IPPS) and Diagnosis-Related Groups (DRGs), Medicare pays hospitals a regulated price. These formulas take into account geography, labor cost, and patient diversity, but do not increase simply because a hospital's internal costs are high.[1] Hospitals must accept these prices as full and total payment.

This payment structure leads hospital systems to frequently state that Medicare and Medicaid reimburse 'below cost' and place a strain on hospital finances. In this context, 'cost' refers to fully allocated accounting cost rather than marginal or service-level economic cost.[2] These statements rely on accounting cost methods that spread overhead, administrative expenses, capital costs, and systemwide spending across individual service lines, rather than on the marginal cost of delivering care to an additional patient. Hospitals allocate overhead, administrative expense, capital investment, and systemwide spending to individual services, which inflates reported per-service cost figures.[3] When overhead is high, services appear unprofitable on paper.

Three events drive this:

- Hospital campuses carry expensive physical infrastructure and staffing models, even when a service could be delivered in a lower-cost setting (e.g., an ambulatory surgical center), resulting in high fixed costs.[4]
- Costs not attached to a patient, such as administration and facilities, are spread across encounters, inflating the "cost per service" number.[5]
- Health systems often target margins to fund capital expansion (buying more facilities or building more), and accounting frameworks embed these expectations into the "cost" of care.[6]

Under this accounting model, even efficient services can appear loss-making when they are assigned a large share of fixed system overhead, particularly when compared against Medicare's administratively set rates.



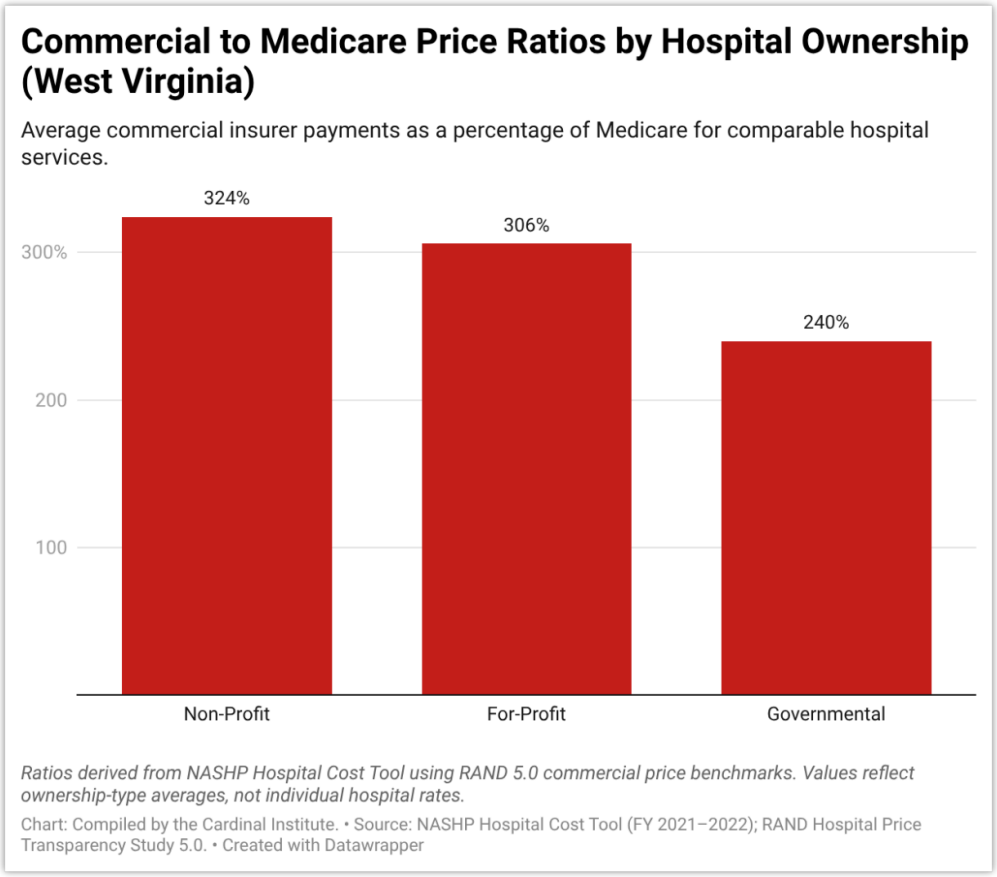
COMMERCIAL PRICING AND MARKET POWER

Facilities such as independent ambulatory surgery centers, imaging providers, home health agencies, and specialty practices regularly operate under Medicare's fixed reimbursement rates while maintaining financial viability.[7] These providers share characteristics including:[8]

- Lower capital intensity
- Lean administrative overhead
- Focused service lines
- Competitive market pressures

These characteristics contrast with traditional hospital cost structures and suggest that the issue is not Medicare's reimbursement rate alone, but rather that high-cost hospital operating models are sustained through consolidated and protected markets rather than pricing that reflects marginal cost, as seen in West Virginia.

Also worth noting is the Affordable Care Act, passed in 2014, which reinforced existing high-cost hospital structures by limiting new market entrants, including restrictions on physician-owned hospitals, and by favoring incumbent systems.[9]

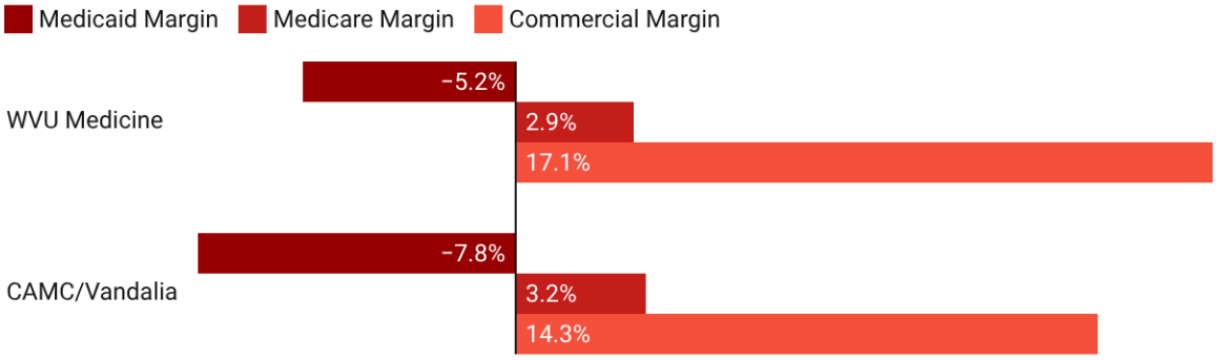


CHALLENGES TO "UNDERPAYMENT" NARRATIVES

The chart below examines profit margins by payer for each of West Virginia's dominant health providers. Commercial prices materially exceed Medicare, indicating payer-specific profitability.

Payer-Specific Margins: WVU Medicine vs CAMC/Vandalia

Both systems experience negative Medicaid margins and modestly positive Medicare margins. Commercial margins are strongly positive (14–17%) and materially exceed public payer margins.



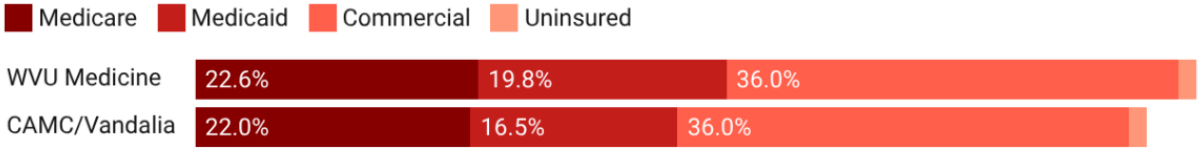
Values reflect system-level averages derived from hospital Medicare cost reports.This shows that payer-specific pricing patterns, rather than payer mix alone, are closely associated with system financial outcomes.

Chart: Compiled by the Cardinal Institute. • Source: NASHP Hospital Cost Tool, 2022 • Created with Datawrapper

As seen in the chart below, the true government payer mix falls below the 75% hospital systems claim.

System Payer Mix: WVU Medicine vs CAMC/Vandalia

Medicare and Medicaid together account for roughly 40% of system revenue, while commercial payers account for more than one-third for both systems.



Payer mix derived from NASHP HCT 2022. PEIA classified as commercial because payment level (≥110% of Medicare) meets commercial payer standards. Uninsured shares are minimal for both systems. System-level values are derived from system-affiliated hospital cost reports.

Chart: Compiled by the Cardinal Institute. • Source: NASHP Hospital Cost Tool, 2022 • Created with Datawrapper

THE CROSS-SUBSIDY DYNAMIC

As a near-rite-of-passage, hospital systems assert that they must charge commercial insurers significantly higher prices to offset losses from their Medicare and Medicaid patients. They claim that this billing technique, known as a "cross-subsidy," is unavoidable, and that set public-payer rates force them to rely on high-markup commercial payers to sustain operations, fund investments, and maintain services.

However, this obscures the structural conditions that make this pricing not only possible, but profitable. Several things shape the "cross-subsidy" in practice:

- Hospital systems possess market power, especially in a Certificate of Need (CON) state, allowing them to charge commercially insured patients up to 200–300% of Medicare rates.[10]
- Commercial insurers accept these charges because they lack alternatives. Hospital systems control essential facilities and referral networks and are often the only healthcare option available.[11]
- Systems employ up-charging not only to stabilize budgets, but also to finance acquisitions, expansions, and consolidations that further reinforce market dominance.[12]

If healthcare were subject to more competitive market forces, prices would be more reflective of the marginal costs of services. Instead, high prices in the hospital system run rampant due to limited competition and constrained patient choice. Indeed, high-cost structures exist not by necessity, but by a market—or lack thereof—that insulates and avoids accountability.

HOW PAYER MIX BECAME A POLICY ARGUMENT

Hospital emphasis on payer mix is merely an argument rather than a financial reality. Audited financial statements, IRS Form 990s (both reported by the systems themselves), and payer mix data from the National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT) do not support this narrative. Examining the state's two largest systems—WVU Medicine and Vandalia—instead demonstrates the following:

- Substantial liquidity (West Virginia University Health System totaling more than $4 billion; Vandalia Health System totaling more than $800M in the latest audited years)
- Positive operating margins
- Strong commercial payer profits
- Minimal charity care relative to revenue (despite their non-profit status)

PAYER MIX DOES NOT EXPLAIN SYSTEMWIDE FINANCIAL OUTCOMES

According to hospital systems, Medicare, Medicaid, and PEIA reimbursement rates create unavoidable financial losses that drive overall system distress. But, when tested against their own audited financial statements and payer margins, payer mix does not materialize an observed strain on financial performance in West Virginia's dominant hospital systems.

Instead, system-level data show the following:

- PEIA reimburses at no less than 110% of Medicare, as required by State Code, operating economically as a commercial-equivalent payer rather than a loss center.[13]
- Commercial margins drive system profitability for both WVU Medicine System and Vandalia Health.
- Like other high public-payer states, West Virginia hospitals exhibit negative Medicaid margins, modest Medicare margins, and strongly positive commercial margins, according to payer-level data from the NASHP HCT.

These results indicate that payer mix does not cause financial anguish for health systems. West Virginia hospital syndicates rely on this framing to excuse price increases, expansion into states without certificate of need laws, and service closures. Audited financial statements directly contradict these claims of structural stress and underpayment.

PEIA IS NOT THE SAME AS MEDICAID AND MEDICARE

Under West Virginia Code § 5-16-5(c)(1), the Public Employee Insurance Agency (PEIA) mandates reimbursement to all healthcare providers at 110% of the Medicare amount, with no statutory ceiling on the amount they may charge. As a result, PEIA functions more as a commercial payer than as a Medicaid-equivalent public program.

Treating PEIA as if it were a traditional government payer misrepresents its payment level and contribution to a system's payer makeup.

> (c) All financial plans shall establish:
>
> (1) The minimum level of reimbursement at 110 percent of the Medicare amount for all providers: *Provided*, That the plan shall reimburse a West Virginia hospital that provides inpatient medical care to a beneficiary, covered by the state and non-state plans, at a minimum rate of 110 percent of the Medicare diagnosis-related group rate for the admission, or the Medicare per diem, per day rate applicable to a critical access hospital, as appropriate: *Provided, however*, That the rates established pursuant to this subdivision do not apply to any Medicare primary retiree health plan.

HOW HOSPITALS CONSTRUCT THE "75% GOVERNMENT PAYER" CLAIM

The claim that 75% of payers in a hospital system are "government" relies on a categorization rather than reality. In review of payer analysis, including through the NASHP HCT, PEIA is included with commercial payers because it reimburses above Medicare and functions as a plan that also includes premium financing.

When PEIA is grouped with Medicare and Medicaid, hospitals inflate the share of lower-paying payers and effectively obscure the role commercial and PEIA pricing plays in their own profitability.

Medicare + Medicaid + PEIA = 75% "government payers"

Actual government share = ~55–60%.

HOW TO READ THE PAYER MIX AND MARGIN DATA

Payer mix is cited as evidence of financial distress. That conclusion does not follow from the data. Financial performance depends on payer margins rather than payer proportion.

Public programs generally reimburse below cost. The Medicare Payment Advisory Commission's (MEDPac) shows that this does not prevent hospitals with strong non-Medicare pricing from remaining profitable. All payer operating margins stay positive even when Medicare and Medicaid margins are negative.[14] (see Table 3-13 from MEDPac below)

West Virginia's hospital systems look the same: Medicaid reflects loss, Medicare near breakeven, and commercial and PEIA are positive. Those margins match national hospital finance patterns and do not indicate an unusual or destabilizing reimbursement problem.

It is therefore inaccurate to treat all payers in West Virginia as financially equivalent. PEIA does not behave like Medicare or Medicaid.

Claims that PEIA should be grouped alongside government programs inflate the portion of low-payer customers and misrepresents the financial picture.

TABLE 3–13

Relatively efficient hospitals performed better than other hospitals but still had a negative median FFS Medicare margin in FY 2023

Metric	Relatively efficient hospitals	Other hospitals
Number of hospitals	123	1,852
Share of hospitals in our study sample	6%	94%
Historical performance, average over 2019, 2020, 2022 (percentage of national median)		
FFS Medicare mortality rate	87%	101%
FFS Medicare readmission rate	92	101
Standardized FFS Medicare costs per unit	92	101
Current-year performance, 2023 (percentage of national median)		
FFS Medicare mortality rate	90%	101%
FFS Medicare readmission rate	93	100
Share of patients rating the hospital a 9 or 10 (out of 10)	104	99
Standardized FFS Medicare costs per unit	91	101
Current-year margins, 2023 (median percentage)		
All-payer operating margin, including coronavirus relief funds	7%	3%
All-payer operating margin, excluding coronavirus relief funds	7	2
FFS Medicare margin, including coronavirus relief funds*	–1	–9
FFS Medicare margin, excluding coronavirus relief funds*	–2	–10

Note: FFS (fee-for-service), FY (fiscal year). Data are for hospitals paid under the inpatient prospective payment systems (IPPS) that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. "Relatively efficient" and "other" hospitals were identified based on their performance during 2019, 2021, and 2022. (For more details, see text box on our identification methodology.)
* The "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system, including uncompensated-care payments and revenue and costs of separately payable drugs, and is reported with and without FFS Medicare's share of federal or other coronavirus relief funds.

Source: MedPAC analysis of hospital cost reports, claims data, data to standardize costs, and CMS's summary of H–CAHPS survey results tables.

DO WEST VIRGINIA'S DOMINANT HEALTH SYSTEMS SHOW FINANCIAL DISTRESS OR STRATEGIC GROWTH?

EVIDENCE FROM AUDITED FINANCIAL STATEMENTS

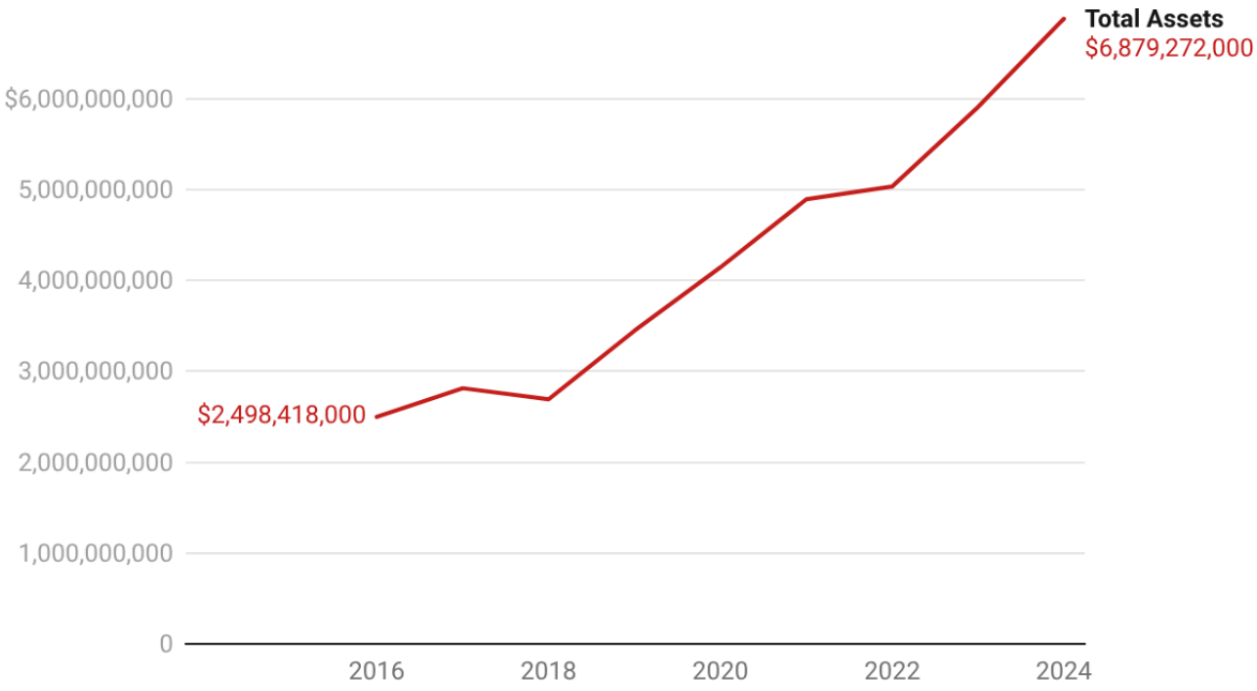
WEST VIRGINIA UNIVERSITY HEALTH SYSTEM (WVU MEDICINE)

Using statements from WVU's own financial audits (FY2016-FY2024):

- Liquidity increased from ~$820M (2016) to ~$4.2B (2024).
- Net assets more than doubled (from $1.20B to $3.36B).
- Long-term debt expanded as the system financed strategic growth.
- Operating margins remained positive every year.

WVU Medicine Total Assets, FY2016–FY2024

Total assets reported in WVU Medicine consolidated audited financial statements show substantial growth over time, coinciding with system expansion and capital investment.

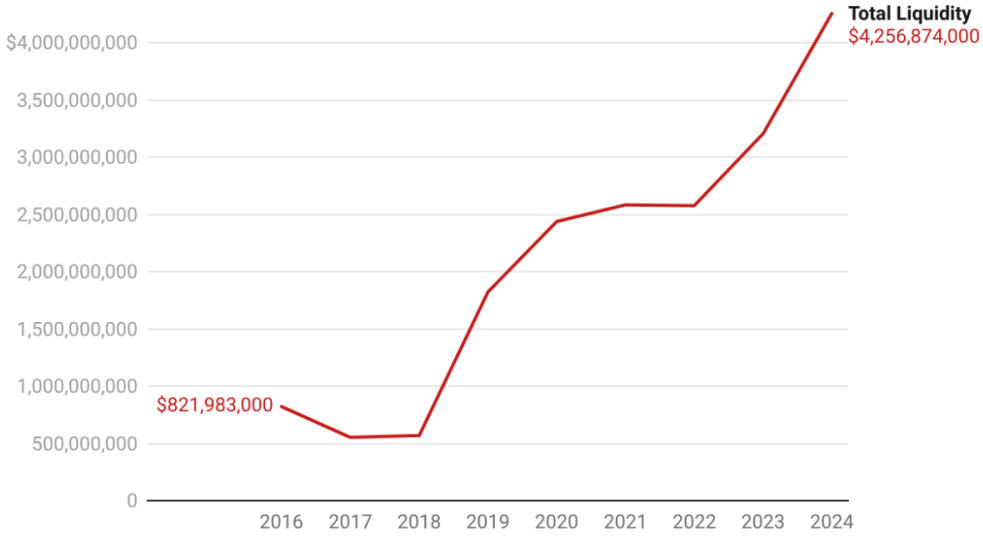


Total assets reflect the consolidated WVU Medicine enterprise, including affiliated hospitals and acquired entities. Values are reported as stated in audited financial statements and public disclosures and reflect balance sheet totals, not operating performance.

Chart: Compiled by the Cardinal Institute • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

WVU Medicine Liquidity (Cash and Investments), FY2016–FY2024

Liquidity reported in WVU Medicine consolidated audited financial statements increased substantially over time, reflecting growth in cash and investment holdings.

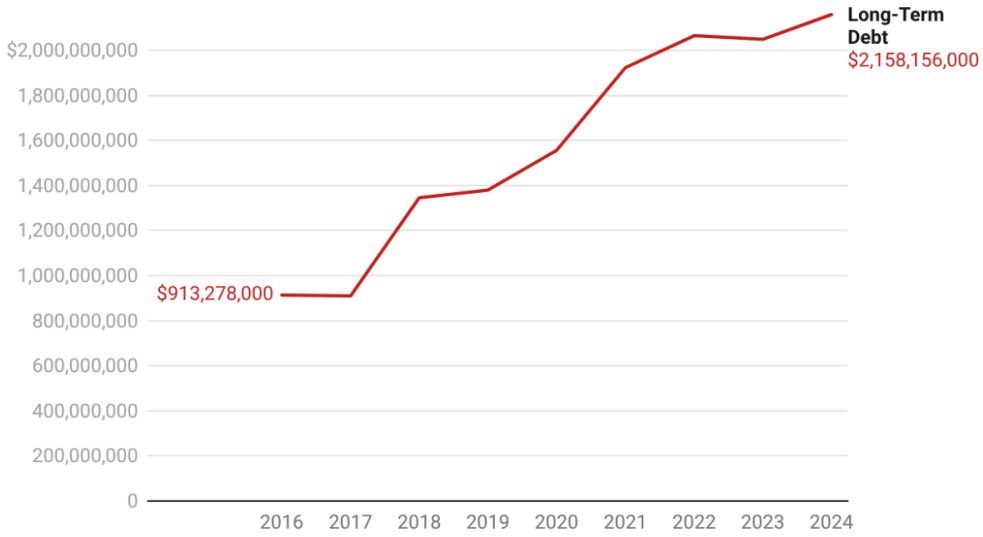


Liquidity includes cash and cash equivalents, short-term investments, and long-term investments as reported in consolidated audited financial statements. Values reflect balance sheet liquidity and do not represent operating margins or annual cash flow.

Chart: Compiled by the Cardinal Institute. • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

WVU Medicine Long-Term Debt, FY2016–FY2024

Long-term debt reported in WVU Medicine consolidated audited financial statements increased over time, reflecting expanded use of debt financing.

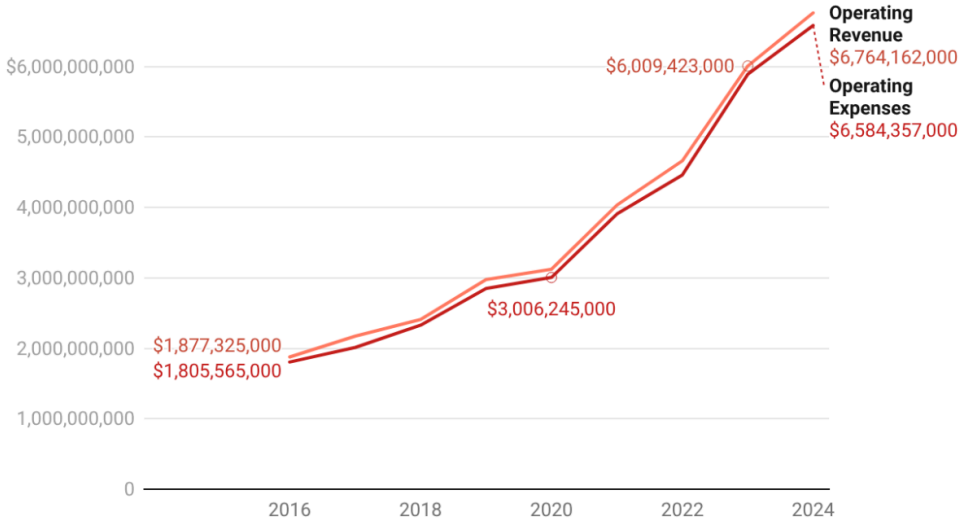


Long-term debt reflects consolidated obligations reported in WVU Medicine audited financial statements and EMMA disclosures. Changes over time coincide with system expansion, capital projects, and refinancing activity. Values reflect outstanding long-term liabilities, not annual borrowing or debt service costs.

Chart: Compiled by the Cardinal Institute. • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

WVU Medicine Operating Revenue and Operating Expenses, FY2016–FY2024

Operating revenue and operating expenses reported in WVU Medicine consolidated audited financial statements increased over time alongside system growth.

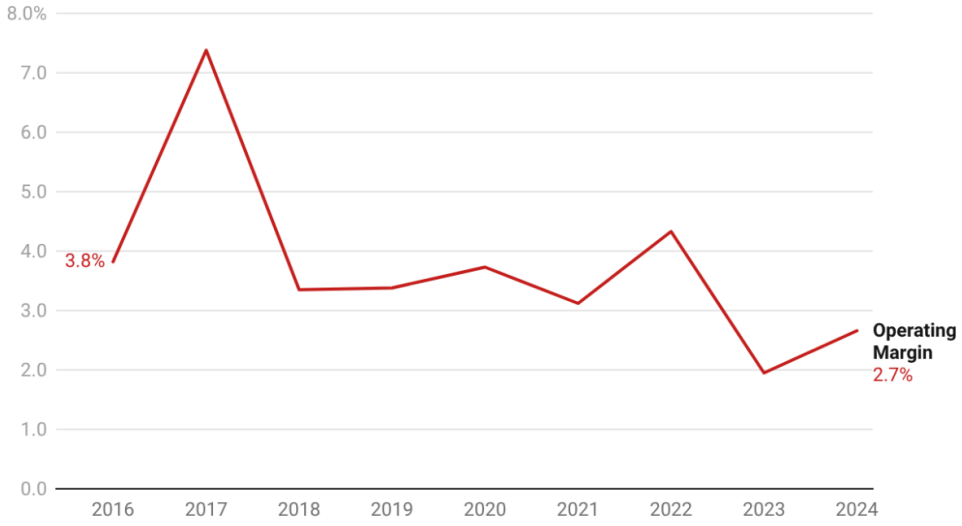


Operating revenue and operating expenses reflect consolidated figures reported in WVU Medicine audited financial statements and EMMA disclosures. Values are reported as stated and reflect system-wide operations, including affiliated hospitals and acquired entities. This chart presents nominal amounts and does not adjust for inflation or changes in system composition.

Chart: Compiled by the Cardinal Institute. • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

WVU Medicine Operating Margin, FY2016–FY2024

Operating margins reported in WVU Medicine consolidated audited financial statements remained positive over the period shown.



Operating margin is calculated as operating revenue minus operating expenses, divided by operating revenue, as reported in consolidated audited financial statements and EMMA disclosures. Values reflect system-wide operations, including affiliated hospitals and acquired entities, and are reported in nominal terms.

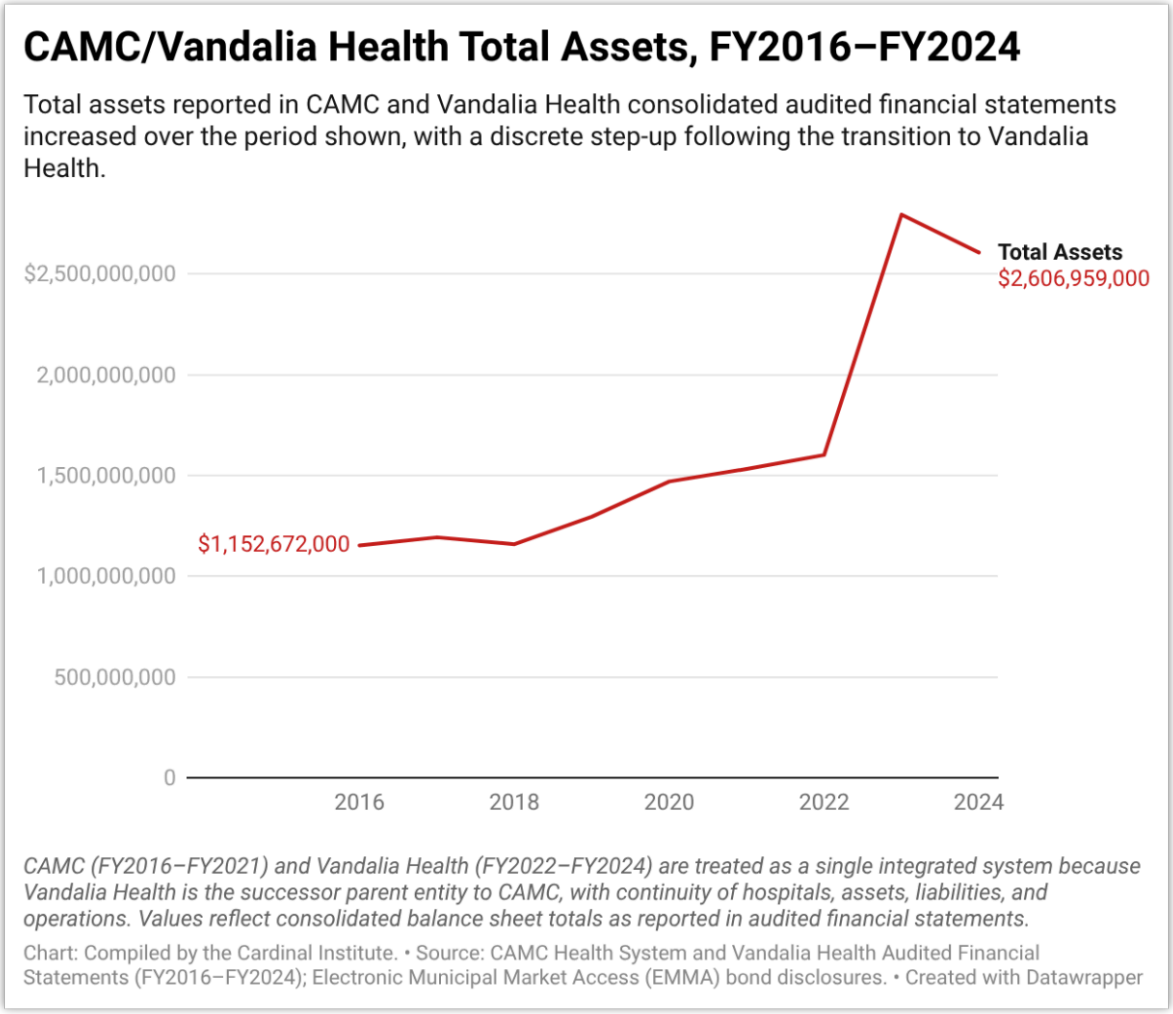
Chart: Compiled by the Cardinal Institute. • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

CAMC/VANDALIA

CAMC/Vandalia's combined audited financials show:

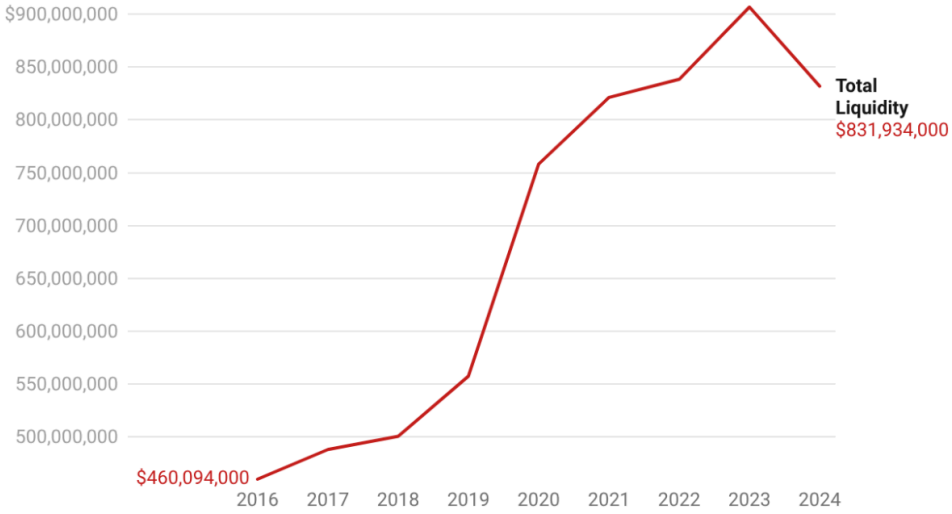
- Consistent profitability
- Liquidity above $830M in 2024
- Sharp increase in long term debt reflects system expansion

Note: CAMC and Vandalia Health Systems are combined in this analysis. Vandalia became CAMC's parent system in FY2022, and all CAMC hospitals, including their assets, liabilities, and financial operations, now roll into Vandalia's consolidated statements. Decisions on capital expenditures, pricing, service, and payer strategies are therefore made at the system level, so financial analysis reflects the organization as a unified entity.



CAMC/Vandalia Health Liquidity (Cash and Investments), FY2016–FY2024

Liquidity reported in CAMC and Vandalia Health consolidated audited financial statements increased over the period shown.

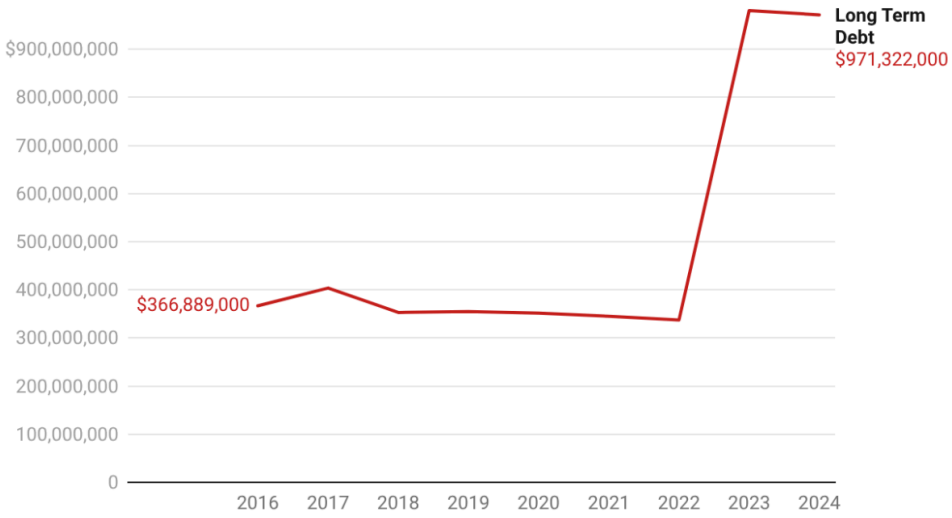


Liquidity includes cash and cash equivalents, short-term investments, assets limited as to use (current and noncurrent), and long-term investments as reported in consolidated audited financial statements. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations

Chart: Compiled by the Cardinal Institute. • Source: CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) bond disclosures. • Created with Datawrapper

CAMC/Vandalia Health Long-Term Debt, FY2016–FY2024

Long-term debt reported in CAMC and Vandalia Health consolidated audited financial statements changed over time, with a discrete increase following system reorganization.

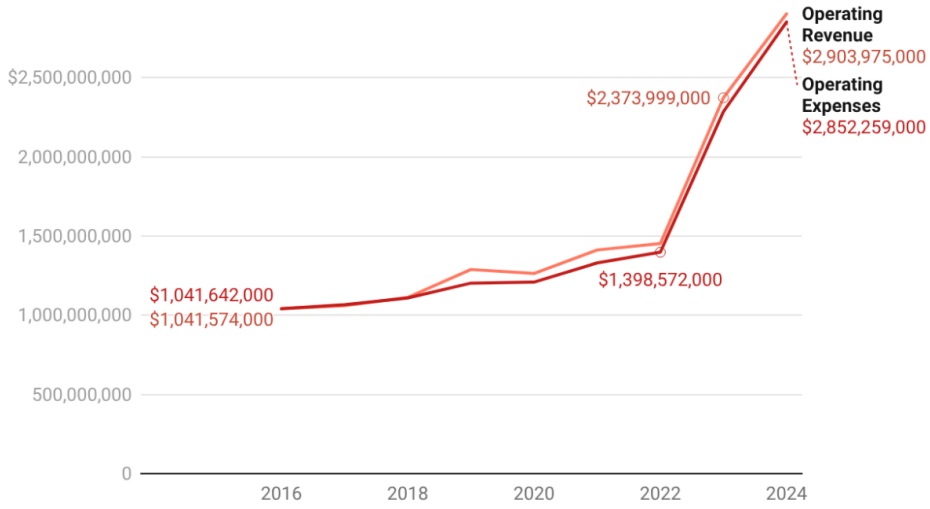


Long-term debt reflects consolidated obligations reported in audited balance sheets. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations. Values represent outstanding long-term liabilities as reported and do not reflect annual borrowing activity or debt service costs.

Chart: Compiled by the Cardinal Institute. • Source: CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

CAMC/Vandalia Operating Revenue and Operating Expenses, FY2016–FY2024

Operating revenue and operating expenses reported in CAMC and Vandalia Health consolidated audited financial statements increased over the period shown.

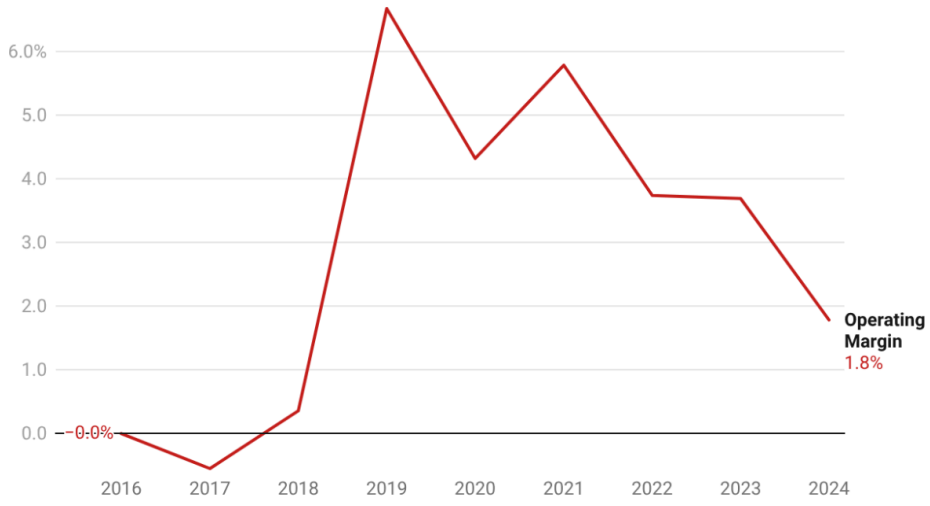


Operating revenue and operating expenses reflect consolidated figures reported in audited financial statements. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations. Values are reported as stated and represent system-wide operations, including affiliated hospitals and acquired entities.

Chart: Compiled by the Cardinal Institute. • Source: CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

CAMC/Vandalia Health Operating Margin, FY2016–FY2024

Operating margins reported in CAMC and Vandalia Health consolidated audited financial statements varied over the period shown.



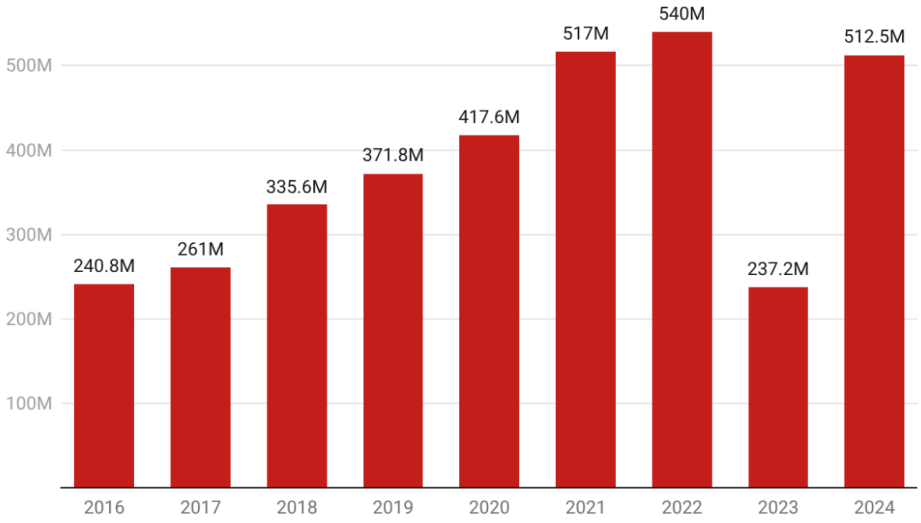
Operating margin is calculated as operating revenue minus operating expenses, divided by operating revenue, as reported in consolidated audited financial statements. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations. Values reflect system-wide operations and are reported in nominal terms.

Chart: Compiled by the Cardinal Institute • Source: CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

SYSTEM COMPARISONS

WVU Medicine Capital Expenditures, FY2016–FY2024

Capital expenditures reported in WVU Medicine consolidated audited financial statements varied year to year and remained substantial over the period shown.

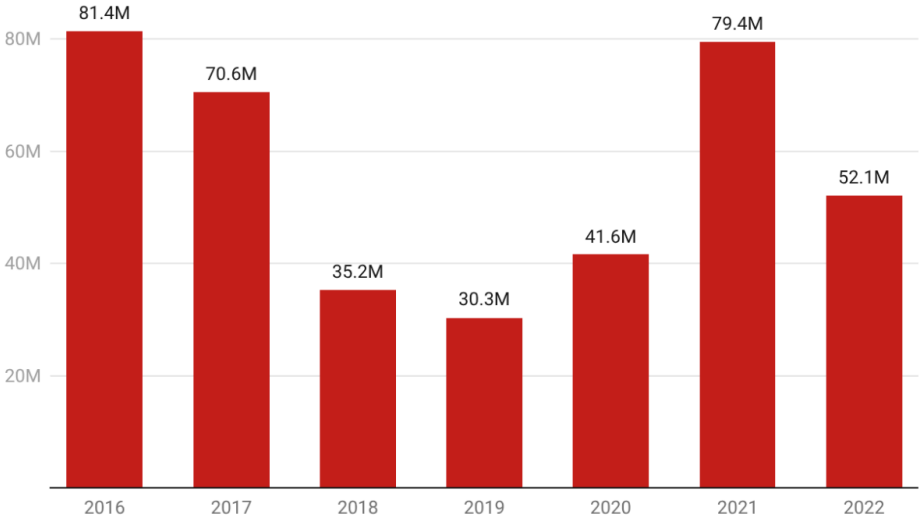


Capital expenditures reflect purchases of property, plant, and equipment as reported on the consolidated Statements of Cash Flows. Values represent gross capital spending in nominal terms and include investments associated with system facilities, equipment, and infrastructure.

Chart: Compiled by the Cardinal Institute. • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

CAMC/Vandalia Health Capital Expenditures, FY2016–FY2022

Capital expenditures reported in CAMC and Vandalia Health consolidated audited financial statements varied over the period shown.

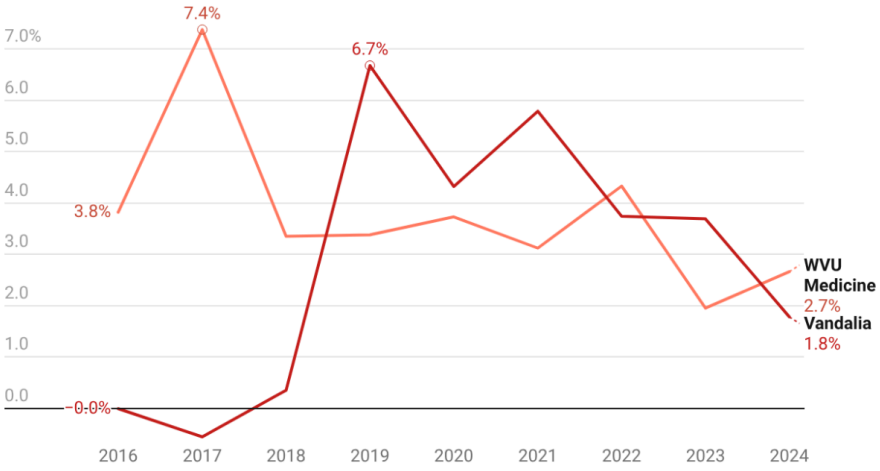


Capital expenditures reflect purchases of property, plant, and equipment as reported in consolidated Statements of Cash Flows. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations. CAPEX values are available through FY2022; no capital expenditure data are reported for FY2023–FY2024 in the audited statements used for this analysis.

Chart: Compiled by the Cardinal Institute • Source: CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2022); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

Operating Margins, FY2016–FY2024: WVU Medicine vs. CAMC/Vandalia Health

Operating margins reported in consolidated audited financial statements for WVU Medicine and CAMC/Vandalia Health varied over the period shown.

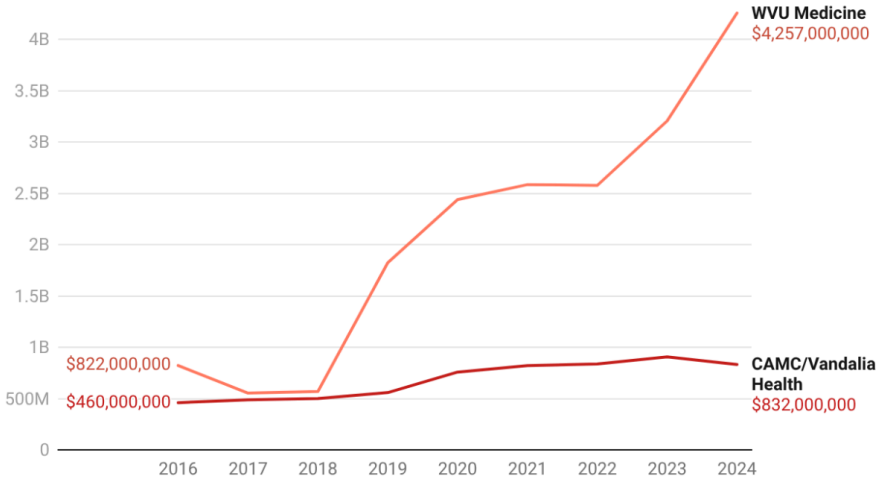


Operating margin is calculated as operating income divided by operating revenue, as reported in consolidated audited financial statements. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations. Values reflect system-level results and do not represent individual hospital margins.

Chart: Compiled by the Cardinal Institute • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

Systemwide Liquidity, FY2016–FY2024: WVU Medicine vs. CAMC/Vandalia Health

Liquidity reported in consolidated audited financial statements for WVU Medicine and CAMC / Vandalia Health changed over the period shown.



Liquidity includes cash and cash equivalents, short-term investments, long-term investments, and assets limited as to use, as reported in consolidated audited financial statements. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations. Values reflect system-level balance sheet amounts and do not represent operating performance.

Chart: Compiled by the Cardinal Institute. • Source: WVU Medicine Audited Financial Statements (FY2016–FY2024); CAMC Health System and Vandalia Health Audited Financial Statements (FY2016–FY2024); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper

CHARITY CARE

Worsening matters, non-profit hospitals receive tax-exemption in exchange for the expectation that they provide charity care, i.e., the reduction or write-off of a hospital charge. Using NASHP and system-level IRS data:

- Most West Virginia hospitals deliver charity care equal to 0.5–1.5% of net patient revenue **(see our report *Who's Caring for West Virginia?*)**
- Patients eligible for the hospital's individual financial assistance policy are often sent to collections and classified as bad debt—another tax write-off.

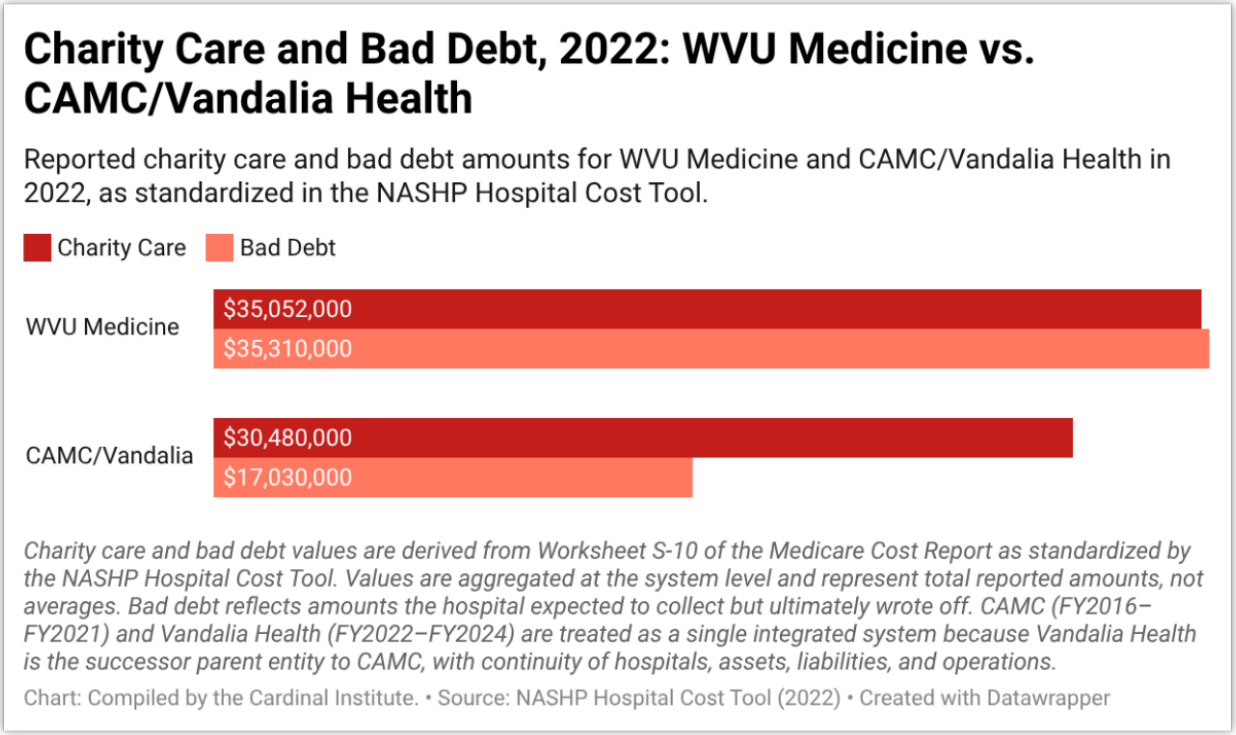
Hospital systems claiming financial distress while holding millions in liquidity reinforce the perception that charity care is simply not a priority, not a natural consequence of capacity or "payer mix."

Financial Assistance Policy (FAP)

Referring to a patient as "FAP-eligible" means that they were likely eligible for elimination or reduction of a bill under a hospital's Financial Assistance Policy; this is not an external standard. Each hospital system has the authority to define what qualifies a potential recipient for discounted or free care based on income, insurance status, and other criteria.

Bad Debt

Bad debt reflects bills that a hospital sought to collect from patients but ultimately did not. These bills are then written off as uncollectible, but only after billing activity, and often after accounts were sent to collection agencies. Bad debt may include patients who met FAP-criteria, making them "FAP-eligible," but were not screened or approved for assistance. Hospitals report the amount of their bad debt write-off likely met their FAP policy.



WHAT ABOUT RURAL HOSPITAL LOSS?

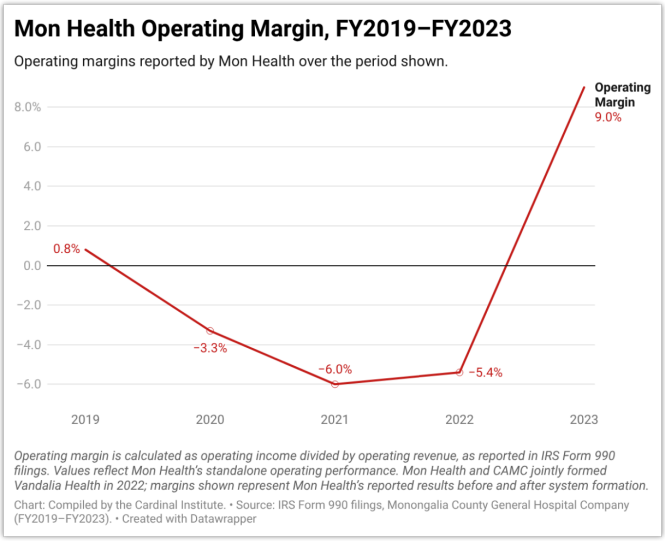
Rural hospitals face greater challenges (including tighter margins), but these pressures stem from structural issues rather than underpayment. For instance:

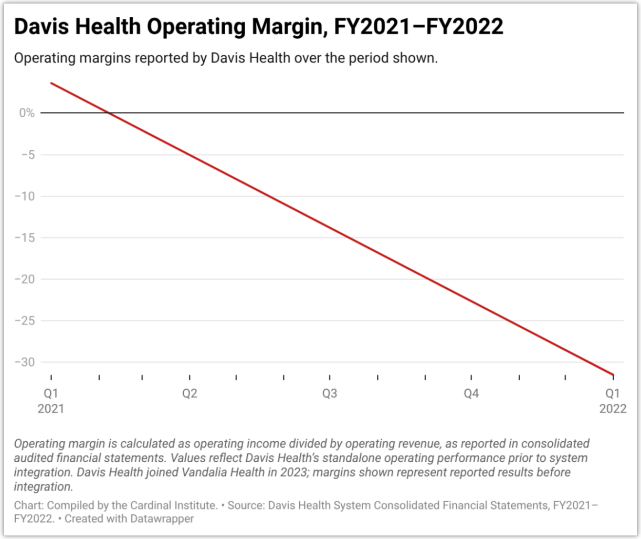
- Low patient volume: rural hospitals have fewer admissions and outpatient visits.
- Fixed staffing requirements: around-the-clock emergency staffing, and licensure apply to all facilities, regardless of size.
- Aging infrastructure: increases maintenance and compliance costs.

While these challenges are often said to be unique to rural facilities, they are not unexpected. In West Virginia, many rural hospitals have been acquired by large systems, including WVU Medicine and Vandalia Health. These systems have access to more liquidity and scale, commonly understood to be essential to sustain vital rural operations. As a result, service reductions reflect strategic decisions rather than closures driven by payment inadequacy.

Financial distress is concentrated in rural facilities, while parent systems maintain positive operating margins. Therefore, closure and reduction indicate prioritization of parent systems rather than a systemwide financial crisis or the claims that payer mix necessitates market protection or weakened accountability.

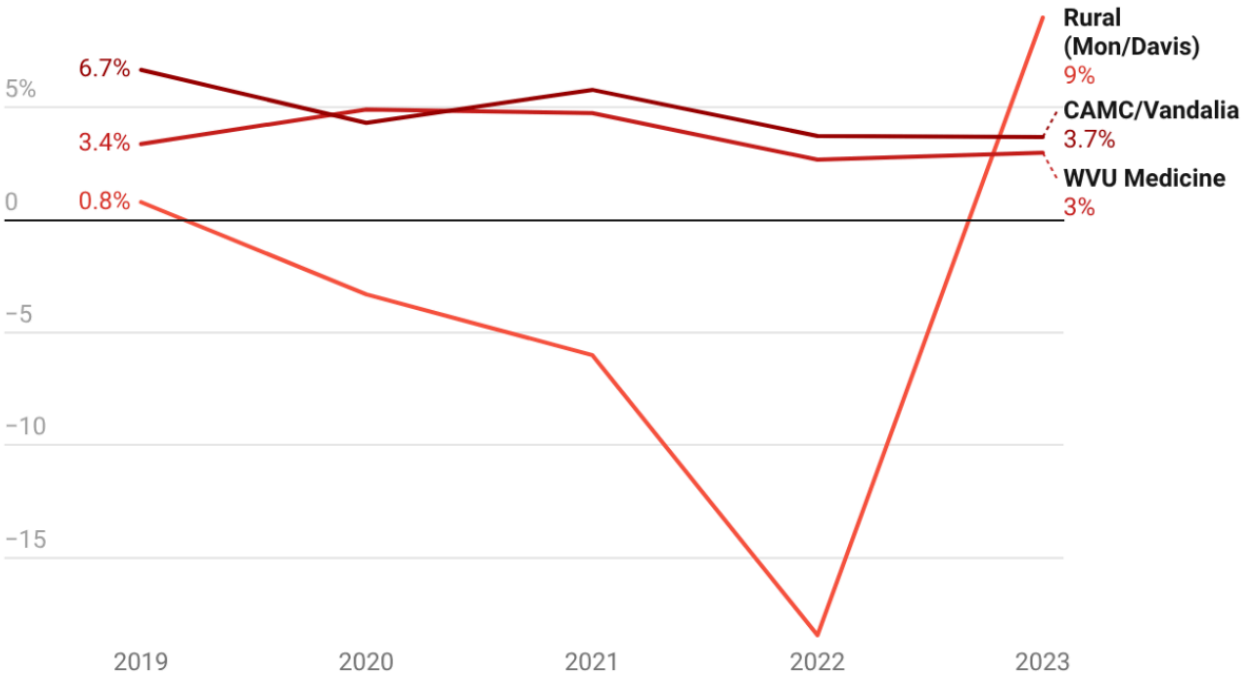
Do patients in rural communities deserve access, even if unprofitable? Healthcare should always put patients first—especially our most vulnerable.





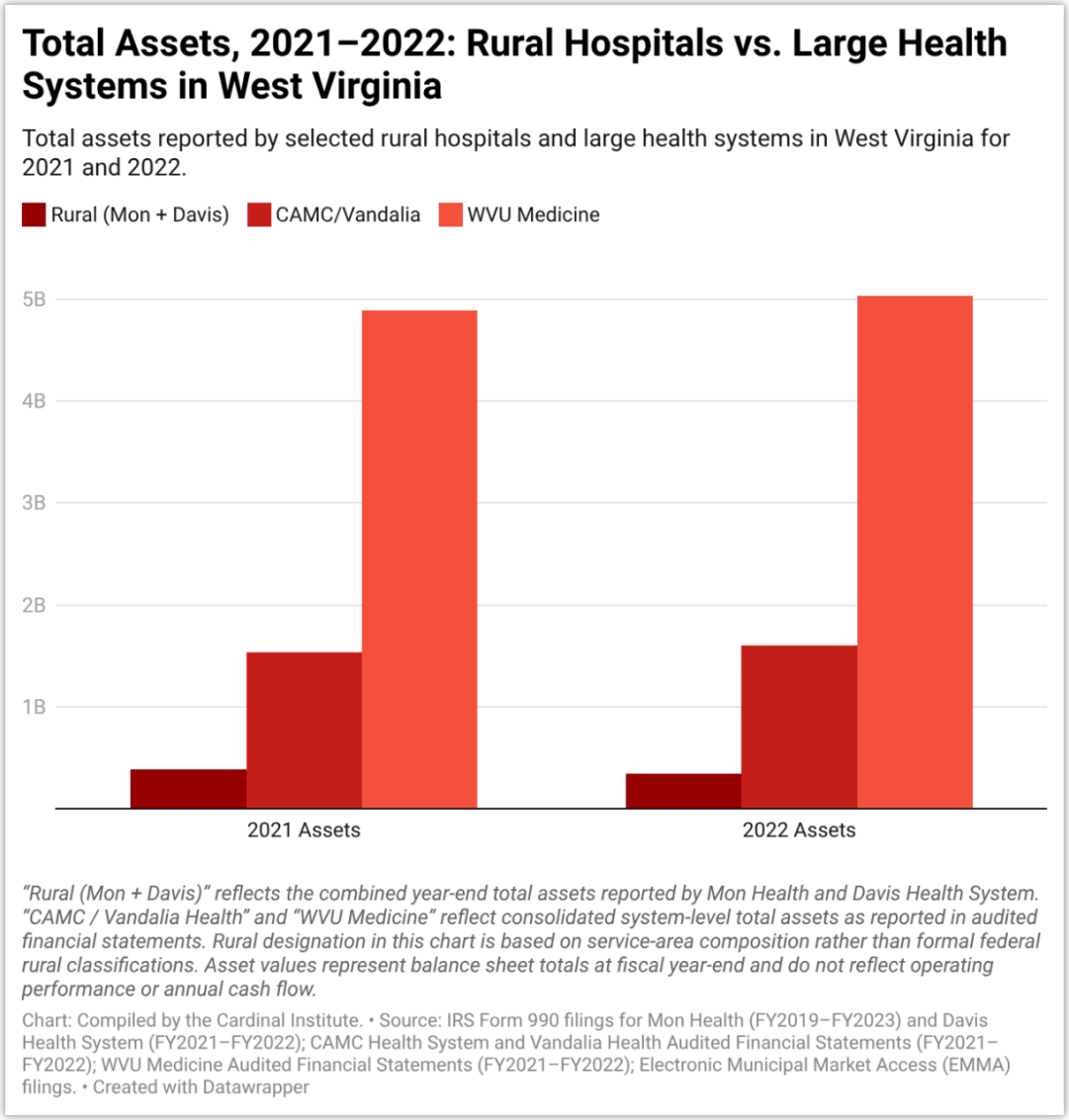
West Virginia Operating Margins, FY2019–FY2023: Rural Hospitals vs. Large Systems

Operating margins reported by selected rural hospitals and large hospital systems in West Virginia over the period shown.



"Rural (Mon/Davis)" reflects operating margins reported by Mon Health and Davis Health System. CAMC/Vandalia Health and WVU Medicine reflect consolidated system-level operating margins as reported in audited financial statements. Rural designation in this chart is based on service-area composition rather than formal federal rural classifications. CAMC (FY2016–FY2021) and Vandalia Health (FY2022–FY2024) are treated as a single integrated system because Vandalia Health is the successor parent entity to CAMC, with continuity of hospitals, assets, liabilities, and operations.

Chart: Compiled by the Cardinal Institute. • Source: IRS Form 990 filings for Monongalia County General Hospital Company (FY2019–FY2023) and Davis Health System (FY2021–FY2022); WVU Medicine Audited Financial Statements (FY2019–FY2023); CAMC Health System and Vandalia Health Audited Financial Statements (FY2019–FY2023); Electronic Municipal Market Access (EMMA) filings. • Created with Datawrapper



REBUTTING NARRATIVES OF DISTRESS

The culmination of this data shows:

- West Virginia's dominant systems are financially healthy.
- PEIA is not a loss payer.
- Commercial prices far exceed cost.
- Charity care remains minimal.
- Systems have flexibility to invest, expand, or cross-subsidize internal operations, including for their rural facilities.

Therefore, payer mix should not drive policy decisions.

RURAL HOSPITAL PRESSURE

Rural hospitals in West Virginia are central to healthcare delivery. While financial pressures on these facilities are well-documented, financial data suggests that instability in rural hospitals primarily results from structural and strategic factors rather than payer mix. Narratives centered on payer mix are frequently employed to justify increased pricing power, regulatory protections, and the shifting of accountability.

Vandalia Health announced the termination of obstetrics services at Greenbrier Valley Medical Center, effective Fall 2025, with plans to convert the facility into a 25-bed Critical Access Hospital. This decision was framed as a matter of "sustainability."[15]

This development reflects a broader trend. Despite substantial support, hospital systems in West Virginia are reducing essential services. The closure of obstetrics at Greenbrier Valley Medical Center, paired with financial data, are more consistent with a shift toward profitability-driven decision-making. The loss of the sole delivery service in a rural community has significant implications for rural family formation.

A 2023 NASHP cost report, using standardized Medicare cost report data, illustrates the disconnect. Prior to its acquisition, Greenbrier Valley Medical Center (GVMC) operated 66 beds, reported $5.3 million in drug costs, and $18.2 million in charges (a markup of 300%). The hospital reported positive net margins through 2022.

Following Vandalia Health's acquisition of GVMC in January 2023, payer mix-adjusted operating margin dropped to -7%, operating expenses increased by 73%, and labor expenses rose by 51% over the course of a single year. These changes are consistent with a shift in cost structure after acquisition rather than an underlying demand change or changes in reimbursement rates.

Similarly, in Fall 2024, Jefferson Medical Center, the sole hospital in Jefferson County, discontinued its labor and delivery services. The system's CEO stated, "we do believe it's the right thing to do."[16]

Unlike an insulated rural community, like the Greenbrier Valley, consequences in Jefferson County are less severe. Some residents of the Eastern Panhandle of West Virginia can travel out of state for care, but can also lack the resources to do so, particularly during emergencies.[17]

All rural health facilities encounter comparable challenges and reimbursement structures. The primary distinction lies in the priorities established by each institution.

The continued presence of positive operating margins and minimal charity care, coupled with reductions in services, indicates that West Virginia hospital systems are reallocating rather than lacking. For example, several weeks after the Greenbrier closure, WVU Medicine System invested $800 million to acquire a regional health system in Pennsylvania,[18] a state that does not require certificate of need.

Despite these actions, hospital systems advocate for restricting the same activities by competitors.[19] A consolidated healthcare market in West Virginia leaves vulnerable patients dependent on a single system, which has limited incentives to sustain low-volume, low-margin services such as maternity care.

CONCLUSION

West Virginia's healthcare landscape faces obstacles. Shrinking services, staff shortages, and teetering facilities hurt patients. These problems demand real solutions, not another round of status quo hand-wringing.

The payer mix argument fails. The audited books and records of WVU Medicine System and Vandalia Health show there is more to the story: there is notable investment and expansion (despite rural closures) occurring, along with positive margins from commercial and PEIA payers. So, **the notion that hospital systems must be shielded from competition is not supported.**

It's time to ditch the old stories and look at the numbers. **West Virginia must encourage competition, ensure non-profit hospitals deliver for their community, and seek reform that opens doors (not close them).**

Do not permit payer mix to remain a permanent excuse.

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- NASHP Hospital Cost Tool, 2022 underlying dataset; payer mix and payer-level margin fields from CMS Medicare Cost Reports (HCRIS).
- AHRQ Compendium of U.S. Health Systems, 2023 system, hospital, and outpatient linkage files.
- IRS Form 990 filings, including Schedule R for related entities (as applicable).
- West Virginia Code – PEIA reimbursement statute (≥110% Medicare requirement).
- RAND Hospital Price Transparency Studies, national commercial price benchmarks.

METHODS

- Operating margins follow Healthcare Financial Management Association standard definition.
- Charity care & bad debt reflect IRS Form 990 Schedule H system-wide self reporting in addition to NASHP reports.
- Liquidity reflects unrestricted and restricted cash/investments directly from Audited Financial Statements.
- System-level values computed consistent with NASHP methods.
- This analysis evaluates publicly reported financial data and does not allege illegal conduct by any institution.

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