OTHER PEOPLE'S MONEY

How CEO Wayne Smith gambled away the future of CHS at expense of patients, investors, communities

National Nurses United

National Nurses Organizing Committee

May 2019

HOW PATIENTS, INVESTORS, AND COMMUNITIES LOSE AT CHS

In the midst of a national crisis marked by rising health care costs, waning access to care, and a simultaneous skyrocketing of salaries for hospital executives, the 11-seat board of directors of Community Health Systems, Inc. (CHS), one of the largest hospital owners in the country, is asking shareholders to vote for their reelection at their upcoming annual meeting. The board also proposes that investors vote for a non-binding, advisory resolution supporting the generous compensation package they have crafted for the chief executive, Wayne T. Smith—quadrupling last year's bonus pay, despite massive losses to shareholders and untold hardship in the communities exploited by CHS. Given the company's collapse years ago both as a business and a health care provider, approving the proposals would be an astonishing endorsement of a corporate leader working only for himself.

CHS COMPANY PROFILE

Company name	Community Health Systems, Inc.
Type of firm	Public corporation
Ticker symbol	CYH
Headquarters	Franklin, Tennessee
Portfolio	106 hospitals (18 states)
Share value	$2.82 (12/31/2018)
Revenue	$14.1 billion
Debt	$13 billion
Income/(Losses)	($788 million)
CEO	Wayne T. Smith (since 1997)
CEO Compensation	$7 million (2018)

The fact that Smith remains at CHS' helm, given a series of fatal calculations that set the company on a downward spiral, is a real wonder. Smith led CHS' transformation from a privately held Nashville-area firm of 40 hospitals in 1997 into a publicly traded empire with more than 200 hospitals by 2014, making him one of the richest and most celebrated executives in the industry. But the "Midas touch" left Smith's hands years ago, and the company has shriveled since then. CHS has lost hospitals, as well as billions in bad investments and costly legal settlements stemming from proven and alleged cases of fraud, and remains incapable of reversing its fortunes.

Along the way, the human cost of CHS' successes and failures under Smith's leadership highlight the absurdities inherent in a market-based health care system that prioritizes profits over patient well-being. CHS' strategy of operating as a sole provider in small, non-urban markets has allowed it to thrive for decades by charging some of the highest health care prices in the industry while investing as little as possible in infrastructure, staffing and supplies, or altogether dropping critical services it found unprofitable. Now, ill health, shortened lives, and despair are the price communities are paying for Smith's mistakes, as underfunded hospitals turn into bare-bones operations.

The Rise of CHS and Wayne Smith

Earning admiration in the business world, Wayne Smith oversaw CHS' transformation from a private firm of 40 hospitals in 1997, when he became its president and CEO, into the nation's largest hospital empire in 2014. By the summer of 2000, three years after taking charge, CHS' portfolio had reached 52 hospitals, and Smith had led the company's conversion into a publicly traded corporation with an initial public offer of $13 per share. CHS shares were selling at nearly $29 apiece by the beginning of 2001, and Smith became board chairman soon after.

CHS' footprint growth was explosive, reaching 206 hospitals in early 2014—an addition of nearly 10 hospitals each year since 1997 — thanks to an aggressive acquisition campaign that fueled talk, wonder, and speculation in the health care industry. After hitting the nine-digit mark in 2002, CHS' net profits grew more slowly, peaking at $280 million in 2010. With the passage of the Affordable Care Act promising to bring an influx of newly insured patients into hospitals, investors continued to put their faith in Smith and CHS, with share prices going beyond $52 in June 2015, four times their value in 2000.

The High Cost of Success

CHS' success, however, did not come without significant expense, both in the form of debt and costs to patient care. As profits at the company slowed, Smith and his team could maintain shareholder value only by undermining the core of what makes a hospital valuable to begin with: the provision of high-quality patient care.

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The ugly side of the "beauty of the rural model"

CHS has long relied on a business strategy that involves having a monopoly in smaller, or isolated, non-urban communities. As far back as the 1990s, more than 80 percent of its hospitals were sole providers in such settings. The then-chief finance officer and executive vice president, Larry Cash, put it this way in 2007: "We look for ones where we're generally the sole or primary health care provider or dominant provider… We also like them where there's not that much of other health care competition."[1]

A former health care executive with a different company described in 2008 what he saw as CHS' business model: "It requires minimum investment in buildings and equipment, and it allowed for maximum return on investment because there is no competition in setting rates for private-pay insured patients."[2]

An analyst with David J. Green & Company put it most bluntly in a 2006 conversation with Cash and Smith, reminding them why they should keep capital expenditures low:

> *The beauty of the rural model is the fact that we are a monopoly in 85 percent of our markets and that we don't have the competitive pressures that would make it necessary for to us spend 7 percent, 8 percent of our revenues on CapEx [capital expenditures]. I will just reiterate to you that shareholders are concerned about the CapEx spend as a percentage of revenues. And the reason why we are invested in a rural hospital operator is because of the monopolistic dynamics….*

Cash reassured the investor that the company dedicates on average 4 percent of revenue on capital expenditures, as opposed to the 7 percent or 8 percent other firms spend in urban hospitals.[3]

Reducing Services

While adding hospitals to its portfolio, CHS was also hurrying to cut back on patient services. From 2002 to 2015, CHS reduced or eliminated emergency rooms, trauma centers, obstetric services, labor and delivery services, pediatrics units, psychiatric units, and medical detox units at hospitals throughout the country. Due to CHS' rural model, many of these services were the only ones available for miles, placing particular hardship on non-urban residents. Community need, however, was not necessarily the basis for CHS decision-making. In remarks to investors in 2013, Cash said: "A lot of our OB business is Medicaid, so it's not as if it's quite as profitable as other business."[4]

Could this be the reason OB services were those most frequently cut by CHS during this period?

Short Staffed and Under-equipped: Bluefield Regional Medical Center

When city officials in Bluefield, West Virginia, announced in April 2010 that they were entering talks with CHS to sell their local hospital, Bluefield Regional Medical Center (BRMC), they expressed hope and optimism that the company would use its vast resources to make necessary improvements to the facility. "They have money and they can make the investment that BRMC can't," said a hospital official to the local paper. It also reported that (according to another official): "CHS has committed to keeping all of the current BRMC employees."[5]

CHS, the only bidder, ultimately secured the 265-bed facility for $5 million several months later, and took control in January 2011. The first round of layoffs occurred that same month. And just over a year later, the staff of 874 had been reduced to less than 600.[6]

By 2019, BRMC's certified beds had dropped to 240,[7] while hospital staff has been whittled down to 435, and "about 200 contract employees," according to a human resources official.[8]

In 2012, the hospital's nurses voted to form a union with National Nurses United, seeking to improve staffing.[9]

As a predictable result of the company's refusal to work with the nurses to improve conditions, BRMC now lacks the staff necessary to care for patients who visit the hospital every day.

A registered nurse in BRMC's labor and delivery unit, Brenda Meadwell, spoke to The Guardian last February about the dangers associated with staff shortages: "When we are short-staffed, you don't get to give patients the individual care they need, which could lead to missing something that could be serious." In addition to insufficient nurses, Meadwell said, understaffing in other areas (like nurses' aides, technicians, and administrative staff) also adds to the challenge of caring for patients by forcing nurses to pick up other tasks, taking them away from the bedside.[10]

More recently, operating room nurses at the Bluefield facility reported to National Nurses United that they are being forced to work additional "on-call" shifts in the endoscopy department due to short-staffing. This means that patients undergoing procedures in that area may be cared for by a nurse working well beyond 40 hours for the week and who may not be experienced in the department. Emergency room nurses also report often being pulled to the medical-surgical floors because management cannot keep enough nursing staff in those areas.

According to MedCity News, which also interviewed Meadwell in January, "She also said BRMC has experienced equipment shortages and has had to go without baby blankets. Instead, nurses have to wrap infants in towels."[11]

Data from the Centers for Medicare & Medicaid Services (CMS) show that the Bluefield facility's readmissions rate has been on an upward trend over the past few years. While most hospitals across the country are penalized every year for high readmissions rates—reducing reimbursement payments per Medicare patient by a percentage reflecting the severity of the problem the previous year—penalties have generally been falling since the program's launch in 2010.[12] Currently, the average penalty among providers is 0.7 percent.[13] At BRMC, the penalty rose to 0.8 percent in 2016, and to 1.25 percent in 2017.[14] The penalty this year is 1.41 percent.[15]

Reduced Capital Expenditures Putting Profits over Patients – Lutheran Health Network

An op-ed last month by a group of concerned physicians in Indiana described how CHS' recent decisions to downgrade or eliminate certain departments at Lutheran Hospital—the flagship of the Fort Wayne-based Lutheran Health Network (LHN)—will likely make it harder to meet local needs. News that Lutheran's Level III neonatal intensive care unit would drop to Level II16 came just weeks after reports that the heart transplant program was being scrapped altogether.[17]

The doctors point out that Smith's recent pay raise was due to a change in CHS' executive compensation guidelines: It is designed to reward for substantial reductions in the company's expenses.[18]

According to the Journal Gazette, LHN hospitals send to company headquarters up to $300 million a year.[19] Two years ago, Thomas Aaron, CHS' new executive vice president and chief financial officer, also referred to the Fort Wayne properties as "one of our larger EBITDA markets."[20]

CHS acquired the network, including Lutheran Hospital, from the now-extinct Triad Hospitals in 2007. Lutheran had started out in 1904 as a faith-based nonprofit, and its 1995 sale to a for-profit operator had provided immediate relief for the struggling community institution. Even a few years later, after it was sold again to a second firm, the proud institution continued to thrive in the Fort Wayne health care hub.

Asked by a local reporter whether it had been a mistake to sell the hospital to a for-profit firm, Bill Zielke, a local businessman and longtime member of Lutheran's board of directors, said no. He pointed out that the first few commercial owners had continued investing in the hospital, and had remained attentive to local needs, supporting his view that a corporation's tax status mattered less than who was running it: "Things didn't sour until after CHS took ownership," Zielke said.[21]

In 2017, a group of LHN physicians sought, in vain, to buy Lutheran Hospital and run it themselves, citing some of the problems that had accompanied CHS' stewardship over the past decade. About 150 LHN employees rallied in May that year to show support for the doctors' efforts, and air frustration over CHS' failure to provide "competitive salaries for staff, high-quality medical supplies and equipment, and renovation of outdated facilities," according to a Journal Gazette editorial.[22]

CHS officials themselves speak of drastically cutting back on hospital upkeep. Noting that Lutheran's previous owner, Triad, had spent a lot more in Fort Wayne, Smith described the cutbacks in May 2009 as promoting "improvements"—bigger "same-store" profit margins. While Triad was registering a 12.5 percent margin, he told investors, CHS had raised it to 14 percent in two years by spending less, among other measures. "So, we've been able to improve those hospitals."[23]

Then in March 2010, Smith spoke again about Triad's greater commitment to renovating its health facilities: "Capital expenditures … we spent about 4.8 percent [of revenue] last year. For those of you who were following Triad, you will recall Triad was spending about 9 or 10 percent in terms of their CapEx expending. We have been able to substantially reduce that."[24]

In 2016, CMS penalized Lutheran Hospital for its high hospital-acquired conditions (HAC) rate the previous year, which is often caused by understaffing and poor management. Unable to show sufficient improvement since then, Lutheran became in 2019 one of only 170 hospitals in the nation—out of 3,200 included in the data—to be penalized for a high HAC rate for the fourth straight year.[25]

Meanwhile, Parkview Regional Medical Center, the other major provider in Fort Wayne, continues to operate as a nonprofit today, as it has since 1878. But in contrast to Lutheran, which has two stars in the CMS Hospital Compare website, where patients rate their hospital experiences, Parkview has four stars,[26] and shows up clean on the CMS penalty database.[27]

Hospital Closures

Beyond service cuts, understaffing, and reduced investment, however, CHS has also closed a number of hospitals entirely, either by shutting down a facility or reducing it to a clinic. A loss like that is often devastating for a community, leaving gaps in acute and specialty care, as well as (particularly in rural and low-income areas) primary care.[28] Moreover, the pain caused by the economic impact of losing a hospital—often the largest source of professional employment in a non-urban locale—can be felt throughout a community for years.[29]

Under Smith's leadership, CHS has been a leader in hospital closures. In Tennessee alone, which has lost one hospital per year for the past decade, CHS has closed four between 2014 and 2018. These and other hospitals it closed during that period include:

SAMPLING OF CHS HOSPITAL CLOSURES

Year	Hospitals Closed	Location	Beds
2014	**Fallbrook Hospital**	Fallbrook, Calif.	**47**
2014	**Haywood Park Community Hospital**	Brownsville, Tenn.	**62**
2014	**Mid-Valley Hospital**	Peckville, Penn.	**46**
2016	**McNairy Regional Hospital**	McNairy County, Tenn.	**49**
2018	**Lakeway Regional Hospital**	Morristown, Tenn.	**135**
2018	**Physicians Regional Medical Center**	Knoxville, Tenn.	**440**
2018	**Twin Rivers Regional Medical Center**	Kennett, Mo.	**116**

Hospital Closures in East Tennessee — "It's a market share issue for us"

East Tennessee is an epicenter of a health care crisis marked by poverty, a severe shortage of medical services, and a devastating opioid epidemic. Further, Tennesseans have lost in the past decade the most hospitals per capita in the nation, creating an emergency unto itself—one largely explained by the profit imperative that moves companies like CHS.

In December 2018, CHS closed two hospitals in the Volunteer State—Physicians Regional Medical Center, in Knoxville, and Lakeway Regional Hospital, in the Appalachian town of Morristown—striking a further blow to people in the region.[30]

According an American Hospital Association (AHA) survey in 2015, Physicians Regional accounted for 1 of every 4 surgical operations conducted in Knoxville, and an even larger share of Medicaid discharges in the city. It was also the only local hospital providing inpatient and outpatient psychiatric services, neonatal intermediate care, a hospice program, or a broad scope of surgical procedures. It also registered that year about a quarter of the city's hospital beds, and nearly a third of emergency room visits.

Lakeway Regional, founded in 1937, had 15 percent of hospital beds in the Lakeway-area counties, according to the same AHA survey. Additionally, it reported 20 percent of all Medicaid discharges in the region, and a quarter of its inpatient surgeries. It was also among only a handful of Rural Referral Centers in East Tennessee.

What's more, both Morristown and Knoxville are in counties—Hamblen and Knox, respectively—that have each been federally designated a Medically Underserved Area, as well as a Health Professional Shortage Area for three different categories: primary care, mental health, and dental health.

When an investment analyst asked if the hospitals had been "money losers"—shortly after learning of their imminent closure in October—Tim Hingtgen, president and chief operating officer, said that they had been "a drag on the market," regionally, and that CHS was carrying out a consolidation process. Then Smith chimed in to make something clear. "And this has no reflection on the employees or the physicians," he said. "These are a good group of people. They're well qualified. They do excellent work. It's a market share issue for us and how we can best consolidate in the market."[31]

Months later, during the February 2019 earnings call (which took place shortly after news of CHS' $788 million loss in 2018), another analyst asked if there were plans to sell the properties where the now-defunct hospitals stood. Thomas Aaron, executive vice president and chief financial officer, replied, "With respect to the two [hospitals] in East Tennessee… we're still… very competitive in those markets, so we're likely not going to sell to a competitor. We'll look for alternative uses. We think we've got a non-health care provider that's interested in our large campus in Knoxville."

In other words, selling either property to another hospital operator would hurt CHS' competitive advantage—something to avoid, even if it further deprives local residents. "And in some cases," Aaron continued, "we can raze the facility and sell the land" if the company is unable to find a buyer outside the health care field.[32]

Since the closing of Physicians Regional, the entire health infrastructure in the Knoxville area has been further strained. Longer wait times at emergency rooms and increased ambulance traffic are cited in reports, in addition to "a 26 percent increase in ambulances waiting with patients at hospitals, compared to January 2018."[33] The consequences of these effects exacerbate the city's health care crisis, as well as personal health emergencies, carrying the potential for endangering lives.

In a recent letter to the editor of Knoxville News-Sentinel, one man said "Knoxville is drastically short of hospital rooms and Level I adult trauma centers." He found out on March 13, when he rushed his wife to the emergency room. Only "about 15 hours later," he said, "all spent on a gurney in the ER hallway," was she finally transferred to an exam room. To his amazement, he learned from others at the hospital that the experience was not an anomaly. "We could be in desperate straits were a major calamity to occur," he writes.[34]

CHS: America's Preeminent Price Gouger

During CHS' highest-performing years, prices charged at its hospitals ranked among the highest in the nation in a 2015 study (based on data from 2012.) The most expensive hospital was North Okaloosa Medical Center in Florida. Further, of the 50 priciest hospitals in the United States, half of them were owned by CHS.

Today, CHS is no longer the most expensive system among the top 50, but instead holds the No. 2 spot, owning 15 of the nation's 50 most expensive hospitals. While no longer the most expensive in the country, North Okaloosa Medical Center now has a 1,760 percent markup on the cost of providing care,[35] up a staggering $40 from the 1,260 percent it charged in 2012.[36]

The strategy presents risks to CHS investors, as illustrated when patients (or concerned medical staff, like those in Fort Wayne) rebel. In the island city of Key West, Fla., residents also attempted to get their city officials to break its contract with CHS, which would have reverted control of the municipally-owned hospital back to the city. Their complaints ranged from feeling overcharged (they were paying 61 percent more than the average patient in CHS' 21 other hospitals in the state[37]) to CHS' aggressive collection practices and poor-quality services.[38]

Reversing Course

After CHS' shedding of hospitals began in 2014, it closed out that year with 197 facilities, nine less than at its peak in January. Two years later, it spun off 38 hospitals into a separate corporation, Quorum Health Corporation (QHC), netting $1.2 billion that it could pay toward its debt.[39] The new company's losses, $22 million, immediately afterwards led to a sense among shareholders that they had been duped into buying QHC shares at inflated prices.[40]

CHS announced a divestiture program in late 2017 to help it pay off its debt. In 2019, down to 106 hospitals, Smith announced that the company would soon stop selling to shrink its portfolio.[41]

What Caused the Collapse?

The casual observer may see Smith's biggest mistake as being the 2014 acquisition of the third-largest for-profit health care provider, Health Management Associates, Inc. (HMA), whose 70 hospitals pushed CHS' total to 206. Not only did CHS add $7.6 billion to its already-huge debt—growing it to $14 billion, a billion more than its 2013 net operating revenues—but HMA had been struggling to make money and its portfolio's need of investment was overdue. "It was a quintessential overreach," reads a 2017 op-ed.[42]

The Department of Justice's decision, in early January 2014, to join several whistle-blowers in suing HMA for its alleged corporate-driven scheme to fraudulently boost hospital admissions, and revenues, had no effect on Smith's pursuit of the deal, which was finalized a few weeks later.[43] CHS had also been sued jointly by the government and whistle-blowers making similar allegations, including management's pressure on emergency room doctors to admit patients, without justification, for the purpose of billing Medicare and Medicaid for reimbursements.[44] By then, CHS had already set aside the $98 million it would pay the government to settle the claims without admitting wrongdoing.[45]

"As we've handled the CHS investigations, we will seek to handle these matters with as little disruption as possible," said Smith shortly after the transaction.[46]

To settle allegations against HMA—whose liabilities came along with the assets—CHS had to pay more than $260 million in 2018, long after it had entered its period of decline. The higher cost of settling those allegations, as compared to CHS' settlement amount four years earlier, may have been partly the result of a growing sense that medical insurance fraud was not being taken seriously.[47] As a New York Times article suggested in early 2014, because "many settlements run only into the tens of millions of dollars," they amounted to "a corporate slap on the wrist for companies whose stocks typically soar when executives push the profit envelope."[48]

But HMA and its troubles might have been only one of several factors that would ultimately punish CHS shareholders, and deal patients and communities with the ultimate betrayal. Despite calling himself risk averse, Smith's comfort level with borrowing and spending appeared risky to industry observers as far back as 2007, when he raised CHS' debt to more than $9 billion in order to buy Triad Hospitals.[49] CHS' own revenues stood at $4.3 billion at the end of 2006.[50]

"Smith's slash-and-burn model of operating a health care system, designed to extract as much wealth as possible from a community while denying it the necessary resources for its continued existence far into the future, was bound to create both a financial and humanitarian disaster within a few years."

CHS DEBT-TO-REVENUE RATIO FROM 2000-2018

Year	Debt (in thousands)	Revenue (in thousands)	Debt as a % of revenue
2000	1,219,023	1,337,501	**91%**
2001	1,038,774	1,693,625	**61%**
2002	1,192,458	2,200,417	**54%**
2003	1,474,658	2,834,624	**52%**
2004	1,831,735	3,332,641	**55%**
2005	1,667,624	3,738,320	**45%**
2006	1,941,177	4,365,576	**44%**
2007	9,098,077	7,095,861	**128%**
2008	8,972,089	10,919,095	**82%**
2009	8,911,108	12,107,613	**74%**
2010	8,871,521	12,986,500	**68%**
2011	8,846,504	13,626,168	**65%**
2012	9,541,305	13,028,985	**73%**
2013	9,453,397	12,997,693	**73%**
2014	16,916,000	18,639,000	**91%**
2015	16,785,000	19,437,000	**86%**
2016	15,244,000	18,438,000	**83%**
2017	13,913,000	15,353,000	**91%**
2018	13,596,000	14,155,000	**96%**

Moreover, Smith's slash-and-burn model of operating a health care system, designed to extract as much wealth as possible from a community while denying it the necessary resources for its continued existence far into the future, was bound to create both a financial and humanitarian disaster within a few years.

Smith's calm disposition to acquire HMA, despite allegations against both the firm and its CEO from 2008 to 2013 – Gary Newsome, who was recently ordered to pay $3.5 million for his personal role in overseeing the fraud[51]—may have stemmed from the two men's close working relationship. Smith had been Newsome's supervisor over several years at CHS and going back to their days at Humana, Inc. In fact, shortly after Newsome took the chief executive job at HMA, Smith described his former subordinate as a "good guy" whom "we sent down to HMA to run HMA…" at a time when the smaller company was struggling. "We've had to coach him a lot, but he's doing really well. So, I think he's making all the right improvements."[52]

For his part, Newsome appeared to acknowledge Smith's role as a mentor, telling *Modern* Healthcare that, while reporting directly to Smith, he had seen the wisdom in a CEO's direct involvement in the company's operations: "Newsome wants to instill more discipline in all aspects of hospital operations, he said, another lesson that he learned at Community."[53]

Rewarding Failure - Wayne Smith's Compensation

Smith's compensation package has at times been out of sync with the company's fortunes, often bolstered by a comparatively modest improvement in CHS' performance, and then descending less dramatically when shareholders experienced massive losses. One example is in 2016, when CHS reported a loss of $1.7 billion, and its share value dropped to $7. Not only did Smith keep his job, but he still took home $10 million.

That may be, in fact, what truly distinguishes Wayne T. Smith from many of his peers: his ability to thrive, personally, even when the company under his leadership is flailing. It is difficult to say when CHS began to fail its patients, given that market-based health care has always prioritized profits. But the company has now consistently failed to stop losing shareholders' money, much less make any. Yet Smith, aided by a loyal board, remains on the job, even after one major investor called for his ouster and a number of others left CHS.

In March 2019, while still reeling from CHS' $788 million loss the previous year — and a year-end share price near its all-time low, $2.82 — shareholders learned that Smith would be awarded a 42 percent raise for his 2018 performance, for a total of $7 million.[54]

A few weeks later, they would learn of a $108 million loss for the first quarter of 2019, too, quadrupling the loss for the same period in 2018.[55] It also brought the total lost in shareholder value over the past three years to $5 billion.

Shareholders and CHS board members now have both a business and ethical decision before them. Do they continue to reward the individual responsible for racking up billions in debt while gutting the company's most valuable assets? Do they continue to overpay an executive to overcharge rural Americans for lifesaving care? Or will CHS change direction—from a company that serves only to enrich its executives at the expense of patients, communities, employees, and even shareholders, to one that invests in the provision of high-quality care? The nation's largest union of registered nurses, National Nurses United, stands strong on this question. For CHS to survive, it must change its leadership.

"What truly distinguishes Wayne T. Smith from many of his peers: his ability to thrive, personally, even when the company under his leadership is flailing. It is difficult to say when CHS began to fail its patients, given that market-based health care has always prioritized profits. But the company has now consistently failed to stop losing shareholders' money, much less make any. Yet Smith, aided by a loyal board, remains on the job, even after one major investor called for his ouster and a number of others left CHS."

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