MetroHealth Medical Center

MetroHealth Medical Center (MetroHealth) in Cleveland, Ohio is a public hospital that serves a high share of Medicaid-enrolled and low-income patients and has historically been reliant on Medicaid disproportionate share hospital (DSH) and other supplemental payments. However, its DSH funding has declined by 65 percent since 2012, due to changes in Ohio's DSH policies and declines in the hospital's uncompensated care costs following Ohio's Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Hospital and Market Characteristics

MetroHealth is part of the MetroHealth System, an integrated health system owned by Cuyahoga County comprising a hospital and an ambulatory network with more than 20 sites. The medical center serves as a teaching hospital for Case Western Reserve University. MetroHealth received $33 million in DSH payments in 2012, which represented 15 percent of its total Medicaid revenue ($224 million) and approximately 5 percent of its total operating revenue ($742 million).

Role in the safety net

MetroHealth is the only public and Medicaid deemed DSH hospital in the Cleveland, Ohio, hospital referral region (HRR). In 2014, MetroHealth's Medicaid inpatient utilization rate (56 percent) was more than double the average share for hospitals in the Cleveland HRR (21 percent) and in Ohio (20 percent) (Table 1). MetroHealth executives said that in 2015 their payer mix was nearly 50 percent Medicaid, around 5 percent self-pay, over 25 percent Medicare, and under 25 percent commercial insurance.

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

Comparison region	Medicaid inpatient utilization rate	Low-income utilization rate
MetroHealth Medical Center (Cleveland, OH)	56%	35%
Cleveland, OH, hospital referral region average	21	11
Ohio average	20	12
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.

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Types of services provided

MetroHealth provides services to residents of Cuyahoga County and certain indigent residents of other counties in Ohio, regardless of their ability to pay. In addition, it is the major provider of care to Medicaid-enrolled patients in the county. MetroHealth also provides care to individuals in foster care, juvenile detention centers, and the county jail system. In recent years, the MetroHealth System has grown substantially and transformed the way it provides care, in particular by shifting toward providing more outpatient than inpatient care. Executives reported that the system has gone from 850,000 outpatient visits in 2012 to an estimated 1.2 million visits in 2016. Reflecting this shift, outpatient revenue was 45 percent of MetroHealth's total revenue in 2012 but it is expected to reach at least 55 percent in 2016. According to executives, this transformation has been driven in part by MetroHealth's need to provide care efficiently to uninsured patients and in part by an effort to position the system to do well in a value-based payment environment.

In making this transformation, MetroHealth has relied on several initiatives, including patient-centered medical homes, to improve quality and reduce costs for uninsured patients. MetroHealth also maintains a number of specialized services that benefit the local community; for example, MetroHealth operates the only Level I Trauma Center in the local area. More broadly, MetroHealth is the only hospital in Ohio that has an Ebola treatment center or an accredited burn center.

Market characteristics

Executives characterized the Cleveland health care market as very competitive, with three health care systems dominating the local market—the University Hospital of Cleveland (1,032 beds), Cleveland Clinic Hospital (1,437 beds) and MetroHealth (397 beds). Executives said that considerable consolidation had taken place among hospitals in recent years and that the number of independent physician practices, particularly primary care practices, also had dropped recently. In addition, Cuyahoga County's population has been decreasing, meaning that the remaining health systems are competing for patients in a shrinking population.

In recent years, MetroHealth has taken steps to expand its presence in the market. For example, in 2016, when a local health maintenance organization (HMO) closed, MetroHealth hired many of the HMO's doctors and took over some of its facilities. This deal brought approximately 40,000 commercially insured patients into MetroHealth's system, broadening the system beyond its traditional patient base of Medicaid-enrolled and uninsured patients and enabling it to enter some nearby suburban markets.

State Context

In 2014, Ohio expanded Medicaid to adults under age 65 with incomes at or below 138 percent of the federal poverty level. Between 2013 and 2014, the state's uninsured rate fell by 23 percent (from 11.0 percent uninsured in 2013 to 8.4 percent uninsured in 2014).

Ohio distributes DSH payments to most hospitals in its state (79 percent) based on criteria developed by the Ohio Hospital Association. The non-federal share of DSH payments is provided by a statewide hospital provider tax.

Effects of the Affordable Care Act

The ACA has had a substantial impact on MetroHealth, according to hospital executives. They reported that the Medicaid expansion has resulted in a change in MetroHealth's payer mix. Particularly noteworthy has been the drop in the system's self-pay revenue, which decreased from about 20 percent of gross patient revenue in 2012 to about 5 percent in 2016. Over the same period, MetroHealth saw a doubling of Medicaid revenue.

State policy changes affecting Medicaid supplemental payments

Executives explained that the Ohio Hospital Association, with state oversight, has long been responsible for distributing DSH funds across hospitals in the state (OHA 2016). In 2015, Ohio changed its DSH distribution policy, in the words of MetroHealth executives, to "accommodate the impact of Medicaid expansion in Ohio on hospitals." Specifically, the state revised its DSH distribution methodology to target a larger share of DSH funding based on a hospital's level of Medicaid shortfall and a smaller share based on a hospital's uncompensated care costs (CMS 2015).

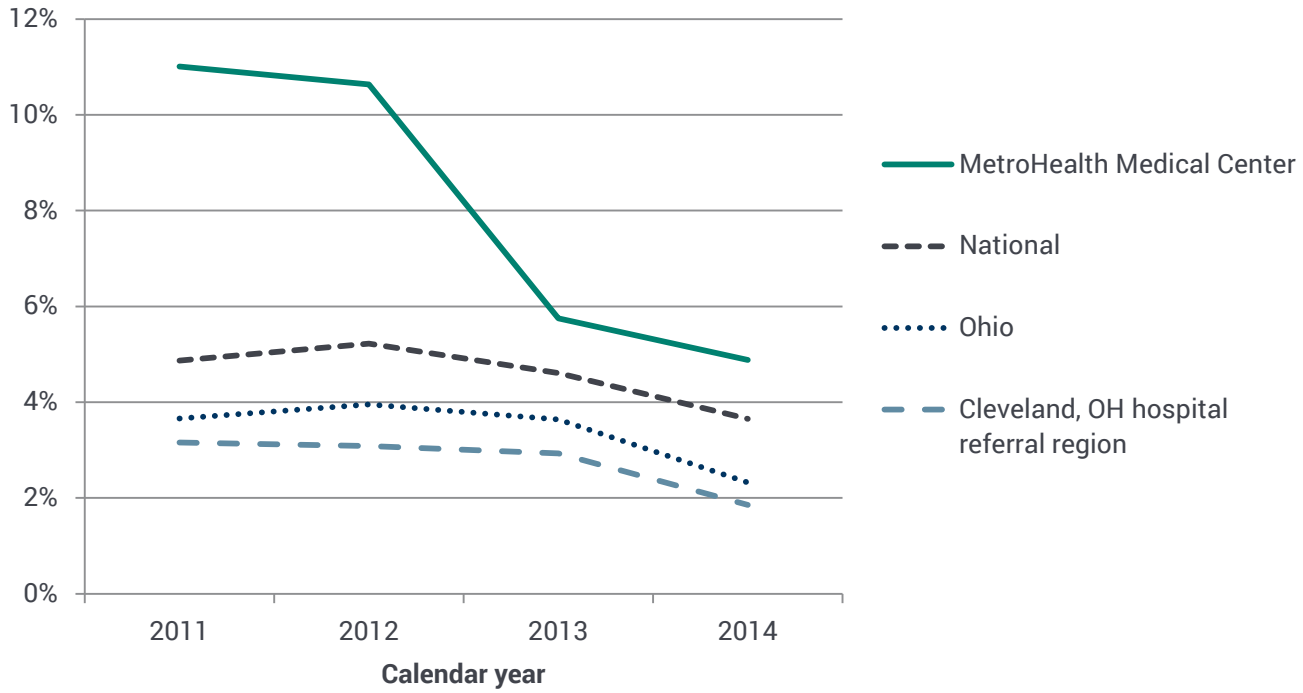
Beginning in 2005, Ohio began to shift from a fee-for-service (FFS) system to a Medicaid managed care delivery system, which reduced the availability of upper payment limit (UPL) supplemental payments that were made previously under FFS.[1]

Hospital financial information

Uncompensated care

In 2011, bad debt and charity care represented about 11 percent of MetroHealth's operating expenses, a significantly greater share than that reported by other hospitals in its HRR and the state at large (Figure 1). Medicare cost report data suggest that MetroHealth's charity care and bad debt costs decreased substantially between 2012 and 2013. MetroHealth executives attributed this drop to its participation in a 2013 Section 1115 Medicaid waiver demonstration, the MetroHealth Care Plus Demonstration. Under the demonstration, Medicaid coverage was extended to up to 30,000 uninsured adults residing in Cuyahoga County, with MetroHealth providing services to these newly covered individuals (Cebul et al. 2015). Bad debt and charity care declined further in 2014, reflecting the effect of the ACA.

FIGURE 1. Uncompensated Care as a Share of Hospital Operating Expenses, MetroHealth 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

MetroHealth executives reported that Medicaid base payments covered about 85 percent of their costs, with a shortfall of about 15 percent. Executives expressed the belief that because of the various efficiency strategies they had adopted, MetroHealth's Medicaid shortfall was considerably less than that of other hospitals in the area, which they estimated in the 25 percent range. MetroHealth executives maintained that under the DSH allocation formula recently put in place in 2015, which put an increased emphasis on Medicaid shortfall, their competitors were being "unfairly rewarded to receive higher DSH payments than typical while ours has shrunk."

Medicaid DSH payments

MetroHealth's DSH payments have declined by 65 percent since 2012 (from $33 million in 2012 to $11.7 million in 2015). Hospital executives attribute recent declines to the recent changes in Ohio's method for distributing DSH payments. In addition, the decline in the hospital's uncompensated care costs following Ohio's Medicaid expansion under the ACA has substantially reduced MetroHealth's hospital-specific limit for DSH payments. According to Ohio Hospital Association data, MetroHealth's DSH limit has decreased from $54 million in 2012 to $14 million in 2016 (OHA 2016).

MetroHealth contributes to its state's share of DSH payments through an assessment that is levied on hospitals that receive these payments. Executives reported that in the past few years, their contributions to the nonfederal share of DSH funding have increased but the payments they receive have decreased. For example, MetroHealth was assessed $3.5 million and received roughly $33 million in DSH payments in 2012, but in 2015 the hospital was assessed $4 million and received $11.7 million, a net decline from $30 million to $7.7 million over this period.

Other Medicaid supplemental payments

Even so, the surge in Medicaid enrollment brought about by the ACA increased MetroHealth's volume of Medicaid-enrolled patients, and this was accompanied by an increase in total UPL payments received by MetroHealth, with net payments rising from $21 million in 2012 to $26 million in 2015. However, MetroHealth executives said, the additional $5 million in UPL payments did not offset the recent reduction in DSH payments.

In 2012, other Medicaid supplemental payments made up about 9 percent of MetroHealth's Medicaid payments. Most of these non-DSH supplemental payments were received through the state's UPL program.

Role of DSH funding

MetroHealth executives reported that Medicaid DSH payments contributed to covering the system's cost of care for the Medicaid-enrolled and uninsured patients they serve. DSH payments also helped offset the cost of community benefit activities and programs that MetroHealth offers for the benefit of low-income, at-risk families in its community. These community activities and programs address a range of issues, including infant mortality, addiction, unemployment, and crime.

Looking ahead, MetroHealth executives said that if their DSH payments continued to decline (which they expected), they would have to increase their commercial patient population to help offset the cost of caring for uninsured and Medicaid-enrolled patients. Executives also expected that with further DSH cutbacks they would have to cut their community benefit programs and services. They said that more reductions would make it difficult to sustain programs that benefit low-income patients as well as those that put clinics in high-need locations. Indeed, MetroHealth has already cut back on plans to put a new facility in a medically underserved area of the county and is considering items that might need to be cut in 2017. In the long run, further Medicaid cuts may result in MetroHealth closing unprofitable clinic locations. As one executive stated, "The survival instinct outweighs the mission at some point." MetroHealth executives suggested that more reductions in DSH payments for safety-net hospitals would cause them "to go away from what they do and to look like the rest of the non-profits."

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 MetroHealth 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

[1] 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.

References

Cebul, R.D., T.E. Love, D. Einstadter, et al. 2015. MetroHealth Care Plus: Effects of a prepared safety net on quality of care in a Medicaid expansion population. *Health Affairs* 34, no. 7: 1121–1130.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Amendment to the Ohio Medicaid State Plan. September 24, 2015. Baltimore, MD: CMS. https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-15-010.pdf.

Ohio Hospital Association (OHA). 2016. Hospital Care Assurance Program (HCAP). Columbus, OH: OHA. http://ohiohospitals.org/Policy-Advocacy/Finance-Policy/HCAP.aspx.