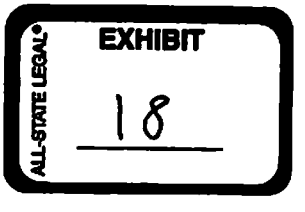
Strengthening the Safety Net in Detroit and Wayne County

Report of the Detroit Health Care Stabilization Workgroup



HADS Final Draft of DHCSW Report
08/13/03

Introduction

Early in the Granholm Administration, the Governor met with the Chief Executive Officers of the three Detroit health care systems – Detroit Medical Center (DMC), Henry Ford Health System (HFHS), and St. John Health System (SJHS). At their request, the Governor convened the Detroit Health Care Stabilization Workgroup (DHCSW) to assess and plan solutions for the crisis in Detroit health care. This is the report of that workgroup.

The workgroup's first step examined safety net models from other urban areas (Chicago, Denver and Saint Louis). The workgroup learned several valuable lessons from health authorities in other cities.

Lesson 1. Safety net services are focused on the Medicaid and uninsured populations.

Lesson 2. The authority relied on Medicaid as a good payer and attempted to attract commercial clients.

Lesson 3. The authority took several years to develop. Problems with payment and delivery systems can not be solved over night. Chicago took 15 years to develop its current publicly based health system.

Lesson 4. The authority provided access to the full continuum of care for its clients. Denver Health, for example has 10 community health centers, 15 school based Health Centers, a 349 bed hospital, 5 dental clinics, the Public health Department, an HMO, substance abuse and mental treatment capacity, and a poison center. (See Appendix 1)

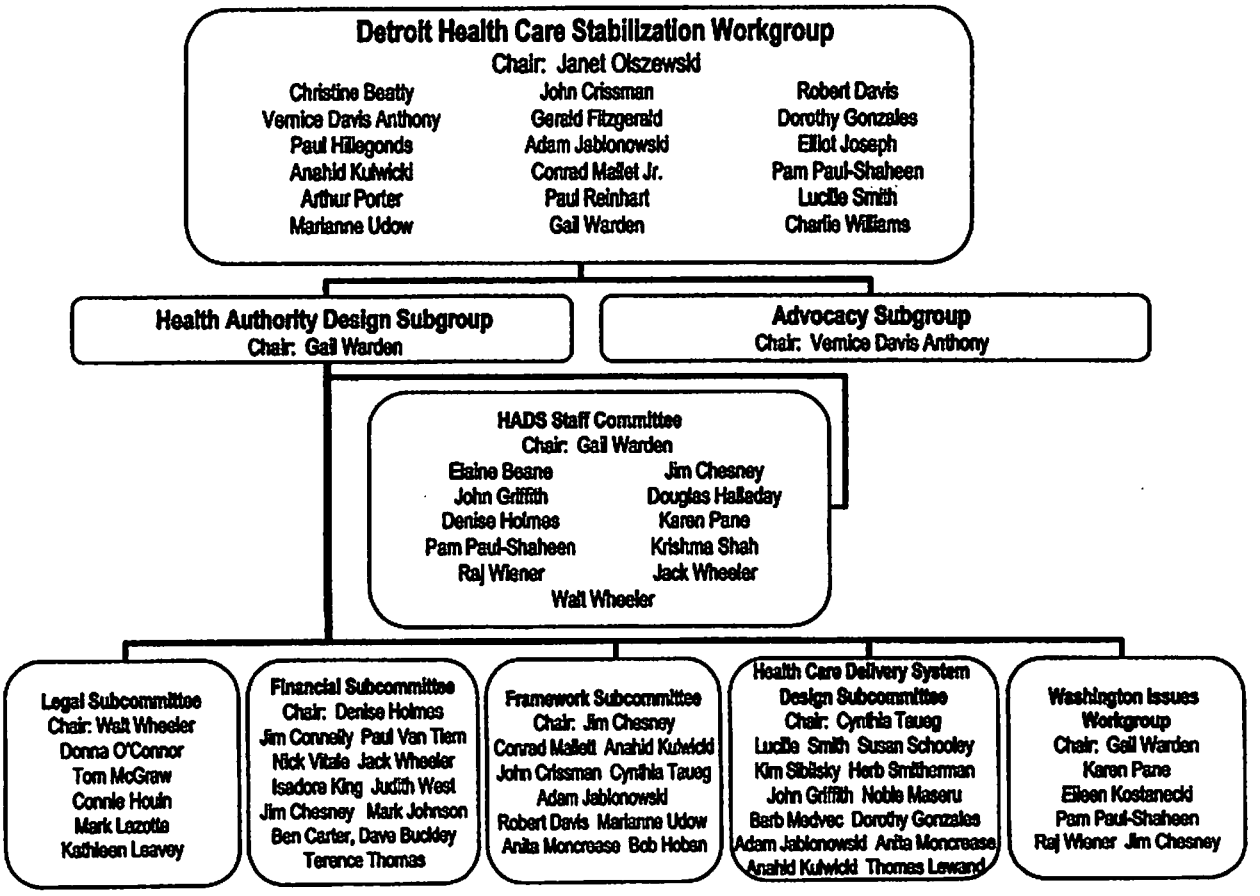
Lesson 5. Prevention and primary care are very important.

Lesson 6. Care management is a core function for the authority. Authority purchasing power must be used to build a more efficient, administratively simple, and integrated delivery system.

Lesson 7. The authority should have a medical school affiliation.

The second step built a structure that transformed stakeholder opinions into a series of recommendations. As shown in Figure 1, the DHCSW acquired the services of ten full time staff and forty workgroup members who gave time to meet once or twice a week for the past two months.

Figure 1. Organizational Structure
Health Authority Design Subgroup



Problem Statement

Unlike Michigan, Wayne County (especially Detroit) has experienced a continuous decline in population over the past several decades.

The challenges of managing a shrinking community are multiplied when significant economic constraints and poor health status accompany the shrinkage, as is the case in Detroit and Wayne County. Poor economic and health status are most vividly demonstrated when comparing Detroit and Michigan. For example, 59% of Detroit's population has an income below the 200% federal poverty level, as compared to 26% of Michigan's population. Male life expectancy in the state is 73.5, compared to 64.5 in Detroit.

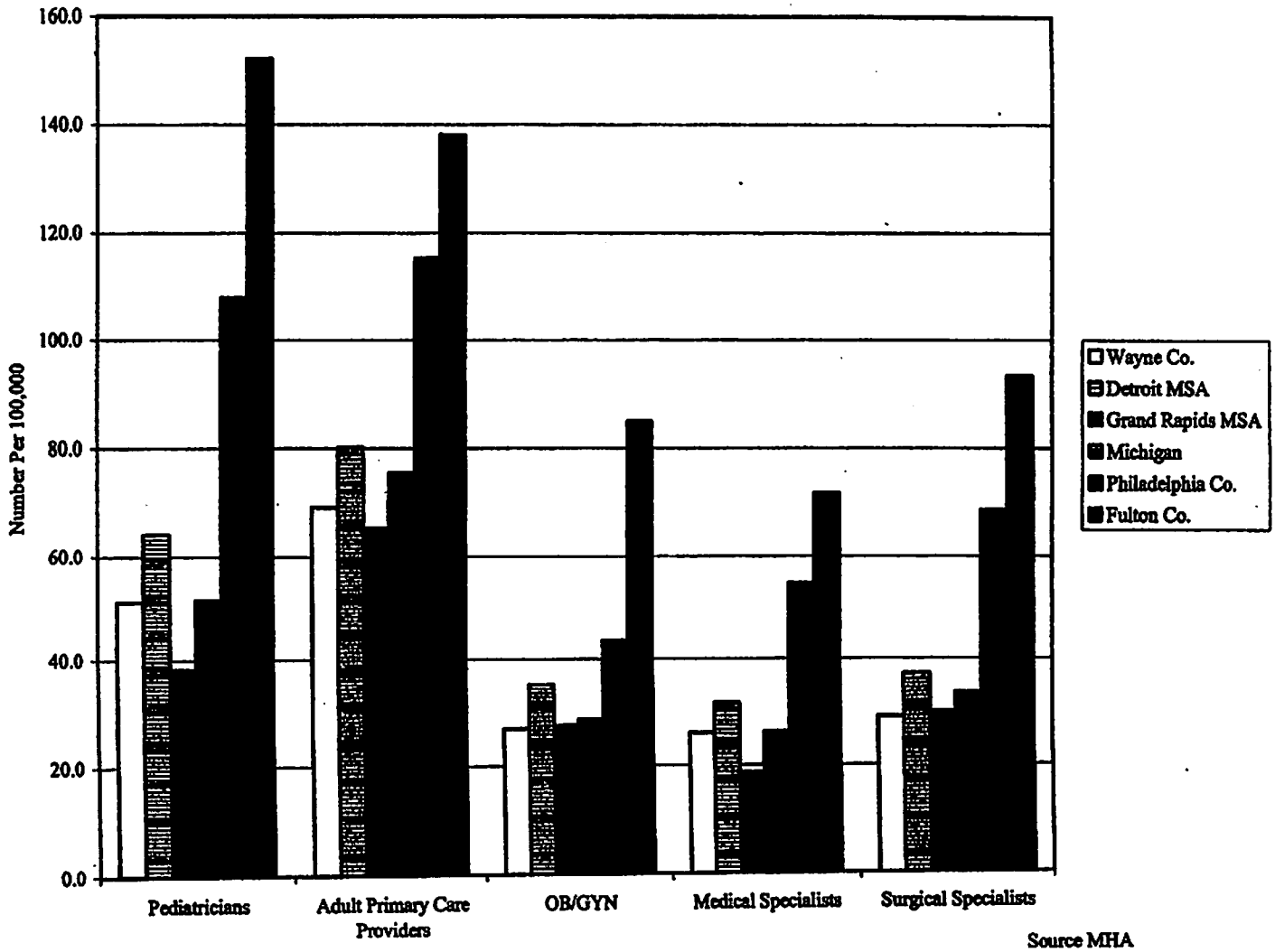
The implications of high rates of poverty and other related economic circumstances for the health care system are profound. Income is inversely related to health status: the lower one's income, the higher the incidence and severity of illness, injury, or death. In addition, low-income persons are more likely to be uninsured or to rely on public sources of financing for health services. High unemployment and a high incidence of self-employment exacerbate this problem.

Detroit's health care infrastructure is eroding. Since 1998, twenty primary care clinics have closed. Since 1997, four hospitals have closed and 1,220 beds and 4,468 full time jobs were lost. An additional Detroit hospital is projected to close before the end of the year, which will reduce capacity by 300 beds.

Detroit's health care infrastructure has suffered because of physician flight out of the city and the city's inability to attract its fair share of funding for Federally-Qualified Health Centers (FQHC). An additional infrastructure problem is the lack of a coordinated plan to care for the Medicaid and uninsured population.

Figure 2 documents the lack of primary care physicians and other types of specialists in Detroit, compared to other communities.

Figure 2. Physician Concentrations by Type by Area

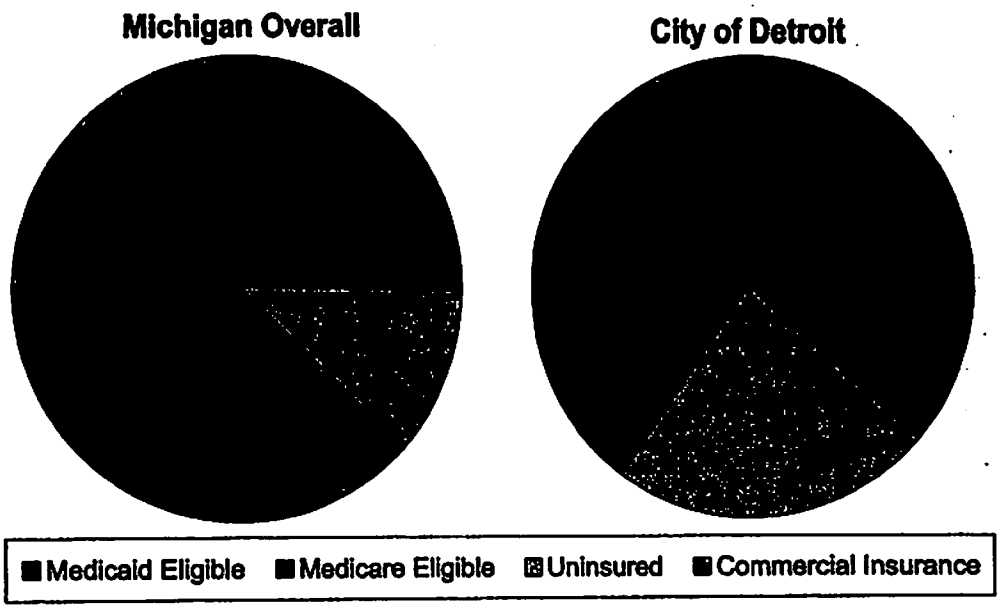


Source MHA

The loss of primary care capacity has left Detroit with inadequate resources in this crucial area. One way to measure this problem is to examine the number of people in medically under served areas. Fifty-nine percent of Detroit's population resides in federally designated areas of medical under service, as compared to 33% of Michigan residents.

Detroit and other similar cities across the nation have increasingly fragile health care systems because there is a concentration of limited resource patients in these communities. In Michigan 22.5% are either uninsured or Medicaid eligible. The corresponding figure in Detroit is more than double, with 52.5 % either uninsured or Medicaid eligible. Only 35 % of Detroit's residents have commercial insurance, compared to 63% statewide. (see Figure 3)

Figure 3. Insurance Coverage Breakdown for Michigan and the City of Detroit.



Instability is caused by the concentration of uninsured and Medicaid eligible residents in Wayne County. A solution must finance a safety net that provides high quality, cost-effective health services for people who are not eligible for insurance and people eligible for state or county insurance programs. In Wayne County nearly seven hundred thousand people fit into this category.

The population estimate is based on the following:

- 280,000 – Uninsured (Wayne County, including Detroit)
- 390,000 – Medicaid
- 25,000 – Plus Care

695,000 Wayne County Total

Medicaid is under funded.
Michigan had the lowest Medicaid health plan capitation rate in the country in 2001. The Urban Institute estimates the state-wide per member per month Medicaid rate for 2001 was $105.35. Michigan's rate was almost 50% lower than the Median national state rate of $150.60. The highest rate in the country was $209.34, nearly double the Michigan rate and 69% higher than the Medicare managed care rate for that state.

Michigan Medicaid increased capitation rates in 2003, but it is likely that rates remain below those paid by other states.

The estimated shortfall in funding for the provision of care to the Medicaid and low income uninsured populations by providers in Wayne County is estimated to be $300 million. The under funding estimate includes:

- The losses on patient care for the four major hospital systems (the Detroit Medical Center, Henry Ford Health System, St. John and Oakwood) providing care in Detroit/Wayne County are estimated at $261million for FY02.

- The HMOs serving Medicaid clients in Detroit/Wayne County lost a combined $9.6 million in calendar year 2001.

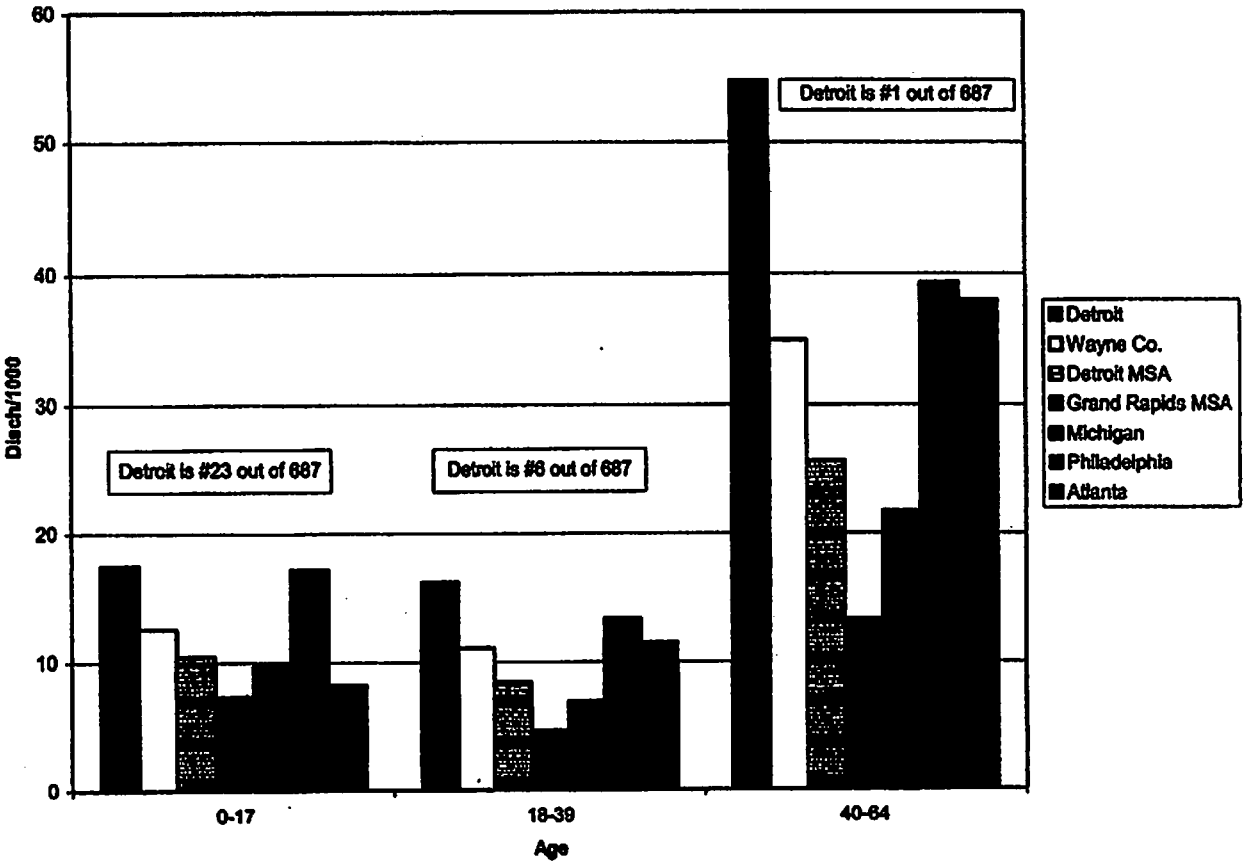
- Billing revenue and Detroit Medical Center subsidies did not cover $17 million of care provided to Medicaid and low income uninsured people by physicians associated with Wayne State University.

The chronic under funding of Medicaid, cuts imposed by the Balanced Budget Act, declining investment income, loss of commercial payments, and the concentration of Medicaid recipients in Detroit has resulted in declining financial margins. The data show that Detroit hospitals had worse margins than their counterparts in Michigan in 2001. Patient margin is the percentage difference between net patient revenue and total expenses. Detroit hospitals were paid nearly 8% less than their expenses, compared with roughly a 3% loss in other areas of the state. In other communities with higher commercial payer mix, and healthier populations, providers are better able to cope with the chronic under funding.

Underpayment has resulted in several of the Wayne County based Medicaid Qualified Health Plans coming under State supervision in order to continue operation. The largest Medicaid health plan in Wayne County (The Wellness Plan) is under state supervision and the County's largest Medicaid delivery system (DMC) recently entered into an agreement to receive a $50 million bridge payment from the state, county and city, which will not be repeated.

Under funding of health care produces a system that is both inefficient and unsustainable. Investing in chronic disease care management is impossible in an under funded system, despite the overwhelming evidence that such management is cost effective. Physician flight, clinic closures as well as hospital closures and financial losses provide clear evidence for the unsustainability of the current system. Examples of inefficiencies include the over use of emergency rooms or the lack of coordinated care for the resource limited patient. Preventable admissions are an indicator of a health system which is not providing the best care for its patients. Detroit has a high rate of preventable admissions as indicated in Figure 4.

Figure 4. **Preventable/Avoidable Hospitalizations by Age Category by Area**
Source: MHA



Recommendations

What can be done? Strengthening the safety net requires participation of all public and private sectors. A strategy that matches public and private abilities with responsibilities must be implemented.

The Authority must strengthen the safety-net health care delivery system. The health care safety net consists of those organizations and programs, in both the public and private sectors, that have a legal obligation or a commitment to provide direct health care services to the uninsured, underinsured, and other under served groups. Broadly defined, these organizations include: public and private hospitals that provide a disproportionate share of services to under served groups; community and migrant health centers; public health departments (both state and local) which directly provide safety net services; organizations funded by federal categorical programs such as Title X family planning clinics, Title V prenatal care programs, and Title XV breast and cervical cancer screening program providers; and other community-based organizations that provide uncompensated or reduced-price services.

Government's ability to provide public health core services and pay for care must be linked with the creation of a public entity that:

- coordinates the public and private components of health care services.
- leverages Medicaid funds to provide insurance benefits to the uninsured.
- expands preventive and primary care using programs such as Federally-Qualified Health Centers.

Providers must be prepared to reorganize their delivery systems in a way that will:

1. Improve access.
2. Enhance primary care capacity.
3. Improve efficiency.
4. Deliver high quality care through integrated partnerships that provide care for the uninsured.

THE DETROIT MEDICAL CENTER
OVERALL PAYER MIX

	2005	2006	2007	2008	2009
Blue Cross	19.8%	17.6%	16.8%	17.0%	15.7%
Medicare	29.1%	28.8%	29.2%	30.3%	30.5%
Medicaid	12.4%	13.9%	14.5%	13.9%	13.1%
Medicaid HMO	13.6%	15.0%	17.5%	17.8%	20.3%
Total Medicaid	26.0%	28.9%	32.0%	31.7%	33.4%
Commercial HMO/PPO	13.6%	13.0%	9.8%	9.6%	9.3%
Other Commerial	4.0%	3.6%	3.6%	3.6%	3.7%
Uninsured	6.2%	6.5%	6.6%	5.6%	5.6%
All Other	1.3%	1.6%	2.0%	2.2%	1.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%