

## Henry Ford Hospital

Henry Ford Hospital in Detroit, Michigan, is a midsize non-profit hospital located in a low-income area. It is part of a larger hospital system that also serves patients with commercial insurance from the surrounding suburbs. Although Medicaid disproportionate share (DSH) payments help offset Henry Ford Hospital's Medicaid shortfall, it is less reliant on DSH funding than other hospitals profiled.

### Hospital and Market Characteristics

Located in Detroit, Michigan, Henry Ford Hospital is the flagship facility of the Henry Ford Health System, a non-profit corporation comprising seven hospitals and the Henry Ford Medical Group, one of the nation's largest group practices. Henry Ford Hospital is also the primary teaching hospital for Wayne State University. It received \$8.6 million in DSH payments in 2012, which represented about 3 percent of its total Medicaid revenue (\$253 million) and 0.5 percent of its total operating revenue (\$1.5 billion).<sup>1</sup>

### Role in the safety net

Although Henry Ford Hospital is not a public institution, executives reported that it acts and looks like a safety-net hospital. The hospital is located in Wayne County, Michigan, a region with lower income than the statewide median for Michigan (\$41,000 median household income for the county compared to \$49,000 for the state). Henry Ford Hospital and other hospitals in the hospital referral region (HRR) care for a higher share of Medicaid-enrolled patients than other hospitals in Michigan and hospitals nationally (Table 1).

**TABLE 1.** Medicaid and Low-Income Utilization Statistics for Henry Ford and Other Hospitals, 2014

Comparison region	Medicaid inpatient utilization rate	Low-income utilization rate
Henry Ford Hospital (Detroit, MI)	28%	13%
Detroit, MI, hospital referral region average	28	13
Michigan average	18	11
National average	18	13

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

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



## Types of services provided

Henry Ford Hospital provides a number of community services, including dental care, HIV/AIDS care, neonatal intensive care, and substance abuse treatment. In addition, the hospital is a Level I Trauma Center and provides an array of advanced tertiary and quaternary care services, such as cardiovascular surgery, neurology and neurosurgery, orthopedics, sports medicine, organ transplants, and cancer treatment.

The Henry Ford System also has an extensive ambulatory care network, a number of social service programs, and a full-service insurance company, the Health Alliance Plan (HAP). The HAP is operated as a subsidiary of the system and offers a variety of health insurance products, including employer group plans, individual plans, Medicare and Medicaid health maintenance organizations (HMOs), and a preferred provider organization (PPO) network. In addition, the HAP offers insurance coverage through Michigan's health insurance exchange. One executive described the dynamics of running a health plan as part of a broader health care system: "So, we have an interesting, relatively unique interaction, where the organization has been taking risk for a long time, and as a result there has been a lot of additional focus on things like population health and managing populations."

## Market characteristics

Henry Ford Hospital is the second largest hospital in Detroit after the Detroit Medical Center system (DMC). Until 2010, DMC served as one of several providers that shared the region's charity care burden. In 2010, DMC became a for-profit hospital when it was acquired by Vanguard; it was subsequently acquired by Tenet in 2013. According to Henry Ford Hospital executives, since the change in DMC's ownership status, the region's safety-net burden has been increasingly shifting to Henry Ford Hospital. They said that other hospitals were shouldering a smaller portion of the burden. There are 13 other hospitals in Henry Ford Hospital's HRR, and most of them are non-profits.

Henry Ford executives described the local health care market in Detroit as competitive—in part because the population has declined to roughly 600,000 residents, but also because the region has two national health systems and a nationally recognized regional hospital. At the same time, executives characterized their relationship with area hospitals as being more collaborative than competitive and said that they try to solve common problems together. Executives noted the particularly close connection with other hospitals in the community given that Henry Ford Hospital receives a high number of referrals from DMC, St. John Providence Hospital, and others in the surrounding market, particularly for high-end and advanced quaternary care.

## State Context

Michigan expanded Medicaid coverage to adults under age 65 with incomes at or below 138 percent of the federal poverty level through a Section 1115 waiver. The state's uninsured rate fell from 11 percent in 2013 to 8.5 percent in 2014.



In 2014, about half of Michigan’s Medicaid population was enrolled in managed care and about 12 percent of Michigan’s Medicaid benefit spending was on supplemental payments.

## Effects of the Affordable Care Act

Henry Ford Hospital executives reported that the system had benefited financially from the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Executives said that the hospital’s Medicaid volume had increased, with many of its patients gaining Medicaid coverage under Michigan’s Medicaid expansion. As a result, Henry Ford Hospital’s charity care costs declined. However, the rise in Medicaid volume and revenue caused an increase in the hospital’s Medicaid shortfall after the expansion took effect. The hospital’s bad debt also increased. Executives reported that another effect of the ACA on the Henry Ford System was that the health plan it offered on the ACA health insurance exchange sustained financial losses.

## State policy changes affecting Medicaid supplemental payments

Henry Ford Hospital executives reported no substantial recent changes in state policy pertaining to Medicaid supplemental payments.

# Hospital Financial Information

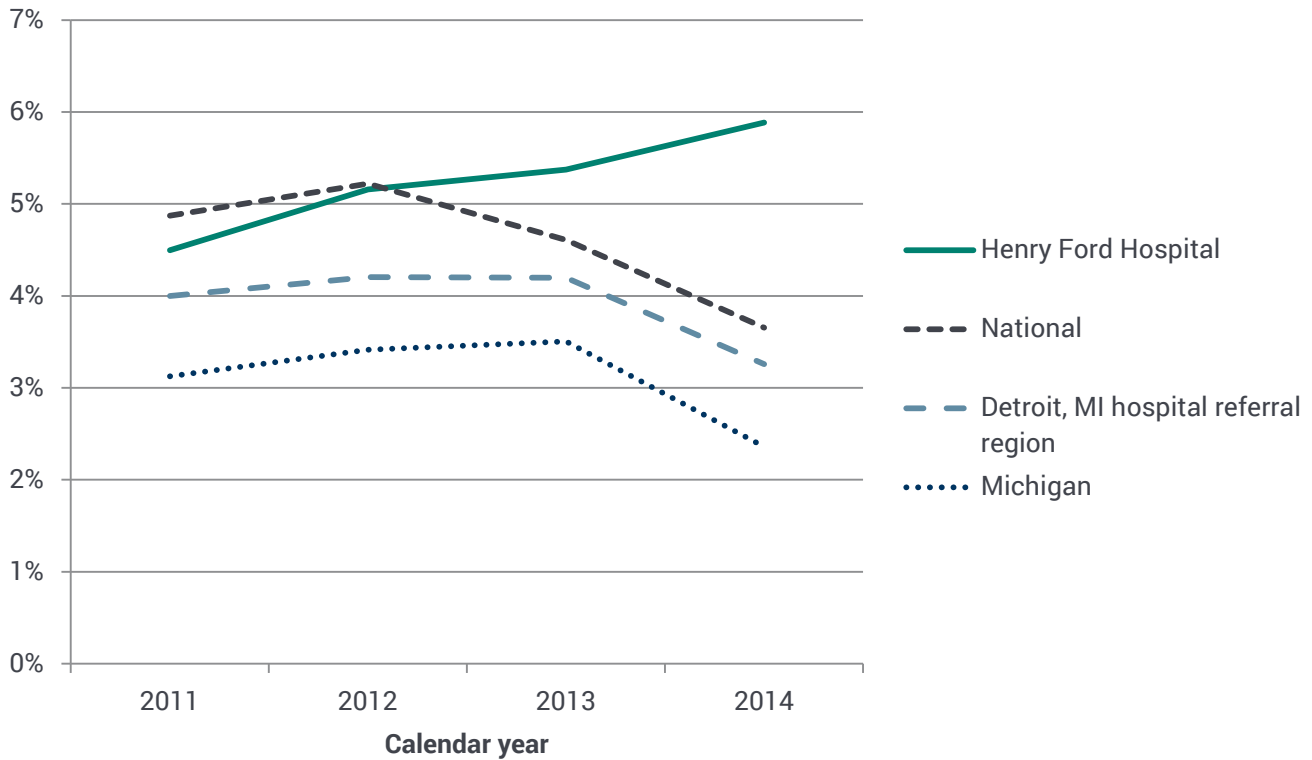
## Uncompensated care

According to 2014 Medicare cost report data, bad debt and charity care represented about 6 percent of Henry Ford Hospital’s operating costs, which was higher than that of other hospitals in the HRR and the state (Figure 1). Medicare cost report data also suggest that Henry Ford Hospital’s combined charity care and bad debt increased between 2011 and 2014. Executives said that expenses for charity care went down due to individuals gaining coverage through the ACA health insurance exchanges, but that there was a rise in bad debt due to a higher proportion of patients who could not pay their coinsurance obligations. Another factor mentioned as contributing to the increase in bad debt was a change in the hospital’s financial support policy. As one executive explained, “We wanted to encourage people to sign up for insurance [through the health care exchange] . . . so we actually changed our financial support policy to say, if you had access to coverage and you chose not to take it, then we would not give you free care . . . . It helped, but it sort of backfired. People . . . couldn’t pay the bills, ended up getting booked as bad debt.” Executives reported that they were able to collect only about 40 percent of what patients owed them, and have since backed off the policy change, recognizing that patients “who didn’t have the economic wherewithal really should be booked as charity, not as bad debt.”

Executives also stated that they continued to have a number of uninsured patients. Some of these people are undocumented and do not qualify for either Medicaid or health insurance exchange plans. And some, as mentioned earlier, are part of the influx of uninsured patients who previously would have been cared for at DMC but, since DMC’s transition to a for-profit institution, were now coming to Henry Ford Hospital.



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



**Notes:** Medicare cost reports define uncompensated care as charity care and bad debt. Michigan expanded Medicaid coverage to adults under age 65 with incomes below 138 percent of the federal poverty level on April 1, 2014.

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

## Medicaid payment shortfall

According to Michigan's 2012 DSH audit, regular Medicaid payment for inpatient and outpatient care (before accounting for Medicaid supplemental payments) covered approximately 55 percent of Medicaid costs. Henry Ford Hospital executives reported that Medicaid shortfall had increased with the ACA Medicaid expansion commensurate with the increase in the volume of Medicaid-enrolled patients.

## Medicaid DSH payments

Henry Ford Hospital's DSH payments have been increasing in recent years. In 2015, for example, the hospital received \$12.2 million in DSH payments, up from \$3.6 million in 2013. Hospital executives attributed the increase to the increased Medicaid volume due to the ACA Medicaid expansion. After accounting for the provider tax that Henry Ford Hospital paid to finance the state share of DSH payments, the hospital netted \$2.3 million in DSH payments in 2013 and \$7.7 million in 2015.



## Other Medicaid supplemental payments

DSH audit data from 2012 show that Henry Ford Hospital received most of its Medicaid supplemental revenue through non-DSH payments. In 2012, Henry Ford Hospital reported receiving \$66.8 million in Medicaid upper payment limit (UPL) payments; by 2015, these payments totaled \$86.9 million.<sup>2</sup> After accounting for the provider tax Henry Ford Hospital pays to finance the state share of these payments, the hospital netted \$32.9 million in UPL payments in 2012 and \$53.9 million in 2015.

## Role of DSH Funding

Henry Ford Hospital executives said that although Medicaid DSH payments accounted for a “relatively small percentage of our overall revenue,” they nevertheless viewed the payments, along with other Medicaid supplemental payments, as an important source of revenue, which helped them cover the hospital’s costs of uncompensated care as well as services offered by the system as one of the primary institutions serving Medicaid-enrolled and uninsured patients in Detroit. Executives stated that Michigan’s base Medicaid payment did not cover their costs of providing care to Medicaid-enrolled patients, prompting them to rely on Medicaid supplemental payments to “backfill low Medicaid rates.” As one executive explained, “If we just got straight Medicaid payment we would be in a world of hurt . . . . If we kept our current book of business, and we saw a reduction in aggregate payments from Medicaid, it would have a very dramatic impact to the point where [we] would have to start deciding if we can continue to be the urban safety net for the city and surrounding counties.”

One executive said that DSH payments were a “source of revenue, which help us subsidize things that, in the absence of DSH payments, we would have to swallow hard and not do.” He went on to note that DSH payments were not used to fund particular initiatives but instead to “give us a bigger margin, which allows us to invest back in programs for the communities.” Examples of such initiatives highlighted by executives include Henry Ford Health System’s extensive ambulatory care network, physician support in federally qualified health centers, and its AIDS clinic.

## 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 Henry Ford Hospital 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.*



## Endnotes

<sup>1</sup> Henry Ford Hospital executives reported receiving about \$3.2 million in DSH payments in 2012, which is less than what was reported on Michigan's 2012 DSH audit (\$8.6 million).

<sup>2</sup> An upper payment limit (UPL) is the maximum aggregate amount of Medicaid fee-for-service payments that a state may make to a class of institutional providers. A UPL payment is a supplemental payment to a Medicaid provider based on the difference between the amount paid in standard payment rates and the UPL.

