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Denver Health: Initiatives For Survival

How one public health care system is not only surviving, but thriving.

by Patricia A. Gabow

Denver Health is an integrated public health care delivery system in a highly competitive market. It includes the 911 emergency response system, a 349-bed acute care hospital, a locked forensic unit, ten federally qualified community health centers, ten school-based clinics, the public health department, a 100-bed nonmedical detoxification unit with a nonambulance transport service, and the regional poison control center. The system has several advantages for survival in the current marketplace, including this vertically integrated structure with neighborhood-based, community-oriented primary care, which has been in place for thirty years; a lack of debt; a good physical plant; high-quality physicians; and a strong university affiliation. However, like all public systems, Denver Health faces some serious challenges to long-term survival. As a department of city/county government, it previously lacked operational flexibility, having the burdens of city purchasing and civil service and legal constraints. In addition, the Denver metropolitan marketplace has become increasingly competitive over the past two years. Just as managed care has swept into the Rocky Mountain metropolitan area, so has hospital consolidation, particularly over the past two years. Columbia entered the Denver marketplace in April 1993 and now has approximately 34 percent of the hospital beds in the metropolitan area. A major not-for-profit religious hospital corporation (Centura) has affiliated with several of the Catholic hospitals and the Adventist system; this new system has approximately 21 percent of the area’s hospital beds. The three government/public hospitals—Denver Health, the University Hospital, and the Veterans Administration Hospital—are independently funded, governed, and operated but are closely affiliated. The Children’s Hospital houses the university’s department of pediatrics but has recently developed an affiliation with the Centura system. Kaiser has a relationship with two of the remaining metropolitan hospitals. While Denver Health has only 7 percent of the area’s hospital beds, it provides 54 percent of the charity care. In 1995 charity care constituted approximately 31 percent of its total gross charges; with the addition of bad debt, unreimbursed care accounted for 40 percent of gross charges. This is in sharp contrast to the for-profit and not-for-profit systems, whose charity care constitutes about 2 percent of their gross charges. The amount of unreimbursed care provided by Denver Health grew an estimated 15 percent in 1996 compared with 1995.

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Survival Strategies

In response to these challenges, Denver Health began a multifaceted approach to permit it not only to survive but also to thrive in this competitive marketplace. This included a change in governance, the development of a Medicaid managed care product, linkage with partners, expansion of centers of excellence, and development of new markets.

Governance. The change in governance began in 1993. Denver Mayor Wellington Webb was convinced that a change in governance was necessary to provide the health care system with the operational flexibility it needed to survive. He appointed a panel of community and business leaders to answer the question, “What is the best structure for the health care system into the future?” The only governance limitations were that the system could not be sold, leased, or contracted to a management company. The panel considered four possible structures: not-for-profit corporation, public benefit corporation, hospital district, and hospital authority. The panel excluded a not-for-profit corporation because the members believed that their constituencies would lack confidence that such an entity would continue its historic mission to the uninsured and underinsured. In addition, a nonprofit corporation would lose the benefits of governmental immunity. A public benefit corporation seemed undesirable, too, because there was no experience in the state with such structures. The panel also rejected a hospital district structure because districts are funded through a taxation mechanism that would require alterations in the property tax and, therefore, seemed unlikely to earn political or public support. The panel chose a hospital authority structure as the best option because (1) it is a public entity, since it is a political subdivision of the state with governmental immunity; and (2) the state and the city had experience with other hospital authorities, and the University Hospital had transitioned successfully to an authority from state government. The mayor accepted this recommendation, and the city council agreed with the plan.

The Colorado legislature enacted the enabling legislation in 1994. The act (S.B. 94-099) contained seven major components and established Denver Health’s current mission. The authority has a nine-member governing board appointed by the mayor and confirmed by the council; members can be removed only by a vote of the council for cause. This insulates the board from political pressures, which ensures relative autonomy. The board governs the authority and appoints its chief executive officer. The authority is authorized to perform all current Denver Health functions subject to an executed contract with the city; the finalization of this contract actually triggered the operation of the entity. The authority can participate in alliances and joint ventures and can create not-for-profit subsidiaries. Current personnel can elect to stay in the city civil service system while continuing to work for the authority or they can join the new authority personnel system; every new employee is an authority employee. The authority can issue debt.

After the enactment of the legislation, a joint committee of representatives from city government and the health care system developed three contracts between the entities—a transfer contract, a personnel services contract, and an operating contract. The transfer agreement transferred all real property and balance sheet assets to the authority. There were four considerations in the transfer of assets: (1) that these assets would be used to support the mission; (2) that the assets could not be sold without permission; (3) that over time the authority would provide an amount of unreimbursed care equal to the assessed value of the properties; and (4) that in the
event of default, all assets would revert back to the city. The personnel services agreement detailed the management of city employees who worked for the authority. The operating agreement detailed the continued operation of the health care system. It contained four critical elements: the delineation of the services to be transferred; the authority’s performance criteria for these services; the mechanism of city payment for indigent care; and the process of dispute resolution.

- Medicaid managed care. The second strategic initiative was the development of a Medicaid managed care product. This was accomplished in two phases: The first was a Denver Health-only initiative; the second, a multiple-partner Medicaid HMO. The development of this product was facilitated by the fact that all Denver Health ambulatory care sites were federally qualified health centers; thus, no HMO license was necessary for Medicaid-only prepaid health plan (PPHP) status. Also, Colorado had a primary care physician program in place, and approximately two-thirds of Denver Health’s Medicaid patients were already enrolled in this program. This component enabled the newly formed PPHP to use a passive enrollment process from the primary care physician program to the PPHP. All categories of Medicaid and all acute mental health care services were included in this program. Denver Health assumed full risk for all patient care, including out-of-agency referrals and emergencies. The initial success of this program prompted phase two, which involved forming a new company with three of the other traditional Medicaid providers, the university hospital, the children’s hospital, and ten non-Denver community health centers. This brought together the state’s largest Medicaid provider, the state’s only children’s hospital and only university hospital, and nonhospital providers.

The company obtained an HMO license and within months of its formation became the largest Medicaid HMO in Colorado. Denver Health Medicaid HMO enrollment grew from 7,400 in 1994 to 17,500 by December 1995. Interestingly, in 1996, to maintain this level of enrollment on a constant basis, 29,000 patients were enrolled, reflecting the fact that patients would be off and on Medicaid. Fewer than 1 percent of patients disenrolled from Denver Health to join a competing HMO.

- Linkage with partners. Although maintaining the Medicaid population through participation in a Medicaid HMO was critical, other alliances for serving other populations were also necessary. Recently, another new company was formed that includes a number of community-owned or government hospitals throughout Colorado. They share the desire for autonomy in governance while wishing to gain the benefits of a provider network. Denver Health has joined this entity. However, the benefits cannot yet be assessed.

- Centers of excellence and new markets. In the current competitive environment, it is important that Denver Health obtain new patient markets that fit within its safety-net mission but that also provide additional revenues to support the provision of care for the uninsured. Two such efforts are the aggressive development of centers of excellence in trauma care and in prisoner care. The former fits with the safety-net mission of caring for the special needs of the entire population; the latter, with the mission of caring for the needs of special populations.

These strategic efforts to provide a strong base for Denver’s safety-net system appear to be promising and are approaches that should be considered by other similar systems.

A version of this paper was presented at The Robert Wood Johnson Foundation/Health Affairs/Alpha Center conference, “What Is Happening to the Safety Net?,” 9–10 January 1997, Washington, DC.

NOTES
1. Personal communication with Larry Wall, director, Colorado Hospital Association.
3. Ibid.