May 2007 Publication 312

Public Affairs Research Council of Louisiana, Inc.

Realigning Charity Health Care and Medical Education in Louisiana

I. EXECUTIVE SUMMARY

Louisiana's public health care system, ailing for decades, is now on life support. The hurricanes of 2005 exposed the system's long-standing shortcomings but so far policymakers have not been able to reach a consensus for change. This report reviews the many aspects of the health care riddle and the viable alternatives for a solution. It builds upon numerous studies over many decades that all have reached a similar conclusion: The concept of 10 charity hospitals spread across 64 parishes and 45,000 square miles is neither an efficient nor effective method of delivering medical care for a state with high levels of uninsured persons. Louisiana should align itself with the nationwide trend of the past 25 years to "bring health care to the people," the reverse of the charity hospital model of care.

Fundamental reform would include, as a necessary first step, coverage for as many low-income uninsured as possible, giving them ready access to nearby medical care instead of long waiting times and, in many cases, long travel times to get to treatment. For the population that cannot be covered, a more effective solution would be a replacement safety net that is decentralized to offer care close to home with nearby availability of locally-operated primary care clinics, doctors and hospitals. Some of the key findings of the report that provide insight into problem areas are as follows:

Louisiana's uninsured and their separate health care delivery system (part III):

- The state has the ninth highest level (19 percent) of uninsured overall, ranks 29th (8 percent) for uninsured children but fifth (24 percent) in percentage of adults without insurance.
- The state's safety net is porous and often fails to provide for the uninsured in need of medical care because of poor access to services and long waits for clinic visits.
- Charity hospitals are overly dependent on state and federal subsidies compared to public hospitals in other states due to an inability to attract insured or Medicare patients.
- A growing reliance on subsidies ensures that the dollars cannot be redirected to coverage expansions or primary care, thereby helping to maintain a two-tiered system of care, one for those with insurance and a separate but unequal tier for the uninsured.
- Expanding insurance coverage is far superior to safety net care: It provides better health outcomes, reduces absenteeism in school and on the job, and improves productivity.

A remedy for the two-tiered system (part IV):

- Alternative coverage plans have been proposed by both the state and federal governments but no agreement has been reached on cost, coverage and other issues.
- For those without insurance coverage, a replacement safety net is needed that will be locally governed and administered and will focus on the needs of the patient, including more choices and better accessibility to primary, specialty and hospital care.

Improving graduate medical education (part V):

- Charity hospitals serve very few Medicare patients, so Louisiana is foregoing up to $160 million in federal funds for physician training through Medicare graduate medical education (GME) financing.
- Disproportionate share hospital (DSH) funds intended for care of the uninsured are being used to finance GME instead.
- Using more community hospitals with high levels of Medicare patients as sites for residency training could provide significantly more federal funds to finance GME as well as provide more diversity in clinical training experiences for residents.

- Louisiana has fewer primary care physicians (PCPs) per population, lags behind the nation in graduation rates of PCPs and has a serious shortage of physicians in rural and other underserved areas.

Charity health care and medical education are physically and fiscally intertwined in Louisiana's state-run charity hospital system. An ever-growing demand for hospital subsidies (Disproportionate Share Hospital payments, or DSH) in place of revenue from paying patients has sustained a two-tiered system of care in which the uninsured are left to seek primary health care in a network of 10 charity hospitals scattered throughout the state. Louisiana charity hospitals rely on Medicaid and DSH revenues for 82 percent of their budget, compared to 37 percent for other United States public hospitals. Louisiana's DSH allotment is fourth highest in the U.S. at $1.1 billion per year, and most of it goes toward charity hospital operations. Even so, patients who are weary of long waits for routine care are leaving the charity system for private sector emergency rooms. This centralized and subsidized approach to health care relies heavily on a steady stream of uninsured patients who have no other choices.

Nearly all public funding for care for the uninsured is directed to the charity hospital system where the capacity is increasingly insufficient. As private hospitals and clinics take on more and more of the indigent care workload, their uncompensated care costs mount, their losses increase and resistance builds to any proposal that would seek to fund expanded capacity at the charity institutions. Instead, there is a growing consensus that the private health care community can deliver medical care to the uninsured more effectively and efficiently than the current system, provided that care does not continue to be uncompensated. The transition to a new system of care will be a lengthy and complex process that will require determined leadership, optimization of new partnerships and long-term support from the Legislature. The reward for these efforts will be an immediate benefit to patients and a long-term advantage for local communities and the state.

Louisiana's approach to medical care for the uninsured has fundamental problems that cannot be solved unless the organizational model itself is transformed from the charity paradigm to a decentralized, community-based system of indigent care. In the other 49 states, patients without insurance are usually integrated into the private sector framework rather than being isolated in a charity system. No safety net is perfect, but other states have local and regional arrangements that provide better access to appropriate primary, specialty and hospital care than Louisiana.

The charity hospital model has failed to provide timely access to medical services in cost-effective settings for the target population of an estimated 650,000 uninsured persons. Given the organizational structure of the charity system and its aging physical plants, it is unlikely to make progress toward self-sustainability, let alone provide improved access. But, with the implementation of expanded coverage and appropriate safety net reforms, the state can develop a more community-based approach to health care that provides improved access and quality and better health outcomes.

However tragic the events that unfolded at the charity hospital in New Orleans during and after Hurricane Katrina in 2005, the closure of that facility opened the door for change and sparked a new level of policymaking debate. Several studies and sets of important recommendations have been developed, and the federal government has expressed a new willingness to assist with their implementation. Regardless of the level of federal support the state ultimately receives, the recommendations in this report can be implemented to transform the state's divided delivery system and set new standards of excellence for both public and private health care providers.

These recommendations call for true regional academic medical centers of excellence in New Orleans, Baton Rouge, Shreveport and Monroe, which would be kindled by community cooperation, partnerships and affiliations between the public and private sectors. The size of these facilities should be compatible with local demographics and medical care needs, as well as the education and research missions of the medical schools.

Under this proposal, the other six charity hospitals would be transferred to local control following a five-year period of careful planning and implementation to assure that access to care and services are improved before any transition takes place. Some communities already have developed plans for such transfer of ownership.

The safety net of care for the uninsured would be broadened to include private hospitals for acute care and clinics for primary care. Rules for funding care for the uninsured and paying health care providers would be developed so that the dollars follow the patients to both public and private care providers. Other budgetary changes would enable the state to capture additional federal funding for graduate medical education.

PAR's recommendations for realigning charity health care and medical education are as follows:

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Recommendation 1: LSU hospitals in New Orleans and Baton Rouge should be replaced and sized in accordance with independent population and revenue projections. The hospitals should be operated as academic medical centers under the jurisdiction of the LSU Health Sciences Center in New Orleans. The LSU Health Sciences Center and University Hospital in Shreveport and the E.A. Conway Medical Center in Monroe should be maintained and operated as academic medical centers.

Recommendation 2: Regionally integrated systems of care should be established by local authorities and health care providers in order to plan for an orderly transition of indigent care over a reasonable period of time from six state-operated charity hospitals to regional and community-based networks that emphasize primary and preventive care, as well as quality specialty and hospital care.

Recommendation 3: Financing for graduate medical education (GME) programs should be restructured to increase substantially Medicare GME payments by locating residency training at community hospitals and primary care training sites. Financing with Medicaid GME funds also should be increased substantially and payments should be linked to specific state policy goals, such as increasing numbers of primary care physicians.

Recommendation 4: State and federal funds currently paid almost exclusively to state hospitals for care of the uninsured should be redirected so that "dollars follow the patient" in order to allow them to choose appropriate health care from a wide variety of accessible inpatient and outpatient services delivered by private- and public-sector providers.

Recommendation 5: Insurance coverage options should be a top priority of the state, regardless of the outcome of negotiations with the federal Department of Health and Human Services.

Recommendation 6: Accountability and transparency should be enforced rigorously by the Department of Health and Hospitals in the spending of Medicaid Disproportionate Share Hospital (DSH) dollars, including immediate issuance of rules that require all qualifying providers, whether public or private, to present full information about services delivered to uninsured patients before being reimbursed.

Recommendation 7: Health care recovery and reform planning should be accomplished by the Department of Health and Hospitals in consultation with the Louisiana Health Care Redesign Collaborative, or a similar entity with broad representation of health care, business and consumer interests. The process should be statewide in scope and include all LSU hospitals and medical schools in addition to the services and programs included in the 2006 Health Care Redesign Collaborative planning effort.

The above set of recommendations outlines the path for improved health care statewide and must be considered as an interdependent set of reforms rather than a list of independent proposals. Louisiana needs to adopt a holistic approach to health care planning and reform unlike any it has demonstrated in the past. The public and private sectors can no longer function in silos, and with steady and determined leadership and a shared vision the entire health care community can be strengthened and the health of the state improved.

II. INTRODUCTION

Louisiana has a long history of providing health care for the poor, dating back to 1736 when the original charity hospital opened its doors. The imposing building that now stands abandoned on Tulane Avenue in New Orleans is the sixth structure in the city to be known as "charity hospital" during the past 270 years. Built during the 1930s and opened in 1939, Big Charity was a memorial to Huey P. Long, the populist governor who expanded the power of state government. Big Charity and other state-operated hospitals were potent symbols of the authority of the state of Louisiana. For many, their good health and quality of life depended on generosity of the government in Baton Rouge.

But, state government has failed for many years to deliver on its longstanding promise to provide timely access to good quality medical care for free to anyone who cannot pay. The list of grievances is long and includes but is not limited to: waiting times often measured in months for clinic appointments; overcrowded emergency rooms and outpatient services; long drives from rural areas to one of the 10 cities where hospitals are located; inability to utilize nearby private doctors, clinics and hospitals; lack of diagnostic and treatment equipment that is commonplace in most hospitals outside the charity system; and poorly maintained buildings. Meanwhile, doctors, nurses and

staff work resolutely to treat illness and save lives under adverse conditions.

This report examines the uninsured in Louisiana and the health care delivery system that was established decades ago to provide care for them. It reviews the problems in the current system and the impact on personal health outcomes in a state that persistently ranks least healthy in the nation. It explores the issues surrounding physician education, including whether a 10-hospital system is needed to train doctors when many top medical schools arrange for training in community hospitals throughout the country.

The report provides a set of proposals that shift the responsibility and decision-making for indigent health care from the state bureaucracy in Baton Rouge to local communities where quality medical care can be delivered by providers who understand the needs of local residents. These proposals would increase access to medical care by allowing patients to choose doctors, clinics and hospitals, rather than being locked into the narrow menu of choices that state government has given them. These proposals also would provide for centers of excellence in physician education, patient care and research at four academic medical centers affiliated with the LSU and Tulane medical schools. This would focus scarce taxpayer dollars on the all-important mission of training tomorrow's doctors to provide the best quality of care for Louisiana citizens.

The separate but unequal systems of care, one for the uninsured and another for those with insurance coverage, set Louisiana apart from the rest of the nation. State-run charity hospitals, once considered progressive, now struggle to maintain a basic menu of services. The destruction brought on by Hurricane Katrina has forced policymakers to speed decisions about the future of the state-run health care system in New Orleans, but system-wide change is not being planned. The status quo threatens to reign if bold political action is not taken now to impose a radical shift in the way health care for the uninsured is funded, administered and accessed.

While health care reform was touted as the top priority by the current governor, fundamental systemic change has not been achieved so far. Opportunity has arisen from the unfortunate circumstance created by the closure of the New Orleans charity hospital, which once served as the cornerstone for Louisiana's now antiquated public health care system. Rebuilding undoubtedly will occur, but re-prioritizing, reforming and reshaping may not occur unless political leadership from the top insists upon it and forces the change. This analysis examines the structure and function of the entire charity hospital system and offers recommendations for improvement.

Louisiana's system of charity hospitals and medical schools would benefit from closer collaboration with the rest of the health care community. The system has strived to monopolize the twin responsibilities of indigent health care and physician education. But charity hospitals are ill equipped to shoulder these responsibilities, lacking capacity and basic clinical tools for some conditions and diseases with which modern hospitals provide medical care. If the public and private sectors shared the burden of indigent care and medical education, true centers of excellence could develop to provide quality care and quality education.

The division between the public and private sectors has become even more apparent since the hurricanes of 2005. The over-centralized and ill-equipped public hospital system was far more vulnerable than any diverse and widely distributed community-based delivery system would have been. The hurricanes accelerated the trend of uninsured patients seeking care outside the charity system. The Louisiana Hospital Association had estimated in 2003 that $100 million in uncompensated care was being delivered by private hospitals without reimbursement of any kind. With the New Orleans charity hospital out of commission, the situation—and the public/private chasm—has been made worse.

This report reviews the demographics of the state's uninsured population and compares the expensive and inefficient state-operated institutional system of care to that of other states where health delivery for the uninsured is more accessible, more cost-effective and provides the patient with more choices. It describes the structure of the interlocked systems of health care for the uninsured and medical education and makes recommendations for change that would above all improve access to care for uninsured residents of the state. It also describes a number of proposals that have emanated from several Louisiana communities that were dissatisfied with their local charity hospital and developed proposals for systemic change. Expanding options for readily available access to quality health care is the primary goal of this cohesive set of proposals, which should be considered as a whole. Only a systematic approach to reform can succeed.

III. LOUISIANA'S UNINSURED AND THEIR SEPARATE HEALTH CARE DELIVERY SYSTEM

Louisiana is ninth worst in the United States in percentage of population uninsured with 19 percent, or 709,130 non-elderly persons, without health coverage in 2004, according to Kaiser Family Foundation. A more recent Louisiana Health Insurance Survey (LHIS) employing different methodologies was conducted by LSU in 2006 and estimated 651,523 uninsured. The state has done an excellent job of expanding coverage for children through Medicaid and LaCHIP since 1998 and

ranks in the top 10 states with only 8 percent of children uninsured, compared to 11 percent nationally. However, the state ranks very high in the percentage of adults uninsured.

In nearly all states, providing a safety net of medical services for the indigent population is the responsibility of local jurisdictions. In Louisiana, state government historically has provided care through the charity hospital system, which also serves as a training environment for physicians from the LSU and Tulane medical schools. Charity hospital service delivery trends show significant decline in both inpatient and outpatient services in recent years compared to significant increases for other public hospital systems in the United States. Louisiana Charity hospitals are also highly dependent on Medicaid and Disproportionate Share Hospital (DSH) funds which accounted for 82 percent of total revenues in 2003 compared to only 37 percent for other public hospital systems. Charity hospital revenues from commercial insurance and Medicare are far lower than other United States public hospitals.

In addition to the problem of dependence on government subsidies, major factors that affect the performance of the charity hospitals are: lack of geographic access, especially for rural populations; long waiting times for outpatient clinics, causing excessive use of emergency rooms for routine health problems; and lack of certain specialty procedures and equipment, which are commonplace in other Louisiana hospitals.

Louisiana falls far below the U.S. average in terms of health care performance and quality but rises above the average in terms of spending and numbers of uninsured persons. The state has held its title as "least healthy state" for 15 of the last 17 years, according to "America's Health Rankings" published by the United Health Foundation. In 2003 and 2005, Louisiana ranked 49th.

The lack of health insurance is a major problem throughout the United States, with about 17 percent or some 44 million non-elderly persons uninsured, according to 2005 survey data. Kaiser Family Foundation estimates for Louisiana show 709,130, or 19 percent, of non-elderly persons are uninsured -- ranking ninth worst in the nation. (Including the elderly population would increase the total uninsured by less than 5,000 for Louisiana and about 300,000 for the nation. Most persons over 65 are covered by Medicare.) Kaiser provides estimates for each state, which allows for state-to-state and U.S. average comparisons. While these estimates are used here for comparison purposes, the 2006 Louisiana Health Insurance Survey is used elsewhere because it is considered more accurate in measuring the number of uninsured within Louisiana. LHIS has adopted appropriate methodologies to estimate more accurately the uninsured population and has addressed the problem of undercounting Medicaid enrollees.

Factual profiles of the uninsured tend to diverge somewhat from popular perception. According to current Kaiser Family Foundation reports based on Bureau of the Census data for Louisiana, more than 59 percent of the 709,130 non-elderly uninsured reside in families with at least one full-time worker. An additional 11 percent are in families with part-time workers. Adults comprise 87 percent of the uninsured population and children 13 percent. Louisiana is fourth highest in the nation for the percentage of adults uninsured, but fares much better at 46th (or fourth lowest) for uninsured children.

Of the 709,130 uninsured, 48 percent are white and 47 percent are black. More than 23 percent have family income levels at twice the federal poverty level, which is $34,340 for a family of three. But while the uninsured tend not to be the "poorest of the poor," they are predominantly in the low-income category with 48 percent below the federal poverty level and 77 percent below twice the poverty level.

In 2005, Louisiana had the ninth highest rate of non-elderly uninsured, ranking better than Texas, Florida, New Mexico, Oklahoma, Arizona, California, Georgia and Nevada.

Numerous factors contribute to the national upward trend in the uninsured, including a dramatic rise in health insurance premiums over the past few years. According to the Kaiser Family Foundation, health insurance premiums increased significantly from 2000 through 2005, with increases ranging from 8.2 percent in 2000 to a high point of 13.9 percent in 2003. This trend was markedly higher than changes in the general inflation rate or workers' earnings, both of which posted increases averaging 3 percent or less over the same period. For 2005, the nationwide average premium for family coverage in employer health plans was $10,880 per year. The employee contribution for family coverage was $2,712 per year in 2005, up 67 percent from $1,620 per year in 2000. The rising cost of premiums is the major factor causing low-income employees to drop coverage.

Also as a result of cost pressures, fewer firms are offering health coverage to their employees, a trend that primarily affects workers in small businesses. From 2000 to 2006, the percentage of U.S. firms offering health benefits declined from 69 percent to 61 percent (see Table 1). The smallest firms (three to nine workers) were hit hardest, with those offering health coverage dropping from 57 percent to 48 percent. As of 2003, only 50 percent of all firms in Louisiana offered coverage. (*Kaiser Family Foundation, Employer Health Benefits 2006 Annual Survey*)

The gloomy picture painted above disguises positive developments in Louisiana, a state that outperformed

Table 1. Resident Insurance Coverage by Type, 2005

	Employer	Individual	Medicaid	Other Public	Uninsured
US average	61%	5%	14%	2%	18%
LA	57%	5%	16%	3%	19%

SOURCE: Kaiser Family Foundation, 2007, based on Bureau of the Census, Current Population Survey, 2005

Table 2. Change in Percent of Population Uninsured

	United States		Louisiana		
	U.S. 2004 rate	U.S. change 2000-2004	LA 2004 rate	LA change 2000-2004	LA rank on 4-year trend
Non-elderly adults	21%	+2.7%	26%	+1.7%	20th best
Children under 19	12%	-0.7%	12%	-7.2%	1st best
Total	18%	+1.7%	21%	-0.9%	6th best

SOURCE: Kaiser Family Foundation, 2006, based on Bureau of the Census, Current Population Survey, 2004

the nation in expanding coverage for children. Table 2 compares Louisiana to the nation by levels of improvement or decline in the uninsured populations by age group.

In 1998, the Louisiana Children's Health Insurance Program (LaCHIP) was launched to provide coverage for children in low-income families. The program provided a phase-in of coverage levels according to family income, from 133 percent of the poverty level up to 200 percent within three years. It also included an aggressive outreach effort to enroll eligible children in either LaCHIP or Medicaid, depending on family income. By January 2004, the total number of children covered by both programs had grown to more than 620,000, nearly doubling the 315,000 covered in 1998. These children and most Medicaid adults were enrolled in a companion program called CommunityCARE, which linked them with private physicians or community health clinics to provide "medical homes." By 2003 approximately 700,000 were enrolled in CommunityCARE, which was evaluated by the federal Centers for Medicare and Medicaid Services (CMS) in 2005 and determined to be a "model program."

These programs are examples of what is possible in reforming Louisiana's health care system with good planning, careful implementation and legislative support. The Blanco administration has continued an aggressive outreach policy for LaCHIP and has set a goal to cover all uninsured children below 200 percent of the federal poverty level.

Despite the gains in coverage and access, some unfortunate recent developments have denied health care to significant numbers of children. Enrollment in LaCHIP and Medicaid has decreased recently as a result of stricter citizenship status requirements imposed by Congress. Most of the enrollment reductions in Louisiana have occurred because Medicaid and LaCHIP clients failed to produce valid documentation, even though citizenship was not an issue in most cases. DHH has taken aggressive steps to counteract the reduction and increase enrollment. Also, some 28,000 children with disabilities were discharged recently from the CommunityCARE program, thereby denying them the benefit of a medical home with a primary care physician. With the renewed emphasis on the medical home concept by the Health Care Redesign Collaborative, this vulnerable population of children should be the first to have this service restored.

Even with reversals such as these, Louisiana maintains high marks for increasing coverage for children. The state ranked ahead of all other states for progress in expanding coverage for the period 2000-2004 and ranked 10th in the nation in 2006 for the percentage of children with health coverage. Despite these achievements, the state continues to fall behind in coverage for adults, a problem unlikely to abate without decisive action by policymakers.

Health Care Delivery Systems for the Uninsured

It is difficult to find commonality among health care delivery systems across the 50 states. Instead, what exist are 50 separate and distinct systems with unique methods of providing and financing care. But there are generally some common aspects that facilitate the categorizing of systems, such as how states handle care for the uninsured. By and large, providing for the uninsured tends to be a local responsibility that is shared by a mix of health care interests, which often include municipal or county hospitals, academic medical centers in some locations, Federally-Qualified Health Centers (FQHCs) and other private and public clinics, and physicians in private practice. Care delivery tends to be decentralized in most cases, geographically and by provider type.

In its latest national survey, the National Association of Public Hospitals (NAPH) lists its members according to the type of governance used. According to the association's taxonomy, Louisiana has 39 hospitals and systems that are separate public entities, seven non-profit corporations, 22 directly operated by local government and 17 directly operated by state government. Of the 17 in the last category, eight are listed as Louisiana charity hospitals.

Louisiana is an outlier in caring for the uninsured, with its highly centralized, 10-hospital charity system operated by state government. In Louisiana, the uninsured have little choice when it comes to medical care. The state has determined through its funding priorities that most care for the uninsured should be delivered at the 10 charity hospitals. While in some communities (primarily in the New Orleans area) there are some off-site health clinics for the uninsured, the general rule is that those patients must visit a hospital or hospital-based clinics for even routine medical care. This is an expensive and inconvenient approach to health care that consigns the uninsured population to a separate delivery system that often lacks timely access to cost-effective primary and preventive care.

In isolated rural areas, the uninsured may have to travel 100 miles or more to the nearest charity hospital. Typically, they will pass a number of hospitals along the route that do not grant access, except in emergency cases, because historically non-charity hospitals are not reimbursed for uninsured care. W hen uninsured patients reach the charity hospital at their destination, they often find ERs crowded with people seeking routine care. Appointments for outpatient clinics or for some types of surgery are made months in advance in most cases. Such delay and difficult accessibility too often discourages people from seeking primary and preventive care and treatment at the early stages of acute and chronic illness. (Note: following the 2005 hurricanes, a temporary fund of $120 million was established to reimburse charity and non-charity hospitals for services provided to hurricane victims.)

Furthermore, the charity clinic system relies heavily on medical residents and students who rotate frequently to multiple locations, rather than permanently assigned faculty doctors. Therefore, the system is often unable to provide a desirable level of continuity of care, an essential ingredient in the doctor-patient relationship and a hallmark of the medical home concept embraced by the Louisiana Health Care Redesign Collaborative, the 40-member committee designated by the Legislature to develop a strategic health care reform plan.

The Economy of Being Uninsured

There is a common perception that the uninsured are provided care when they need it through a safety net with accessibility and quality comparable to what is available for the insured population. The reality is that there are significant disparities between the insured and the uninsured with respect to access to care and the resulting impact on health outcomes. The negative effect on individual health and economic well-being multiplied by the total number of uninsured produces a substantial statewide and nationwide impact on population health, educational performance and economic productivity. Studies by the Institute of Medicine of the National Academies of Science and the Kaiser Family Foundation (KFF) document the problems of lack of coverage. All evidence points to the conclusion that safety net care is no substitute for insurance coverage.

A KFF study ("The Cost of Not Covering the Uninsured," June 2003) cites research showing that having health insurance leads to improved health and longer lives because of better access to medical care. One of the key findings is that the uninsured receive about half as much health care as the continuously insured. If the state were to provide the uninsured access to continuous health coverage, mortality rates would decline and education and productivity levels would rise. Primary and preventive care is less expensive and more cost-effective to provide than treatment of chronic conditions and diseases that require specialty or hospital care

In short, safety net medical care is not comparable to insurance coverage, primarily because it lacks ready access to primary, specialty and hospital care. As detailed below, the Louisiana safety net is even more limited than what is found in other states. Furthermore, charity hospitals are in poor shape physically and financially. They are highly dependent on DSH subsidies and derive little revenue from other sources to enable adequate maintenance and upgrade of medical equipment.

The Charity Hospital System in Louisiana

> *"Louisiana's health care system, in essence, consists of two systems – one for the insured and one for the under and uninsured. The current financing of health care delivery to the uninsured promotes referral patterns that encourage this structure. The insured are mostly cared for by the private sector, and the uninsured are mostly cared for by the public hospital system. This two-system model appears to be detrimental to the health of all Louisianans and is likely an important reason for the lower system quality, both in the public and private sector." ("Report on Louisiana Health care Delivery and Financing System," PricewaterhouseCoopers, April 2006)*

Louisiana's system of 10 charity hospitals serving the uninsured is unique among U.S. public hospitals. The

state's charity hospitals are the only officially designated provider of patient care for the uninsured and until recently were almost the sole providers of such care. Most, but not all, charity hospitals are used for medical student education, resident training and post-residency specialty training, although the bulk of the training occurs at New Orleans and Shreveport. These two locations are also sites for conducting biomedical and other health care research. Table 3 lists the 10 hospitals from largest to smallest according to staffed bed count prior to Hurricane Katrina.

Management of the charity hospital system has shifted among three different state departments over the past 20 years, producing little in the way of fundamental improvements. In 1997, responsibility for managing the hospitals was transferred from the Louisiana Health Care Authority to LSU, which also operates the state's only public medical schools. Eight of the facilities are charity hospitals run by the LSU Health Care Services Division (LSU HCSD). The LSU Health Sciences Center in Shreveport operates University Hospital in that city, as well as E. A. Conway Medical Center in Monroe. The state Department of Health and Hospitals (DHH) maintains the responsibility for establishing rules that govern Medicaid and Disproportionate Share Hospital (DSH) payments for the charity hospital system. The Louisiana State Board of Medical Examiners (LSBME) under DHH licenses physicians and regulates the practice of medicine in Louisiana.

The Board of Regents, which oversees the state's four higher education systems, recently sent a letter to the LSU Board of Supervisors outlining its concerns that LSU's continued management of the charity hospital system is a distraction from the system's academic mission and goes well beyond the responsibilities of medical education and training.

Problem Areas

According to national surveys, Louisiana's charity hospitals are none too healthy compared to other public hospital systems around the country. Over the past few years, the numbers of patients treated and services provided have declined at charity hospitals. Meanwhile, indigent care at private hospitals has increased, despite the lack of provider compensation. Federal rules requiring all hospital ERs to treat patients regardless of ability to pay make it all but impossible for private hospitals to turn away patients.

Increasingly, patients are seeking care outside of the public system where they can find immediate and close attention in more modern facilities. The estimated cost for providing care to the uninsured in non-charity hospitals exceeded $100 million annually prior to the hurricanes of 2005. Most private hospitals, however, are not being reimbursed for this "uncompensated care" with federal and state funding that is currently reserved mainly for the charity hospitals. Of the total $1.1 billion in DSH spending, most goes to the LSU hospital system, with major exceptions for mental hospitals ($98 million) and rural hospitals ($84 million) to sustain operations in medically underserved areas. Post-hurricane funding of $120 million has been provided on a temporary basis for private hospitals to offset uncompensated expenses.

The decline in patient census and services rendered at the charity hospitals demonstrates the uninsured population's dissatisfaction with the outmoded dual delivery system. Long waiting periods for outpatient appointments and crowded ERs are clearly forcing patients to seek care elsewhere. Data collected by the National Association of Public Hospitals for the period 1998 to 2003 showed significant disparities between national and Louisiana trends in public hospital service delivery.

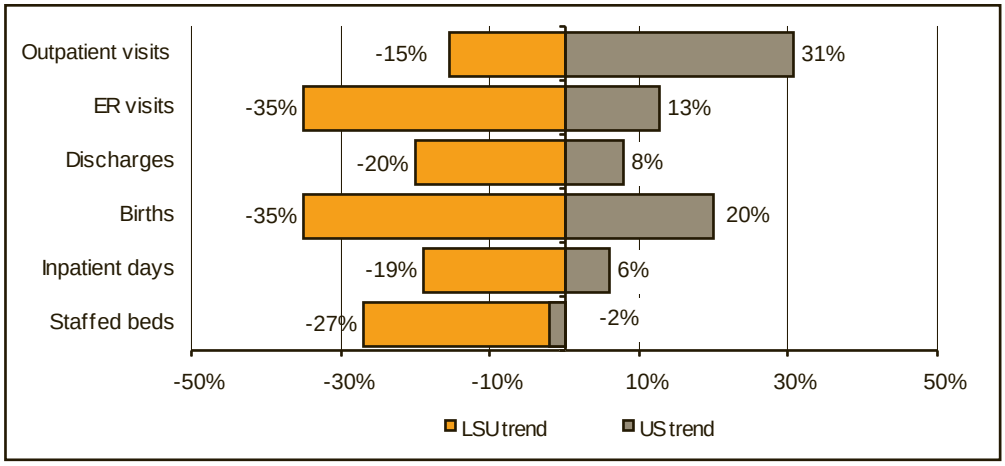
Table 3. Charity Hospitals in Louisiana, 2005

Hospital Name	Beds	City	Discharges	Patient Days
Med Ctr of LA at N.O. - Charity Hospital	424	New Orleans	19,308	109,267
Louisiana State University Health Sci Ctr	371	Shreveport	17,830	116,889
E. A. Conway Medical Center	126	Monroe	6,645	37,974
Huey P. Long Medical Center	108	Pineville	2,741	10,889
University Medical Center at Lafayette	105	Lafayette	4,424	20,297
Leonard J. Chabert Medical Center	104	Houma	3,851	24,636
Earl K. Long Medical Center	102	Baton Rouge	4,706	25,673
Bogalusa Medical Center	48	Bogalusa	2,594	13,723
Lallie Kemp Regional Medical Center	36	Independence	1,218	5,233
Dr. Walter O. Moss Regional Medical Ctr	18	Lake Charles	818	4,049
Total	**1442**		**64,135**	**368,630**

SOURCE: American Hospital Directory, 2005. MCLNO closed after Hurricane Katrina.

Figure 1 shows the service delivery trends for the Louisiana charity hospitals under LSU HCSD compared to public hospitals nationwide for the period 1998-2003. Nationally, the delivery of services through public hospitals has increased sharply as the numbers of uninsured persons continue to rise. However, in Louisiana this pattern is demonstrably different, owing to two unrelated factors. The contrast between Louisiana charity hospitals and public hospitals elsewhere has become more severe in the post-Katrina environment.

Figure 1. Public Hospital Service Delivery Trends, 1998-2003



SOURCE: National Association of Public Hospitals 2005, 1998-2003 data

Significant progress has been made since 1998 in providing Medicaid coverage for more than 300,000 uninsured children and providing them with a wide choice of hospitals, primary care physicians and other providers. While some continue to seek treatment in charity hospitals, most receive care through private providers.

Private hospitals throughout Louisiana have experienced significant increases in uninsured patients seeking care, mainly through their emergency departments. The Louisiana Hospital Association estimated the cost of uncompensated services provided to the uninsured at more than $100 million per year and growing, prior to Hurricane Katrina. This increase in uninsured patients at private hospitals is likely related to long waiting times for appointments in Louisiana charity hospital outpatient clinics.

Total revenues declined for Louisiana charity hospitals during the 1998-2003 period by 1 percent compared to an increase of 40 percent for U.S. public hospitals. Furthermore, the Louisiana system is nearly totally dependent on Medicaid and Disproportionate Share Hospital (DSH) revenues to pay its operating expenses. The story of Louisiana's seduction by DSH funds is a lesson in how the lure of "free" federal dollars can derail sound health care policy, as well as tarnish the state's image.

The Medicaid DSH payment program was established by Congress in the 1980s for hospitals that treat a "disproportionate share" of uninsured and Medicaid patients. With the program's introduction in Louisiana in 1989, the state quickly learned to exploit this revenue source by using the state-operated charity hospital system to generate surplus dollars, which were then used to match additional federal funds. In 1992, the state began to pay charity hospitals 300 percent of the cost of providing care to the uninsured, which generated surpluses totaling up to a billion dollars annually.

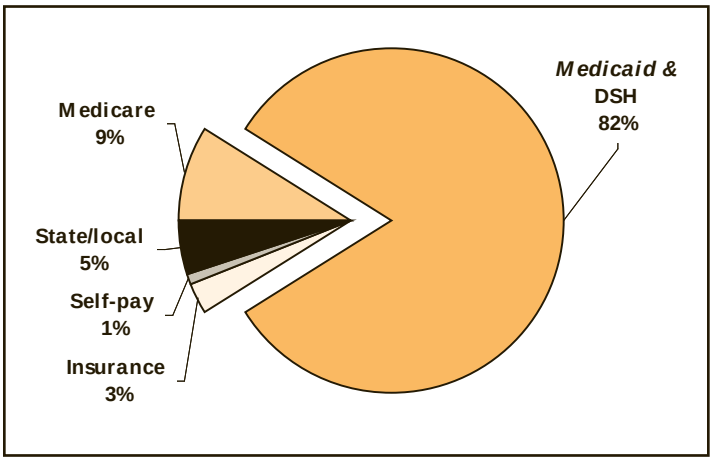
Indigent care programs that had been funded historically with state dollars, including charity hospitals and mental hospitals, were refinanced with DSH funds. The Medicaid budget grew from $900 million in 1988 to $4.6 billion by 1994. Fraud and abuse became widespread as some disreputable providers took advantage of lax oversight by the state, all duly noted in the pages of The Washington Post and other leading national newspapers. In 1993, Congress restricted DSH

Table 4. DSH Spending per Uninsured Person

	Uninsured	Percent Uninsured	DSH Allotments (federal only)	DSH per Uninsured	U.S. Rank
United States	44,365,600	17%	$10,305,260,129	$232	
Louisiana	709,130	19%	$731,960,000	$1,032	2
New York	2,397,270	14%	$1,512,959,000	$631	6
Texas	5,355,230	27%	$900,711,000	$168	23
California	6,495,870	20%	$1,032,579,800	$159	25

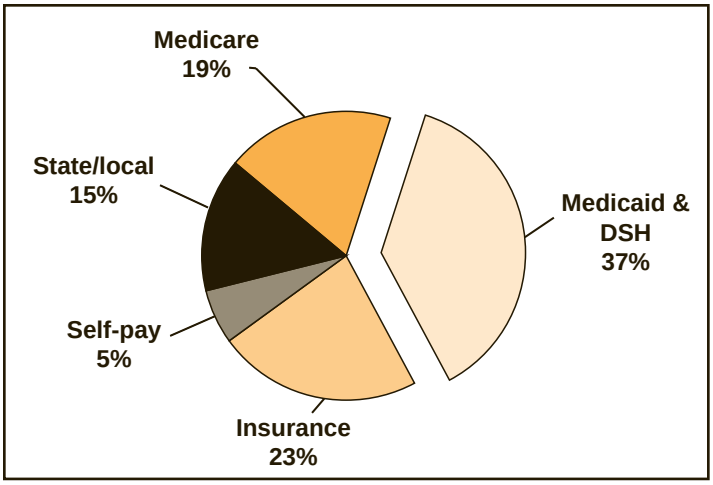
**Non-elderly uninsured and DSH allotment estimates from Kaiser State Health Facts, 2007. DSH allotments are federal only and do not include state share. Total spending for Louisiana is $1.05 billion when state match is included.*

Figure 2. LA Charity Hospital Revenue Sources, 2003



Data for eight charity hospitals under HCSD; Shreveport and Monroe excluded. National Association of Public Hospitals 2005, based on 2003 data.

Figure 3. Nationwide Public Hospital Revenue Sources, 2003



Data for 89 public hospitals nationwide. National Association of Public Hospitals, 2005, based on 2003 data.

payments to no more than 100 percent of costs. This provision became effective in 1995, thereby creating a budget crisis as Louisiana scrambled to replace the huge federal surpluses that would no longer be available. To this day, the state remains reliant on this revenue source and has the fourth largest allotment of federal DSH funds ($732 million federal or $1.05 billion when combined with state match), surpassed only by California, New York and Texas. Louisiana's DSH amount per uninsured person of $1,032 is more than four times the national average of $232, another indication of the level of dependency on this revenue source (see Table 4).

Figures 2 and 3 show the revenue sources that support operations in public hospitals nationwide compared to Louisiana charity hospitals under LSU HCSD. Medicaid and DSH account for 82 percent of revenues by 2003, compared to 37 percent for U.S. public hospitals, which have a more diversified revenue base. This dependence results from the decline in numbers of paying patients, i.e., those with Medicare and private insurance, who choose not to access the charity system for medical care.

The historical mission of charity hospitals in Louisiana has been to provide free medical care for any patient seeking treatment. This is no longer technically true. The charity system beginning in the 1980s started to bill patients on a sliding fee scale for persons with incomes above 200 percent of the federal poverty level, which is currently $41,300 for a family of four. However, the total amount collected from the uninsured is projected at $3.9 million for next fiscal year out of a total budget of $1.227 billion, or less than one-third of 1 percent.

The charity hospital at Shreveport is often touted as being the ideal model for charity hospitals in the rest of the state to emulate. However, a comparison of revenue sources shows that even Shreveport stands apart from other public hospitals around the nation in its level of dependence on subsidies. Figure 4 demonstrates this comparison.

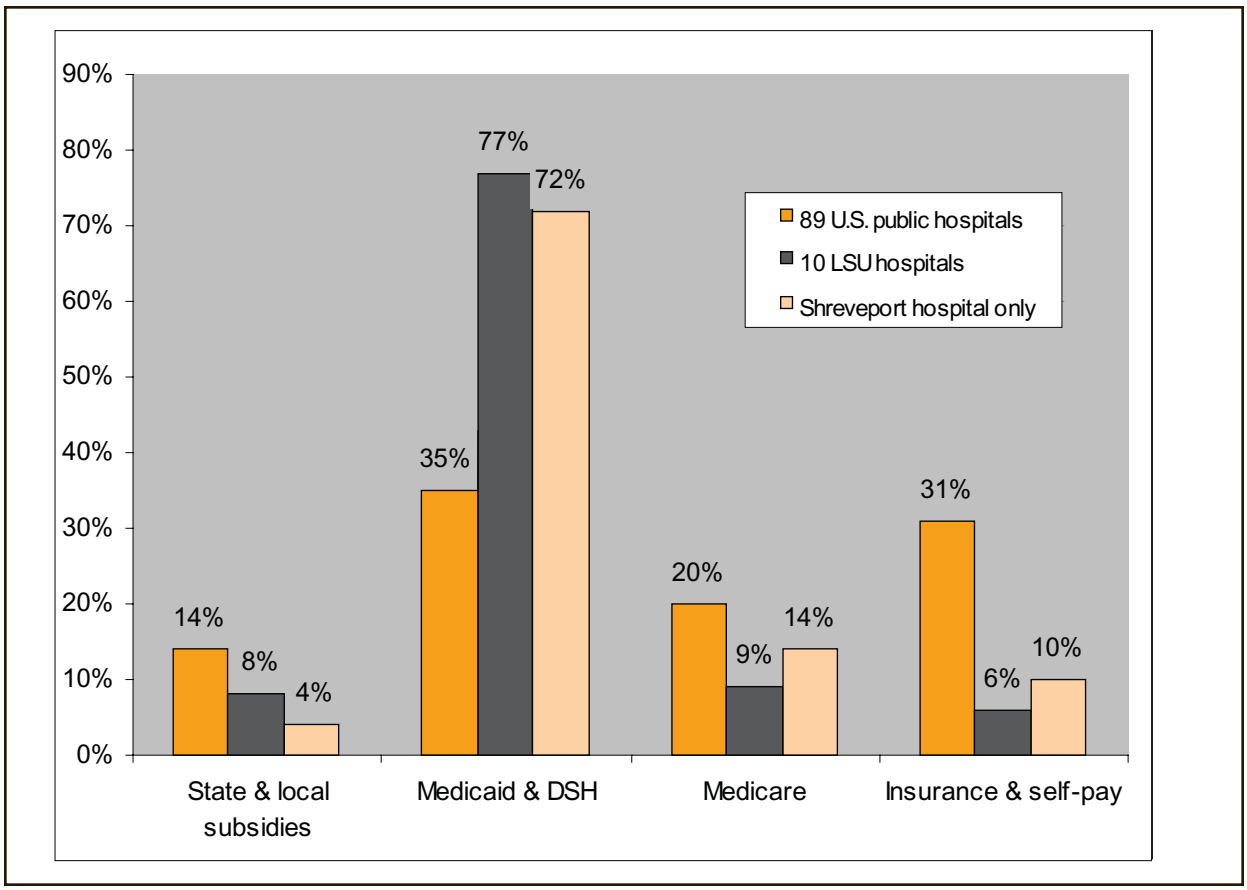
Given the continuing decline in patients, services and revenues and the increasing need for subsidies, it is apparent that the state-operated public hospital system is financially unsustainable for the long term.

Quality of Care

Over the past 10 years, health care quality has become a nationwide movement to focus attention on the need for measuring clinical practices to improve patient care, reduce medical errors and decrease costs. In Louisiana, provider associations and hospital systems have acknowledged the importance of improving quality and have begun to implement best practices for treatment of a wide variety of diseases and conditions. Health information systems have been developed to gauge quality and performance and make the results available to the public. Many health care providers have been responsive in moving to best practice standards and measures in their day-to-day operations. Furthermore, quality principles have been central to the formulation of Louisiana's health care reform plans since hurricanes Katrina and Rita in 2005.

While the charity hospitals, as well as many other hospitals throughout the state, are to be commended for striving to make improvements in quality, statistics that measure quality and the systems required to track these measures are still under development. Medicare is the only health program that collects data on a sufficiently consistent basis to allow comparisons of quality among states. The data show that Louisiana Medicare patients received the lowest quality of care in the nation at the highest cost for 2000-2001. However, these data primarily describe care given outside of the charity hospitals, which treat very few Medicare

Figure 4. Comparison of Dependence on Public Subsidies for Public Hospitals



SOURCE: Shreveport data from House Fiscal Division, April 2006: FY 05-06 budgeted amounts. Other data from National Association of Public Hospitals 2006 Survey of 89 public hospitals nationwide: (1) 14% state/ocal contribution includes substantial local support common in other states (2) 35% Medicaid and Disproportionate Share payments (UCC) are combined: (3) 31% includes 24% insurance. 7% self-pay

patients. The reasons why Louisiana makes such a poor showing are not yet fully understood. Very limited data exist to compare quality of care in the charity system to other hospitals and health care systems. Furthermore, patients become eligible for Medicare at age 65. Many who were uninsured for most of their lives prior to that time may not have had the benefit of the wide range of choices and primary and preventive care available with health coverage. When uninsured persons become Medicare eligible, they may be plagued with severe chronic conditions and diseases that were not addressed adequately or at all by the state's difficult-to-access safety net structure.

What can be noted about quality of care in the charity hospital system is that some of the tried and true advanced technology procedures, such as cardiac catheterization, angioplasty and heart bypass surgery, are still not available in most charity hospitals. Catheterization is currently offered in Shreveport and was offered in New Orleans prior to Hurricane Katrina. Meanwhile, 50 Louisiana hospitals, both public (local hospital service districts) and private, are equipped with cardiac catheterization capability and 26 hospitals can provide heart surgery. Earl K. Long hospital in Baton Rouge has requested $840,000 to install a heart catheterization lab during the upcoming fiscal year 2007-08 and an additional $2.5 million to contract with Baton Rouge General Medical Center to perform heart surgery for uninsured patients. Though advancements are in progress, the charity hospitals lag significantly behind the private hospitals in the range of services they can provide and the immediacy of care available as it relates to current standards of medical and surgical cardiac care.

A recent study published in the New England Journal of Medicine finds that patients experiencing heart attacks on weekends have significantly worse mortality rates than patients who have heart attacks during the week. The reason cited is that a hospital's capability to perform cardiac catheterization and administer balloon angioplasty is likely to be shut down on weekends. The authors of the study believe that a new standard of care should be set for hospitals to maintain that capability 24 hours per day, seven days per week. Yet an uninsured patient in Louisiana will not have access in charity hospitals to either catheterization

or angioplasty at any time. A lengthy trip to the LSU Medical Center in Shreveport, the only facility currently offering such services, is usually out of the question: Patient survivability deteriorates significantly if these procedures are delayed even a short time.

The pervasive lack of ready access to the basic menu of primary care and specialty medical services offered by the charity hospitals is the most glaring problem with Louisiana's current system of care for the uninsured. Louisiana ranks worst in the nation for accessibility to primary and preventive care services with 36 percent of the population lacking access *("2007 Health Care State Rankings," Morgan Quitno Press)*. Patients who have private insurance, Medicare and Medicaid generally have ready access compared to the uninsured. Uninsured patients in Louisiana have average waiting times for appointments to outpatient clinics at charity hospitals that are significantly longer than in the private sector. For example, the average wait for an OB/GYN appointment at charity hospitals takes 67 days compared to 23 days for an appointment with a private doctor. An orthopedic surgery appointment takes 202 days compared to 17 days in the private sector. In contrast, cardiology appointments for medication treatment are relatively quick -- 26 days compared to 19 in the private sector. As mentioned above, however, the full array of diagnostic and treatment options were previously available only at New Orleans and now are lacking altogether, with the exception of Shreveport in the northwest corner of the state. *(Waiting times from "Louisiana Healthcare Delivery and Financing System," PricewaterhouseCoopers, April 2006)*

Although the emphasis on quality is a welcome development in the health care sector, the fact that one in five persons in Louisiana is uninsured and is likely to have difficulty accessing medical care cannot be overlooked. Measuring true quality is still in its infancy. Remedies for poor quality should be implemented throughout the delivery system, in both public and private facilities. However, quality improvements may have little meaning for those uninsured who are unable to get timely access to medical care. Care delayed is often care denied.

IV. A REMEDY FOR THE TWO-TIERED SYSTEM

Providing insurance coverage for the uninsured will allow them much better access to primary, specialty and hospital care. Louisiana has very poor access to primary care compared to other states, a major contributing factor for the state's low health performance. Those most in need of coverage are adults with incomes below 200 percent of the federal poverty level ($34,340 income for a family of three). Alternative coverage plans have been proposed by the Louisiana Health Care Redesign Collaborative and also by the secretary of the U.S. Department of Health and Human Services. So far, no agreement has been reached on financing and other issues.

In the absence of universal coverage, a safety net still will be needed for those remaining uninsured. A replacement safety net for the current state-operated, hospital-based, often- inaccessible charity network can be established with private sector resources in most regions of the state. Plans already have been developed in Lake Charles and Alexandria and interest has been expressed in other areas for alternatives to charity hospital care. Regional plans emphasize primary and preventive care, as well as specialty and hospital care, by local providers. However, a limited number of state-operated hospitals should be maintained as academic medical centers that can be developed into true centers of excellence for medical education, research and patient care.

Secretary Michael O. Leavitt of the U.S. Department of Health and Human Services (DHHS) took note of Louisiana's two-tiered delivery system soon after the hurricanes of 2005 and made an unusual offer to assist the state in improving and reforming its health care system. As a result of his interest, in January 2006 the Louisiana Recovery Authority embarked on a planning process intended to replace the split delivery system with a single integrated model that would provide higher levels of coverage and access, improved efficiency and better quality. The process was made official when the 2006 Legislature created an independent Health Care Redesign Collaborative with a membership of 40 representing diverse health care and business interests and a mandate to develop a redesign plan for Louisiana, starting with the Orleans region.

The collaborative completed the initial phase of a Region 1 (Orleans, Jefferson, St. Bernard and Plaquemines parishes) system redesign proposal on Oct. 19, 2006, and submitted the plan to secretary Leavitt on October 20. The plan envisions a number of fundamental changes in the health care system, with emphasis on improving care for the uninsured population. The plan focuses on six key concepts that define a strategy to expand coverage, improve access to primary care and medical homes and improve quality. The most far-reaching features include:

- Coverage for uninsured parents and childless adults up to 200 percent of the federal poverty level
- "Medical homes" that would link the uninsured to primary care providers who would offer diagnosis and treatment services, referrals to specialty and hospital care, disease prevention, health promotion and behavioral health care.
- A "health insurance connector" to provide those who need health insurance with convenient access to affordable coverage options, as well as potential premium subsidies for low-income persons. The "connector" would serve as a central clearinghouse where personal, portable insurance coverage could be purchased by individuals and by workers in small businesses.

Table 5. Impact of CMS Coverage Model on Safety Net Funding

	Year 1	Year 2	Year 3	Year 4	Year 5
Estimated uninsured	651,524	651,524	651,524	651,524	651,524
CMS model - persons insured	**62,116**	**124,233**	**186,349**	**248,466**	**319,385**
Remaining uninsured	589,408	527,291	465,175	403,058	332,139
Patients treated - 60% annually	353,645	316,375	279,105	241,835	199,283
DSH funds diverted for coverage ($ 000)					
DSH allotment cap	$1,050.3	$1,050.3	$1,050.3	$1,050.3	$1,050.3
CMS est. coverage cost	$34.3	$119.3	$210.3	$306.3	$770.3
Residual funds for safety net	**$1,016.0**	**$931.0**	**$840.0**	**$744.0**	**$280.0**

(1) Uninsured estimate from the 2006 Louisiana Health Insurance Survey by the Public Policy Research Lab at Louisiana State University.
(2) One of the elements of the proposed waiver, if granted by DHHS, is to allow the state flexibility to use DSH funds normally reserved for hospital-based care to be used for insurance coverage, in this case for 319,000 adults with incomes below 200 percent of the federal poverty level, including either parents of Medicaid children or childless adults.

- A health care quality forum to oversee and measure improved quality of care and reduce medical errors.
- Health information technology initiatives to increase efficiency and improve patient safety. This would include a statewide electronic medical records system.
- A Medicare demonstration project to improve quality and reduce cost for end-of-life care.

The reform model developed by the collaborative is a promising demonstration of the consensus that can be built around health care reform options for the state. However, the collaborative's work was only a preliminary step toward operational plans that can be implemented provided adequate funding is available.

Table 5 summarizes one scenario of an analytical model presented February 2007 by the Centers for Medicare and Medicaid Services in response to the redesign plan submitted to the secretary of DHHS by the Louisiana Health Care Redesign Collaborative on October 20, 2006. A lower estimate of the number of uninsured has been substituted for the CMS estimate of 806,000.

The Louisiana collaborative limited its focus to Region 1 (Orleans, Jefferson, St. Bernard and Plaquemines parishes) instead of producing a statewide proposal. Negotiations have been proceeding since October between DHH and CMS. No public meetings of the collaborative have been held to provide progress reports on the negotiations or to seek input from the members. DHH has released a rebuttal to the CMS analysis but has not made public a statewide analysis or proposal of its own.

After a five-year phase-in period, the $770 million annual cost of coverage will leave a residual of $280 million to provide care for some 200,000 of the 332,000 remaining uninsured at the end of the phase-in. The $280 million suggested by the model will be insufficient to fund a charity hospital safety net. A safety net of community providers made up of clinics, doctors and local hospitals would be less costly because primary and preventive care could be offered in non-hospital settings. However, the $280 million residual is dedicated to other purposes.

In addition to care for the uninsured, DSH funds now pay for the following expenses: mental hospitals,$98 million; rural hospitals, $84 million; and GME, $100 million plus. These amounts total at least $284 million and leave nothing of the $280 million the federal model would provide for a "safety net." No detailed estimate of the amount of DSH funding that pays for GME has been made so far. The Board of Regents is conducting a study that will take eight to 10 months. Recommendation 3 of this report proposes a substantial infusion of new Medicare or Medicaid (30 percent match) GME dollars wherever possible in order to free up DSH funds for patient care purposes. Even so, a substantial problem remains, because DSH payments are treated like grants to hospitals. Switching to a system to review and pay claims similar to Medicaid (Recommendation 6) will assure that dollars are spent for the intended purpose.

If $280 million were actually free for the sole purpose of indigent care, it would approximate the value of services needed to provide for an estimated 200,000 indigent persons expected to seek treatment annually. But the state has tied up $280 million in subsidies listed above with major interest groups vested in each. Refinancing GME with Medicaid dollars would require approximately $30 million in state matching funds. The subsidy for rural hospitals should not be disbanded but reorganized so that more primary and preventive care for the uninsured can be provided through rural hospital clinics. Refinancing state mental health institutions

would require the use of 100 percent state funds, unless other coverage options are available. There are solutions but no easy ones.

In the meantime DHH should continue to negotiate aggressively with DHHS, which originally had promised the state some transition funding over a five-year period. Any spending that reduces the two-tiered system in favor of coverage and better access for the remaining uninsured should be embraced by the federal government. Therefore, the Blanco administration and DHH also should change the agenda from charity hospital preservation to constructing an enhanced safety net that maximizes patient choice by allowing DSH payments to community providers. Significant growth in community health clinics (FQHCs), rural health clinics and school-based health centers will assist in transferring the inpatient and outpatient caseload away from charity hospitals.

Regional and Statewide Proposals

A number of other reform proposals have been made in recent years, both before and after the hurricanes of 2005. Most studies have a regional focus of how to integrate indigent care into a community or regional health care network, though some are aimed at statewide reform. A 2005 study by the Franciscan Missionaries of Our Lady (FMOL) focused on the health care safety net for the uninsured, as well as on graduate medical education (GME) to facilitate a discussion process and provide a framework for change, including alternatives to the public hospital system. The Louisiana Recovery Authority Foundation funded a 2006 PricewaterhouseCoopers analysis of the Louisiana health care system that proposed sweeping statewide changes to transition away from the two-tiered delivery system.

In 2002-2003, the Department of Health and Hospitals and the LSU Board of Supervisors Task Force on Indigent Care and Medical Education launched an outreach program in communities across the state to determine local preferences for system change. Several communities had developed (or were developing) plans that addressed reform issues, including the disposition of charity hospitals. Lake Charles, Alexandria, Lafayette, Baton Rouge and New Orleans all displayed significant interest in assuming control of indigent care on a community-wide or regional basis. Specific studies and/or plans were developed or revised for three of the five regions as described below.

Such plans could become the basis for pragmatic system improvement by transferring health care oversight and control from state government to local communities. Those communities that lack plans might contract with third parties for plan development or with private sector providers for managing operations of existing or new facilities. A process can also be designed to facilitate transition activities at the state level by appointing a third party such as DHH, which exercises considerable authority over health care financing but is otherwise independent of the charity hospitals, to act as an intermediary between state and local interests. DHH would be directed to assist communities in each region to design a detailed and comprehensive plan for the transfer of indigent care within a period of three to five years. LSU HCSD would work closely with both DHH and local interests to assure an orderly and successful conversion.

The Legislature could assist by removing barriers and providing incentives for local authorities to bring an agreed upon plan to fruition. Incentives could include various reasonable financial inducements to assure that the transition would be successful. These might include tax credits or the use of time-limited subsidies to encourage the investment of local or private funds to build infrastructure, such as additional outpatient facilities, community health clinics and school-based health centers. DHH would provide continuous assistance for an extended period of time in order to assure that medical care for the uninsured improves in both quality and access. DHH would provide progress reports to the Legislature on a frequent basis along with recommendations to provide state assistance if needed and desired by local authorities.

A reasonable period of time for an orderly transition would be three to five years, including up to 24 months to develop a regional strategic plan. An initiative such as this should be budget neutral for the state over the long-term. As a policy matter, the state would be expected to set minimum standards for indigent care, including standards for payment, but would have no role in day-to-day operations. Each of the following examples lends itself to a close partnership between state government and local government or providers to ensure success. The plans described here have more similarities than differences and each could be replicated in other parts of the state with regional cooperation and planning. All of these proposals are the product of local dissatisfaction with the current system and local resolve to find solutions. Nevertheless, the success of any plan will depend heavily on the willingness and support of the Legislature and state health agencies.

For the most part, these proposals focus on ways to improve the safety net, rather than on expanding coverage. However, unlike the current system, each of these plans when implemented would provide a friendly climate for any coverage expansion that might occur. Local community health networks have a broad mix of patients and payers, so the conversion of patients from indigent to insured would be a welcome development.

Charity hospitals, on the other hand, are caught in a downward financial spiral: unable to attract paying

patients and becoming more and more dependent on large but limited subsidies for their indigent patient population. The stark reality for the charity system is that it relies on a steady stream of uninsured patients in order to survive. Most public hospitals have a broader mix of patients and payment sources, allowing some cost shifting to absorb the expense of indigent care. Expanding coverage and integrating the remaining uninsured into the statewide delivery system for the insured would allow improved access to primary care services as well as specialty procedures and modern equipment, which do not exist in most charity hospitals.

Lake Charles Region: Two studies were published in 2004: "An Assessment of Health Care Safety Net Needs and Services in the W. O. Moss Catchment Area" by The Lewin Group and "Healthcare Reform in Southwest Louisiana" by Kurth and Burckel. The latter report made recommendations for reform of the regional health system, including the transfer of W.O. Moss to a regional public health board that would operate the facility in a new role as facilitator of primary care services and specialty referrals. The hospital no longer would be a "bricks and mortar" acute care facility but would be converted to a "cyber" hospital operating a network of primary care clinics and contracting with private hospitals and specialists.

The main features of the system would include wellness programs throughout the five-parish region; primary care clinics in rural and underserved areas; diagnostic clinics adjacent to hospital emergency rooms to take care of routine problems or to arrange for appropriate clinic or hospital care; and an administrative center with staff to provide case management for chronic conditions, telemedicine services to clinics, an interactive Web site and a health care hotline. Another innovative feature would be an integrated patient information system based on user cards. This element of the plan would allow for better tracking of costs for the uninsured and improved performance monitoring. Like an insurance or Medicaid card, it also would provide a level of assurance to former users of the charity system that there was a new system in place that will provide for their medical care. If coverage options are provided in the future, the card would help to identify and track patients to facilitate the conversion to an insurance model or Medicaid.

With respect to financing the new system, reasonable user fees and co-pays would be implemented in accordance with "a shift in thinking from providing 'free' medical care through the charity hospital system to making health care accessible to all Louisiana residents." A regional board of health is planned with authority to levy taxes, provided there is broad public support to do so. The planners believe that system reform and public confidence would enable passage of a reasonable level of local taxes to improve services.

Alexandria Region: A joint study, "Proposal for Safety-Net Delivery System for Central Louisiana," was published in April 2005 by CHRISTUS Health System and Rapides Regional Medical Center. The study recommends an alternative to state plans to replace the Huey P. Long (HPL) charity hospital whereby non-state hospitals in the region would assume responsibility for inpatient and emergency room services historically provided by HPL. A not-for-profit entity would be established to provide and coordinate clinic and urgent care services to be supported by non-state hospitals in the region.

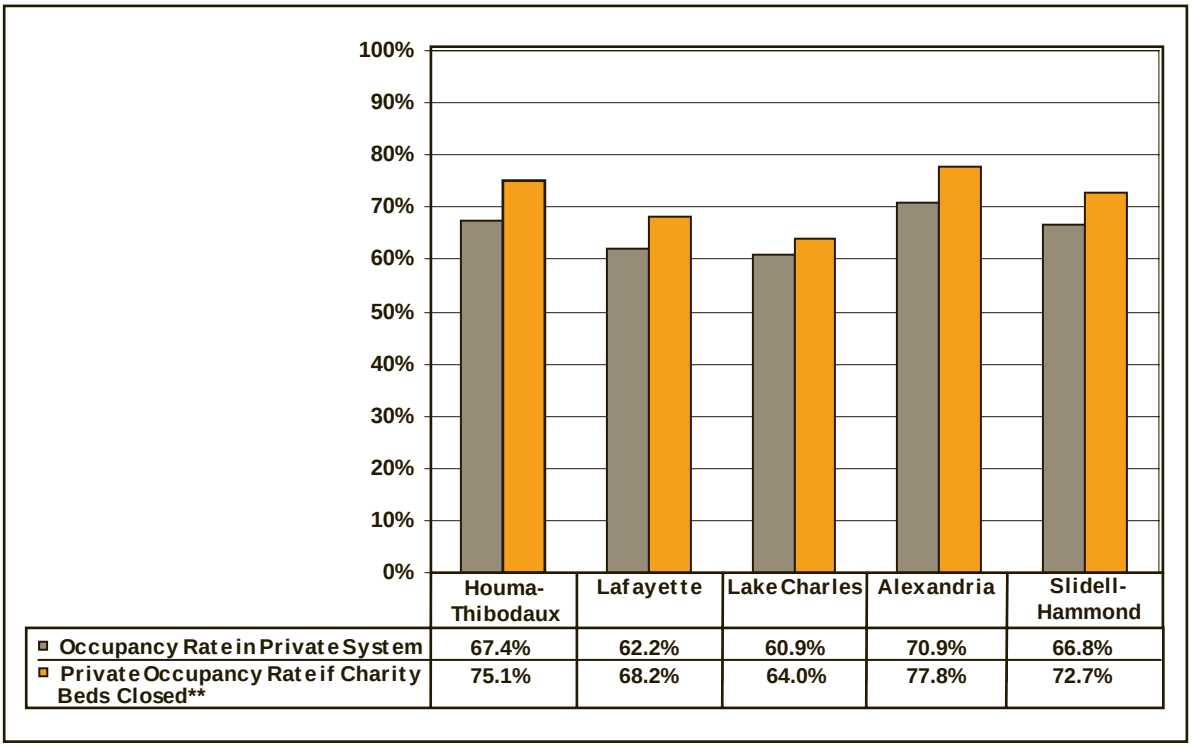
This plan anticipates the following benefits: (1) offer a single standard of care regardless of insurance status or ability to pay (2) lower the cost of care compared to the cost at the proposed replacement charity hospital and (3) improve access to care with a broader array of resources available to the community. It also proposes to improve the financial stability of the safety net in the region, as well as addressing the issue of low capital investment that has been a historical problem for charity hospitals. Because DSH dollars cannot be used to pay faculty and contract physician services, malpractice insurance premiums and outpatient prescription drugs, the hospitals have allocated depreciation funds to pay for these "non-allowable" expenses.

The plan proposes establishment of a flexible DSH pool to fund inpatient care and to obtain federal approval to use part of the funds for outpatient clinic and physician services, replacing the charity hospital DSH arrangement currently in use. The pool would be dedicated solely to the nine parishes in the Alexandria region. The plan also calls for a regional millage to contribute local funding to enhance programs for indigent care.

Another study released in May 2004 by The Lewin Group, "Assessment of Health Care Safety Net Needs and Services in Central Louisiana," proposes a set of alternatives to the rebuilding of the Huey P. Long hospital, including establishing a pool of Disproportionate Share Hospital (DSH) funds to pay for indigent care in private hospitals in the area. A number of other recommendations propose different means to provide care for the uninsured without building a new charity hospital.

Baton Rouge Region: In June 2004, The Lewin Group issued a report, "Development of a Cooperative Health Care Delivery Strategy in Baton Rouge, Louisiana," which outlined a number of options to rebuilding Earl K. Long Medical Center. The report found that merger alternatives, i.e., merging Earl K. Long with a non-state hospital under a non-profit community board, would have the most favorable financial outcomes. The report also describes how alternative arrangements for indigent care were successfully made in six major cities (Washington, D.C., Milwaukee, Detroit, St. Louis, San

Figure 5. Occupancy Rate in Private Hospitals With and Without Charity Beds



	Houma-Thibodaux	Lafayette	Lake Charles	Alexandria	Slidell-Hammond
Occupancy Rate in Private System	67.4%	62.2%	60.9%	70.9%	66.8%
Private Occupancy Rate if Charity Beds Closed**	75.1%	68.2%	64.0%	77.8%	72.7%

***In regions where charity hospital remains open under local governance, total adjusted occupancy rate would be lower.*

Francisco and Austin, Texas) after closure of the public hospital or negotiating partnerships between the public hospital and private community hospitals.

PricewaterhouseCoopers, "Report on Healthcare Delivery and Financing System," April 2006: This 246-page report is the most comprehensive study of Louisiana health care yet produced and covers nearly all aspects of the delivery system. It advocates that the state change its divided delivery system to a single integrated system of care and provides guidance about improving coverage, access and quality, as well as reducing certain excess costs. It proposes closing most charity hospitals but provides no details as to how that would be accomplished. The hospital at Shreveport would be maintained and the Baton Rouge and New Orleans facilities would be rebuilt, but as smaller and more specialized academic health centers and trauma centers.

Figure 5 compares numbers of available and occupied beds in private and charity hospitals in the five regions outside of the four regions where LSU academic medical centers would be located, Baton Rouge, New Orleans, Shreveport and Monroe. It shows that the vast majority of occupied and available hospital beds in those regions are in private facilities. These data also show that the private sector currently has the capacity to absorb the additional demand that would be created if the charity hospital in each region were closed. Figure 5 shows that if public hospital occupied bed counts were absorbed by the private hospitals, their occupancy rates would all remain below 80 percent, which is recognized as the upper limit average for community-wide hospital occupancy rates.

The situation with respect to outpatient clinic and emergency department services is not as simple to plan for. Private capacity for accepting large volumes of additional outpatient services is difficult to gauge and may vary significantly from one region to the next. In some cases, regional plans have addressed the issue and have proposed a private sector solution. When calculating need for additional resources, several factors need to be considered. According to Kaiser State Health Facts, Louisiana ranked fourth in the nation in ER visits in 2004 (548 per 1,000 population compared to a national average of 383 per 1,000). The state also ranked 16th in outpatient visits (2,303 per 1,000 compared to a national average of 1,946 per 1,000).

Any plan to shift outpatient services from the charity hospital system would need to include strategies to reduce the excessively high utilization rate of hospital emergency rooms in Louisiana. The highest rates within the state are occurring at government-operated hospitals. In PAR's 2005 report "Action Steps for Access to Care," several proposals were outlined that would reduce ER visits from the current level of 2.4 million to 1.9 million, a move that could save more than $100 million per year by shifting primary care out of the ER to free up needed capacity for real emergencies. Louisiana still would rank high at 10th in the nation, down from fourth currently.

Table 6. Total Acute Care Bed Capacity by Region, With and Without Charity Hospitals

	Region 3 Houma-Thibodaux	Region 4 Lafayette	Region 5 Lake Charles	Region 6 Alexandria	Region 9 Slidell-Hammond	
Charity hospitals in region	**L.J. Chabert**	**University Medical Ctr.**	**W.O. Moss**	**Huey P. Long**	**Lallie Kemp, Bogalusa Medical Ctr.**	**TOTAL**
Private Licensed Beds	1,493	2,195	1,324	909	1,271	**8,683**
Available/staffed Beds in Private System	1,149	2,002	962	842	1,206	**7,380**
Occupied Beds in Private System	775	1,246	586	597	806	**4,790**
Occupancy Rate in Private System	67.4%	62.2%	60.9%	70.9%	66.8%	**64.9%**
Unused Capacity <80%* (Private System)	152	397	184	102	175	**1,232**
Occupied Beds in Charity System	88	120	30	58	71	**493**
Private Plus Charity Occupied Beds	863	1,366	616	655	877	**5,283**
Private Occupancy Rate if Charity Beds Closed**	75.1%	68.2%	64.0%	77.8%	72.7%	**71.6%**

**Does not include psychiatric, rehab or long-term acute beds. Calculation assumes optimum occupancy rate of 80%.*
***In regions where charity hospital remains open under local governance, total adjusted occupancy rate would be lower.*
SOURCE: DHH Statewide Survey of Hospitals, 2006.

There are also plans to increase outpatient capacity in Federally Qualified Health Centers (FQHCs), an area where Louisiana has lagged far behind other states in numbers of sites. The Louisiana Primary Care Association recently released its plan to expand existing and new sites over the next one to five years, with most expansions occurring during 2007 and 2008. LPCA estimates that this initiative will provide outpatient care for 125,000 uninsured persons statewide. Any expansion of FQHC capacity will need to include strategies that assure a primary care workforce to staff the clinics. Linkages with medical schools and GME programs have been shown to be effective at increasing the entry of graduating residents into FQHC practices.

Rebuilding the New Orleans Charity Hospital

Damage from Hurricane Katrina caused the closure of the Medical Center of Louisiana at New Orleans (MCLNO), also known as Big Charity, which HCSD already claimed was in need of replacement prior to Hurricane Katrina. Now with federal disaster aid available to fund partially a replacement facility, plans are being drawn by LSU to determine its appropriate size and function. An opportunity exists to construct a smaller teaching hospital and trauma center with a mission to serve a more diverse patient mix. This would enable the medical schools (both LSU and Tulane) to develop community-based affiliations, improve the hospital's funding structure, expand its research opportunities and improve access to primary care through a clinic focus. Careful design could yield an academic teaching hospital and trauma center that complements the existing medical facilities in the region with specialized care unavailable elsewhere while providing a sufficient supply of primary care physicians to enable the development of a decentralized system of care for the uninsured.

A contractor was hired by the state to design a business plan for a new hospital to replace charity hospital at New Orleans. A preliminary version of the plan was presented to the Louisiana Recovery Authority in December and recommended a $900 million, 427-bed facility -- much larger and more expensive than the $630 million, 350-bed facility LSU initially estimated it would need. While the preliminary plan was generally dismissed as being too costly and ambitious to deserve serious consideration, the final plan released in April called for a $1.2 billion, 484-bed hospital. The reasoning behind the upward adjustment is that more beds are needed to generate enough revenues to make the project financially feasible. But, feasibility is totally dependent on the future demographics of the city, and it is far from certain what the population of New Orleans will be in five, 10 or 15 years. The composition of that population in terms of age, income and health insurance status is also the subject of much speculation but scant certainty. Yet, these details are essential to inform the most appropriate size of the new facility. The debate continues regarding the appropriate size for a third academic medical center (together with Tulane and Ochsner hospitals) in a city with half its pre-storm population.

According to a recent report from the federal Government Accountability Office, total bed capacity in New Orleans still exceeds the ratio of beds per 100,000 population in cities of similar size, as well as the national average. Yet, hospitals in the region are overcrowded because the lengths of stay post-Katrina are longer. With fewer step-down facilities to which to refer patients (i.e., nursing homes, psychiatric units, rehabilitation facilities, etc.) the overbedded region suffers from overcrowding. As other types of care facilities are replaced to normalize the lengths of stay for patients in the region, the overcrowding will ease. Construction of more excess beds will put the LSU hospital in direct competition with the private sector hospitals in the region, thereby exacerbating an already tenuous situation for all players.

Planning for overall recovery and reform has been handled by the Health Care Redesign Collaborative, but its focus was limited solely to New Orleans, rather than the entire state. Furthermore, planning for the future of the charity hospital system was never addressed by the collaborative, either at the statewide level or for the New Orleans region. Although some members expressed interest in addressing the issue, it was never included on the agenda for the full collaborative. Replacing MCLNO is being handled by a separate and insulated planning process under the auspices of LSU Health Care Services Division without regard to the collaborative's mission. Like the collaborative process, the LSU HCSD planning effort lacks a statewide focus.

The wisdom of constructing a hospital the same size or greater than the pre-Katrina facility without any clarity of the new demographics of the New Orleans area, which has about half the population it had in August 2005, is in question. Furthermore, there has been little discussion of the challenge of staffing large new facilities in a city with a reduced population and severe shortages of medical personnel. Moreover, the process for planning does not seem up to the task of developing a blueprint to transform the double standard of health care delivery into a patient-centered, integrated structure that is highly accessible and produces high quality results, To implement a true dollars-follow-the-patient model, however, will require statewide reforms that adjust funding strategies for both public and private hospitals and other providers.

V. IMPROVING GRADUATE MEDICAL EDUCATION

In addition to providing care for the uninsured population, charity hospitals serve the LSU and Tulane medical schools as the venue for most of the graduate medical education (GME) taking place in Louisiana. The largest facility providing GME was shut down when the Medical Center of Louisiana at New Orleans (MCLNO) was damaged by Hurricane Katrina and closed. Problem areas related to GME include the following:

- *Most teaching hospitals utilize Medicare funds to finance GME programs. According to one estimate, charity hospitals forego substantial amounts of Medicare GME funds (up to $160 million) because of the small number of Medicare patients treated.*
- *Louisiana lags behind the nation in the proportion of primary care physicians (PCPs) and graduation rates and residencies reflect a downward trend in future numbers of PCPs. High performing states and health systems tend to have good access to primary care.*
- *Pre-Katrina data show a ratio of 1.3 residents per bed at MCLNO, making the hospital one of only three in the United States with a ratio of 1.0 or better.*
- *Many medical schools in other states rely on local community hospitals as training sites to allow residents exposure to high quality specialized treatment procedures and a broad mix of patients and conditions. Affiliation agreements with private hospitals have broadened in the New Orleans region since 2005, but are still limited compared to other states.*

Charity hospitals in Louisiana have a dual mission: providing training sites for physician residents and providing medical care for the uninsured population. Physician training occurs at six of the eight HCSD hospitals, as well as the Shreveport and Monroe facilities. HCSD officials have indicated they also plan to resume physician training at Lallie Kemp in Independence and W.O. Moss in Lake Charles. Thus, physician training would be spread over the entire 10-hospital system, though the bulk of the workload would be shouldered by New Orleans and Shreveport.

Most graduate medical education still takes place in New Orleans. Historically most of the resident training has taken place at the Medical Center of Louisiana at New Orleans (MCLNO or "Big Charity"), which has been shared as a training site by the LSU and Tulane medical schools. According to the 2005 report of the Medical Education Commission, the LSU Medical School had 660 residents and fellows pre-Katrina and Tulane University Health Sciences Center, along with Tulane University Hospital and Clinic, had 497 residents and fellows. Ochsner Foundation Hospital continues to be a significant presence in the city, training 205 residents in various specialties in 2005. Earl K. Long Hospital in Baton Rouge had 74 residents in 2005 and University Medical Center in Lafayette had 47. Community hospitals sponsoring family residency programs include East Jefferson Hospital with 17 residents in 2005 and Baton Rouge General Hospital with 22.

Comparing graduate medical education in Louisiana to the nation reveals some striking differences. MCLNO is one of only 17 hospitals in the United States with

500 or more residents. On average, teaching hospitals nationwide have 73 residents. There are more than 1,000 teaching hospitals nationwide, but only three have ratios that exceed one resident per bed. MCLNO had a ratio of 1.3 residents per bed in 2003, not optimal from the standpoint of high quality physician training activities.

LSU has made the medical education mission a top funding priority since taking over the hospital system in 1997. While it would seem that physician training and patient care would go hand in hand, having to prioritize the allocation of dollars sometimes produces uneven results. The bulk of funding for the uninsured goes to the hospitals that treat the smallest share of the uninsured but are responsible for medical training. The Medical Center of Louisiana at New Orleans and the LSU Medical Center at Shreveport, both headquarters for LSU medical schools, treat a total of 35 percent of uninsured caseload but receive nearly 70 percent of disproportionate share funding. Seven other system hospitals receive the remaining 30 percent of funds to support their aggregate uninsured caseload of 65 percent of the system-wide total. These hospitals, however, do receive funding from other sources, including Medicaid and very limited amounts of Medicare and private insurance. Some state subsidies in the form of 100 percent state general fund dollars also are appropriated.

A more logical financing structure would allow funding for the uninsured to follow those patients to whichever hospitals they use. Accordingly, a more diverse set of revenue sources would be used to fund the medical training programs.

Transforming the dual health care system is key to improving the funding structure of the medical training programs. To decentralize and improve access to care for the uninsured, the medical education establishment will have to develop new strategies for training the medical workforce. Louisiana faces a shortage of primary care physicians, which serves as a formidable barrier to implementing any of the proposed health care reforms. A range of options exists for reforming the funding structure and training environment for medical students in the rebuilt medical school in New Orleans.

Primary Care Physician Shortage

For several years, there has been an ongoing debate in academic medicine circles about whether a shortage of physicians in the United States will occur within the next 15 years. Those who project a shortage focus on the demand for more physicians resulting from continuing growth in the U.S. population combined with rapid increases in the numbers of elderly citizens who presumably will have greater wealth to spend on more health services. On the supply side, up to one-third of physicians are now over age 55 and will retire by 2020. Furthermore, the projections assume that younger physicians will not be willing to work the long hours that their predecessors were accustomed to working. The physician workforce has benefited in recent years from greater gender diversity, with the proportion of women physicians increasing to 27 percent nationally and 24 percent in Louisiana. It is not yet clear how this will impact the workforce over time and whether it will be a factor in expanding or contracting the overall shortage of physicians.

A growing body of research indicates that the actual problem is a shortage of primary care physicians (PCPs) and a surplus of specialists. The American College of Physicians points to numerous studies that show countries and states with the healthiest populations have high ratios of PCPs to patients. Attempts to expand the graduation rates of primary care physicians have not met expectations and many regions are experiencing shortages. Many rural and other underserved areas have profound problems recruiting and retaining PCPs. There are some discouraging signs that this situation may be worsening. Of graduates finishing medical schools in Louisiana this May, only 26 or about 8 percent will enter Family Medicine residencies. Of the 26, only 10 are remaining in Louisiana for their residency, while 16 are leaving the state.

Louisiana lags behind the nation in terms of primary care physicians per population. The state ranks seventh worst in access to primary care services. Although Louisiana medical schools have made marginal increases in graduation rates for the primary care specialties, shortages persist in some geographic areas. Most physicians reside and practice in metropolitan areas, while underserved areas often lack the presence of a doctor on a permanent basis. Some rural communities with hospitals and clinics are dependent on visiting physicians for part-time help several days a week.

Primary care graduation rates for Louisiana improved slightly until 2000, then began to decline. Graduation of adequate numbers of PCPs is needed to assure sufficient capacity to staff the proposed “medical home” delivery model proposed by the redesign collaborative. But according to a draft report from the graduate medical education work group, as few as 65 to 70 PCPs may graduate each year from Louisiana residency programs. With retention rates of around 50 percent, according to the report, the state will realize only 40 entering practice in Louisiana.

After the hurricanes of 2005, the shortage of primary care doctors worsened dramatically in many areas, especially the New Orleans region. A DHH profile of the Orleans region indicated that ratios of persons per primary care physician changed from 758 per PCP before Hurricane Katrina to 1,291 per PCP within eight months after the storm The medical education establishment in New Orleans was also hit hard by the storm. According

to the HealthLeaders Report for December 2005, Katrina dislocated 6,000 physicians and 1,300 medical residents from LSU and Tulane University.

Louisiana will need to take extraordinary measures to produce and retain a steady supply of doctors, especially primary care physicians. Such measures could include legislation to mandate the number of primary care physician graduates per class, a remedy successfully used in several states. Just as health care delivery systems would benefit from a decentralized, community-based model, medical education would gain from a new paradigm that encourages closer partnerships with community hospitals. Rather than competing with those hospitals for market share, cooperation and shared responsibility for educating doctors and caring for the uninsured can provide mutual benefits for the community, the region and the state, not to mention the patient.

Medical Education Funding

Because so few Medicare patients seek care in charity hospitals, all of the three medical schools whose residents train in these hospitals forfeit a portion of federal funding for Medicare graduate medical education that is widely accessed at other schools around the nation. Some estimates show that an additional $160 million in Medicare payments annually is left untapped because of the limited patient mix at charity hospitals. Federal reporting for 2003 indicates that $65 million in Medicare GME funds was paid to Louisiana hospitals in that year. The amount per resident paid to individual hospitals ranged from $16,000 per year at MCLNO to more than $100,000 per year at several community hospitals. The wide variation in payment levels stems from differences in Medicare patient utilization rates and deviations in costs incurred by various hospitals.

Affiliation agreements with other hospitals that have high levels of Medicare patients and a commitment to resident training would provide significant additional dollars for training LSU and Tulane residents. Distributing residency training in this manner also would alleviate the very high ratio of residents to beds at Medical Center of Louisiana at New Orleans ("Big Charity"), which had 1.2 residents per bed in 2003. Only three hospitals in the country have ratios of residents to beds above 1.0, which is undesirable from an educational perspective.

Funding for Medicare residency slots was capped by Congress in 1997 to help reduce a projected oversupply of physicians. Although that surplus now seems unlikely to materialize, the caps remain in place. Residency slots are "owned" by teaching hospitals, like MCLNO, rather than medical schools. MCLNO therefore "owns" 534 slots and has the ability to assign them to affiliate community hospitals—or not—as it sees fit. Alternative methods of funding and assigning slots could increase accountability and provide incentives for achieving specific goals for medical education.

GME funding is only one dimension of the complex graduate medical education structure. All residency programs must be accountable to an accreditation agency (the Accreditation Council on graduate medical education and its 26 residency review committees) that imposes strict standards. Decentralizing residency programs to other locations, such as community hospitals and primary care sites, introduces complications in terms of faculty supervision, coordination and communication These issues have been dealt with successfully by other GME programs throughout the country. The obvious benefits to Louisiana include more diverse opportunities for resident training, increased funding and better financial stability for GME programs.

Research Funding

Another major source of funding most medical schools tap into is from the National Institutes of Health (NIH) for biomedical and health research. The NIH funds those programs that have good research track records and the best chance of success. The level of NIH funding has become a commonly used indicator of medical school performance. NIH funding for LSU has been well below what would be considered acceptable for a research center of excellence.

According to measures of NIH 2005 research funding, LSU Health Sciences Center in New Orleans ranks 75th out of 123 medical schools with $39 million in total awards and the LSU Health Sciences Center in Shreveport ranks 102nd with $13.7 million in total awards. Tulane ranks 59th with $59.1 million in total awards. For comparison purposes, the University of Alabama Birmingham medical school ranks 18th with $191 million in research awards from NIH.

The Association of American Medical Colleges has compiled a list of major research achievements dating back several decades. Tulane leads the Louisiana list with 17 research accomplishments, 15 of them occurring since the year 2000. The LSU Medical School at Shreveport has two accomplishments to round out Louisiana's total of 19.

Biomedical research is an important activity of medical schools to train students in scientific rigor, expand the cross-section of the population to which students are exposed, improve the health of the community and spur economic development. A new focus on increasing the research capacity at the LSU Medical School in New Orleans could improve the economic viability of the New Orleans region and attract essential additional federal funding. Both LSU and Tulane have expressed interest

in expanding research capacity. A number of research collaborations between the schools are underway, some fostered by the post-Katrina reality of faculty shortages.

Need for Affiliations

Medical education, as well as care for the uninsured, should be a shared responsibility of the entire health care community. Under the current system in Louisiana, the private sector has a limited role in medical education and patient care for the uninsured, though its involvement has been increasing over the past few years. Yet, private sector hospitals and health care facilities have much to contribute to the educational experience and to sound patient care in terms of resources, expertise and specialized technology.

Affiliation agreements, therefore, can benefit both the sponsoring academic medical center and the affiliate hospital. It should be noted that even if a new 400 or more bed hospital is constructed, it will not be sufficient to accommodate the 534 residency slots that MCLNO owns. This problem can be solved through affiliation agreements, which allow transfer of residency slots to other training sites, preferably on a permanent or at least long-term basis to provide programmatic and financial stability for the host hospital.

The current two-tiered system has fostered an attitude of rivalry and sometimes even hostility between public and private interests. Instead of a unified team working toward a common goal of creating excellence for New Orleans or Baton Rouge or for the state, there is a public sector with enormous responsibility but inadequate clinical resources competing with a better prepared and better equipped private sector.

A review of the structure of medical schools around the nation shows that affiliation agreements range from being supplemental to comprehensive in the extent to which they are relied upon to provide clinical training opportunities to medical students. Claims that accreditation agencies insist on each medical school having its own teaching hospital as a "clinical home" for residency training are not accurate. While it is true that most medical schools have teaching hospitals, it is becoming increasingly common for fully accredited schools to have affiliation agreements with other nearby community hospitals that can meet strict accreditation standards. Such affiliate hospitals can either augment the role of the integrated academic medical center or replace it altogether.

There are 18 community-based medical schools in the United States, the most notable example being Harvard University Medical School. These medical schools use community hospitals for clinical facilities rather than a traditional academic medical center hospital. Additionally, many new medical schools being constructed in areas of high population growth are electing to partner with local community hospitals for resident training, rather than incurring the considerable expense and administrative burden of building a new teaching hospital, or even buying an existing facility. However, medical schools without proprietary teaching hospitals are not the most appropriate solution in every locality.

While the Harvard University Medical School has found great success with this model, most experts are reserving judgment on how replicable the pure community-based model will be. Academic medical centers are likely to continue to be the most common method of training medical residents well into the foreseeable future. There are 107 medical schools in the nation that have an integrated academic medical center, which assimilates the interdependent missions of professional education, research and patient care.

The Commonwealth Fund issued a landmark report, "Envisioning the Future of Academic Health Centers," in 2003 following a seven-year study of academic medical centers and how they will evolve in the future. The report points out a number of challenges that academic medical centers are expected to face over the next few decades and concludes that they will survive and thrive, but only if they continue to adjust in response to societal needs and the imperatives of economic, demographic and technological changes.

The report documents the challenges that academic medical centers faced during the 1990s when the health care system was entering a period of "unprecedented turmoil resulting from profound changes in private markets and public policy." The task force concluded that they fill a unique role in the nation's health care system, but cannot survive if they cannot adapt. Accordingly, the task force points to several areas where change will be imperative, including the development of more specialized missions in terms of research scope, training opportunities and patient care.

VI. RECOMMENDATIONS

The following proposals should be considered as a unified set of recommendations. For example, PAR support for Recommendation 1 (to establish and operate academic health centers in New Orleans and Baton Rouge) would be withdrawn if Recommendation 2 (to close or transfer governance of six charity hospitals to local operational authority) were ignored. Louisiana cannot afford to continue to operate 10 charity hospitals and construct two or more new replacement hospitals at considerable capital outlay and operational costs and have centers of excellence in New Orleans, Shreveport, Baton Rouge and Monroe and introduce a promising new plan for better primary care access, better coverage and better quality.

Therefore, although each of these recommendations has individual merit, no single element should be separated from the whole. These recommendations address systemic health care issues that are well beyond the single concern of how large a new hospital in New Orleans should be.

These recommendations can be accomplished through the appropriations process, concurrent resolution or administrative rulemaking. No statutory changes are needed, with the exception that transfer of a hospital or other facility from state to local ownership must be done by legislative act prior to transfer, which probably would occur two to five years after beginning a regional planning process.

Recommendation 1: LSU hospitals in New Orleans and Baton Rouge should be replaced and sized in accordance with independent population and revenue projections. The hospitals should be operated as academic medical centers under the jurisdiction of the LSU Health Sciences Center in New Orleans. The LSU Health Sciences Center and University Hospital in Shreveport and the E.A. Conway Medical Center in Monroe should be maintained and operated as academic medical centers.

Discussion: The hospitals in New Orleans and Baton Rouge should be converted from charity hospitals to academic medical centers. Each hospital should strive to be a center of excellence for medical education, research and patient care, including clinic-based services. Financing of operations for these facilities should maximize self-generated revenues from Medicare payments, private insurance payments and uninsured self-pay. The Shreveport and Monroe hospitals should be maintained and operated as academic medical centers.

The use of guaranteed subsidies of Medicaid Disproportionate Share Hospital (DSH) payments appropriated by the Legislature should be minimized and shared with private providers. DSH funds should be reserved for financing coverage options, whether through private insurance or Medicaid, and for establishing an improved regional and community-based safety net in place of the state-operated charity hospitals. New and larger hospitals in New Orleans and Baton Rouge will not necessarily be more self-sustaining than the ones they are replacing and may consume more DSH subsidies than their predecessors. Additionally, considerations of staffing with doctors, nurses and allied health professions need to be taken into account. Post-Katrina shortages have plagued the medical workforce in south Louisiana, including medical school faculty and residents.

Less dependency on subsidies and reaching out to a broader patient mix that includes more private insurance patients and even regular Medicaid eligibles will provide a more sustainable revenue picture. LSU hospitals also need to generate more Medicare dollars for graduate medical education.

Each academic medical center should set short-term goals for a payer mix that tracks the national average for public hospitals as reported by the National Association of Public Hospitals. When achieved, this revenue picture would reduce reliance on Medicaid and DSH funds from the current 82 percent down to 37 percent. This can materialize if state government takes a hard-nosed approach toward the DSH program. In the past DSH funds have been used as grants that guarantee the charity hospital system will "make budget" regardless of how inefficient the system is.

The academic medical center in Shreveport is often touted as a model that other LSU hospitals should emulate. That hospital has marginally higher levels of Medicare and insurance revenues, as well as somewhat less dependence on disproportionate share subsidies. Although its revenue picture is little different from most charity hospitals, the facility is well maintained and has a reputation for quality care in the northwest region and even serves patients from adjoining states.

In designing the hospitals' operational plans for the future, emphasis should be placed on partnerships with leading hospitals in each community. Encouraging their participation in the mission of training physicians will benefit the LSU and Tulane medical schools, as well as the community hospitals. It also will improve the quality of medical education and patient care. Furthermore, the distribution of some components of the medical education process will increase efficiency. There is no need to duplicate each specialty training program if there are outstanding programs already in existence at other community hospitals.

Each hospital should have specific specialized areas of patient care that would serve community needs. The hospital in New Orleans should include a trauma center and other specialized services to distinguish it from the other hospitals in the region. Some specific hospital specialties that academic medical centers around the nation feature are cancer treatment, cardiac care, burn units and trauma care, to name a few. The University Hospital at Shreveport is the only facility in the LSU hospital network that provides an array of cardiac treatment services, including a catheterization lab, heart surgery and other invasive procedures.

Provided it follows a strategic roadmap, a "center of excellence" at a new hospital in New Orleans serving both the LSU and Tulane health science centers is definitely possible, but not predestined. Initiating the project with a plan that is centered in the realities of the

new downsized demographics and economics of south Louisiana will be a step forward.

Recommendation 2: Regionally integrated systems of care should be established by local authorities and health care providers in order to plan for an orderly transition of indigent care over a reasonable period of time from the six state-operated charity hospitals to regional and community-based networks that emphasize primary and preventive care, as well as quality specialty and hospital care.

Discussion: Louisiana's system of care for the uninsured should be converted over time from the current network of 10 charity hospitals, to a patient-centered, widely accessible and integrated structure composed of public and private hospitals, community-health clinics (FQHCs), rural health clinics, school-based health centers and primary care physicians and specialists. Local and regional referral protocols and plans for coordination and integration of care should be developed. Methods of financing the delivery of care should be formulated in agreement between state, local and federal authorities in consultation with service providers. If coverage is expanded to cover a portion of the uninsured population, the need and cost for safety net resources will be correspondingly reduced.

Six of the 10 state-operated charity hospitals should be transferred from state ownership and control to local governance. These six hospitals are W.O. Moss Regional Hospital in Lake Charles, University Medical Center in Lafayette, Leonard J. Chabert Medical Center in Houma, Bogalusa Medical Center, Lallie Kemp Medical Center in Independence and Huey P. Long Medical Center in Pineville. Hospitals in New Orleans and Baton Rouge would continue to be state facilities under the control of the LSU Health Sciences Center in New Orleans and operated as academic medical centers affiliated with the LSU and Tulane medical schools. Hospitals in Shreveport and Monroe would continue to operate under the supervision of the LSU Health Sciences Center in Shreveport in conjunction with the medical school in that city.

The E.A. Conway Medical Center in Monroe was transferred from the Health Care Services Division and placed under the jurisdiction of the LSU Health Sciences Center in 2004. The Monroe hospital serves as an integral part of the Shreveport residency training program and is the base for the family practice residency program in northeast Louisiana. In the four cities with academic medical centers, coordinated planning by community providers with LSU for indigent care and graduate medical education should be pursued in order to maximize affiliations with community hospitals. E.A. Conway would be transitioned to academic medical center status by following clinical practice standards according to the Shreveport model. However, both hospitals remain highly dependent on disproportionate share (DSH) payments for operating revenues and each should find ways to broaden its patient mix and payer base to reduce that dependence.

The Lake Charles and Alexandria regions already have been active in developing plans and proposing solutions regarding indigent care in their local communities (see discussion pages 17-22). Planners in the Lake Charles region produced a plan in 2004 to convert the W.O. Moss charity hospital into a "cyber" hospital under the auspices of a regional board of health that would operate a system of primary care clinics as well as contract with community hospitals and specialists for appropriate care. The Lake Charles regional plan envisions the use of fees and co-payments, as well as local millages, to help pay for operations and finance enhancements. A user card system also is proposed to track patients and monitor costs and performance.

Two private hospitals in Alexandria, Rapides General and Christus Cabrini, have jointly developed a plan that would enable community hospitals to take over inpatient medical care for indigent patients. Outpatient care would be handled by a new not-for-profit entity that would be established to provide and coordinate clinic and urgent care services. The plan would be financed by a flexible DSH pool for the nine-parish region to fund inpatient care. Federal approval would be pursued to allow a portion of those funds to be used for outpatient clinic and physician services. A regional millage also is proposed to generate revenues for program operation and enhancement.

DHH, in consultation with LSU HCSD, could represent the state in this transition effort and assist local interests in developing alternative inpatient and outpatient capacity in the five regions where the six hospitals are located. A focal point of this initiative would be to establish an improved infrastructure for primary and preventive care. This infrastructure would rely on private physicians, school-based health centers, federally qualified health centers and rural health clinics. Expanding family medicine residency practices also would be a viable way to increase primary care and provide additional clinical training opportunities for residents.

Transfer of these hospitals from state operation need not result in outright closure of all or any hospitals. Local authorities, health care interests and community leaders at each location should be provided an opportunity to determine if medical need and local circumstances dictate continued operation of the facility. The Legislature could authorize DHH to work with LSU, local officials, health care providers and community leaders to determine the shape and structure of the indigent care system in each region and develop a plan for the ultimate disposition of each facility. If a

community or parish found it desirable to maintain operation of a local charity hospital, it would be able to jointly plan with DHH for a transfer of ownership to local government or a private entity. Each regional plan would ensure that the level of access to care and services would meet or exceed current standards in the charity system. Any transfer of ownership to local government would require approval by the Legislature. Medicaid DSH payments would be available to offset the cost of care for the uninsured in accordance with legislative appropriations.

It is vital that this process be carried out in a transparent manner and that local citizens, health care consumers and providers be kept informed and have opportunities for input. Toward that end, committees would be established of local officials, local providers and local residents to engage in the planning effort.

Recommendation 3: Financing for graduate medical education (GME) programs should be restructured to increase substantially Medicare GME payments by locating residency training at community hospitals and primary care training sites. Financing with Medicaid GME funds also should be increased substantially and payments should be linked to specific state policy goals, such as increasing numbers of primary care physicians.

Discussion: Graduate medical education (GME) in the LSU Health Care Services Division hospital system is financed primarily with Medicaid disproportionate share funds. To a significantly lesser degree, Medicare GME payments and higher Medicaid inpatient and outpatient rates also are paid in accordance with a hospital's teaching status (major or minor). Medicare GME, which is highly desirable because it is 100 percent federal funds, is paid according to a formula that increases payments as levels of Medicare patient utilization rise. Recent studies have estimated that as much as $160 million in Medicare GME is left "on the table" because of low numbers of Medicare patients in the charity system. One obvious solution is to attract more Medicare patients, but that is a distant goal dependent on many factors, such as clinical focus on programs and services geared toward the elderly, referral patterns and physical plant upgrades. An easier solution that could be undertaken immediately would be to shift training to sites that are educationally sound and offer substantially improved access to Medicare patients. This is feasible under current federal law through the use of "affiliation agreements" between MCLNO, as the home hospital that owns more than 500 resident slots, and host community hospitals that would become long-term sites for resident education.

In the meantime, Louisiana continues to use Medicaid Disproportionate Share Hospital (DSH) payments as an all-purpose method of financing (e.g., a surrogate for Medicare GME payments), but one that is fraught with confusion and often controversy. More than $600 million per year in DSH payments was budgeted to the 10 LSU hospitals pre-Katrina for care of the uninsured, as well as graduate medical education, but the amount that went toward each purpose is hard to determine. For reasons related to planning, budgeting and measuring performance, it is essential to know the amounts spent on any given program. Furthermore, the confusion over what are allowable costs under DSH rules resulted in a legislative audit finding against LSU in 2002 that monies were improperly used to pay medical school faculty salaries. A federal disallowance against Louisiana Medicaid means that the state may have to repay up to $210 million.

Increasing Medicare GME revenues through affiliation agreements with community hospitals will be helpful but, due to federal caps on residency slots and highly restrictive rules, other solutions are needed to ensure a stable funding stream for medical education while freeing DSH funds for other uses. An alternative way to restore order to budgeting and spending dollars for medical education is to make use of the GME provisions in the Medicaid program. Unlike Medicaid DSH dollars that are capped at current levels, Medicaid GME has no restrictions as to amount and use of funds within the broad category of graduate medical education except that state matching funds at the rate of about 30 percent are required.

Replacing Medicaid DSH funding currently used for medical education purposes with Medicaid GME funding offers a twofold advantage: It frees up DSH dollars below the current $1.1 billion allotment for other uses and it brings a more cohesive structure to GME spending. Furthermore, it provides better accountability and an ability to exercise control over how GME payments are used.

Louisiana has several problems that need to be addressed at the medical school and resident training level, including the need to infuse the physician workforce with more primary care doctors. It is well documented that high ratios of primary care physicians in a state or health system mean lower costs and better health outcomes.

Medicaid GME dollars appropriated with a directive to spend them to achieve specific policy goals can ensure better results. One goal that should be set is to improve the geographic distribution of primary care physicians and some specialists. Graduating more PCPs will not solve problems for rural and underserved areas without a concerted effort to direct new doctors to areas where they are needed instead of to already saturated urban areas. Medicaid GME payments can provide incentives for activities that can help to realign the composition and distribution of physicians toward a more favorable

balance of primary care and specialties. Legislation may be helpful to outline goals and mandate remedies to the problems of undersupply and maldistribution of primary care physicians. Medical students recruited from rural areas are more likely to return to those areas to practice as physicians, so recruitment programs that target rural areas may be an effective way to help correct PCP maldistribution.

The total amount of DSH funds currently used for GME purposes in Louisiana is unknown, but is estimated to be $80 million or more, with a true figure likely to be much higher. According to a 2002 survey sponsored by the Association of American Medical Colleges, Louisiana Medicaid spends approximately $40 million in Medicaid GME (as opposed to DSH) funds, mainly for community hospitals that participate in resident training programs. This represents about 5 percent of total Medicaid inpatient hospital payments in that year. Several states spend well in excess of that. New York spends almost a billion dollars in Medicaid GME, or about 20 percent of inpatient hospital expenditures.

The provisions of the Medical Education Commission established by Act 3 of 1997 should be strengthened to provide the Department of Health and Hospitals with authority and resources to investigate, monitor and report to the governor and Legislature semi-annually regarding GME organization, financing and performance, as well as recommending workforce development priorities for training and distribution of primary care and specialty physicians. These activities will increase awareness of problem areas in physician graduation rates and resident training programs and will stimulate transparency and open debate. The Legislature should initiate a review of medical education and residency training (GME) programs similar to a comprehensive study conducted by the Florida legislature prior to launching a new medical school in 2000 at Florida State University. The resulting legislation provided a blueprint for the new medical school to include community-based clinical training, a technology-rich learning environment and a new curriculum focused on the elderly, rural populations, minorities and the underserved. A similar study might serve the state well as it attempts to reinvigorate medical education in New Orleans.

Recommendation 4: State and federal funds currently paid almost exclusively to state hospitals for care of the uninsured should be redirected so that "dollars follow the patient" in order to allow them to choose appropriate health care from a wide variety of accessible inpatient and outpatient services delivered by private- and public-sector providers.

Discussion: The primary source of payment for health care for the uninsured is Disproportionate Share Hospital (DSH) payments. Louisiana spends close to $1 billion per year for these services, most of which are used to support the charity hospital system. Until 2001, such payments could only be made directly to hospitals for inpatient and outpatient services, a provision in federal law that perpetuated Medicaid's already lopsided preference for institutional services. In 2001 the Health Insurance Flexibility Act (HIFA) allowed the secretary of the Department of Health and Human Services to grant states the ability to use these funds for other purposes, such as payments to non-hospital primary care providers such as physicians and clinics. Under this new flexibility some states use DSH funds to assist employees in paying private health insurance premiums.

In order for Louisiana to shift from a predominantly hospital-based system to one that emphasizes primary and preventive care, there will have to be a corresponding shift in the way providers are paid. A system described as "dollars follow the patient" would allow the uninsured a choice of participating providers, whether hospitals, physicians or clinics.

A payment methodology should be established to qualify providers to participate in the program, including private hospitals, clinics, physicians and others. While the choice of providers would therefore be significantly greater than the current menu of 10 charity hospitals, it would not extend to every provider of services. It would, however, establish opportunities for patients to choose providers in their local communities in most cases. Provider reimbursement levels would be determined according to a sliding scale or a percentage of costs.

Recommendation 5: Insurance coverage options should be a top priority of the state, regardless of the outcome of negotiations with the federal Department of Health and Human Services.

Discussion: Numerous options and alternatives have been analyzed, debated and included in the Louisiana Health Care Redesign Collaborative plan and the federal response. Given the fact that funds are limited, it must be recognized that the insurance coverage options have the greatest benefit in terms of modernizing the Louisiana health care system and improving health outcomes for the state's population. Changing a person's status from "uninsured" to "insured" will enable that person to gain timely access to medical care. In terms of reducing costs and saving lives, nothing else can be as effective.

Delaying or failing to receive treatment can result in more serious but avoidable illness and health problems. The Kaiser Family Foundation says that women with insurance are significantly more likely to have had recent mammograms and other types of cancer screenings than the uninsured. For example, uninsured cancer patients are likely to be diagnosed later and die

earlier than those with insurance. Although Louisiana ranks 15th in the incidence of cancer of all types, it ranks second in mortality rate from all cancers. A major contributor to the high mortality is that many people (mostly the uninsured) delay diagnosis and treatment, often with fatal consequences.

Research studies indicate that continuous health coverage could produce a 5 percent to 15 percent reduction in mortality rates compared to the episodic care provided by the safety-net system of health care.

Louisiana has excelled in providing coverage for children through LaCHIP and Medicaid. Today the number of children covered is more than 600,000 compared to about 300,000 in 1998. The families of these children can choose a medical home for their children with a primary care provider who provides comprehensive primary and preventive care and coordinates specialty and hospital care when needed. The continuity of care provided by this model far exceeds what is found in Louisiana's safety net. Although Medicaid coverage provides much greater choice and access than the safety net, private insurance coverage allows for better access to specialties, such as orthopedic surgery, which are sometimes scarce even for Medicaid recipients.

Providing similar coverage for adults would result in better outcomes and a more cost-effective health care system. Expending limited dollars on coverage options should be top priority ahead of any expansion or preservation of safety net services. If no agreement can be reached with the secretary of DHHS on the current waiver proposal to cover 319,000 parents and childless adults, there are alternatives that can be pursued for a more incremental approach.

An increase in eligibility for parents of Medicaid and LaCHIP children can be undertaken by the state without special approval by the federal government. According to CMS, there are currently almost 100,000 parents who could become eligible if the state reset its eligibility limits higher. At 14 percent of the federal poverty level, parent(s) in a family of three are currently eligible for Medicaid if total family income is under approximately $2,400 per year. Louisiana has the second lowest eligibility threshold in the nation for parents at about one-third of the national average. As a result, Louisiana has the lowest percentage of adults enrolled in Medicaid of any state, 11.6 percent in 2003, less than half the national average.

Total cost to enroll this population is estimated at $300 million-$350 million, depending on whether coverage is public (Medicaid) or private, the types of services included in the benefits package and whether a managed care plan will be utilized to control costs.

Recommendation 6: Accountability and transparency should be enforced rigorously by the Department of Health and Hospitals in the spending of Medicaid Disproportionate Share Hospital (DSH) dollars, including immediate issuance of rules that require all qualifying providers, whether public or private, to present full information about services delivered to uninsured patients before being reimbursed.

Discussion: The state should adopt and enforce rules that ensure accountability and transparency in the spending of state and federal Medicaid DSH dollars for medical care of the uninsured population. No DSH payments should be made to any public or private hospital or other provider absent filing of patient-specific data, preferably in electronic form, that identify recipients of treatments and services, as well as the type, quantity and cost of the care provided. Such claims should be subject to review by the Medicaid Surveillance and Utilization Review System (SURS), as is the current practice for all other claims submitted for Medicaid payment. Once collected and analyzed, this information should be used to measure system performance at every level to help determine how to improve health outcomes for the uninsured and make safety-net services more cost-effective.

Louisiana Medicaid is a $6 billion plus program that closely monitors the way state and federal match dollars are spent. Copious amounts of data are collected and analyzed by various subprograms to assure compliance with all provisions of federal Medicaid law and any applicable state laws and administrative rules. Dozens, of detailed reports provide information about spending and services for agency managers, legislators, auditors and providers.

DSH payments for the uninsured represent more than $1 billion of total Louisiana Medicaid spending, yet there is only limited information to inform legislators, policymakers, agency managers or the general public about how these dollars are spent each year. From the inception of the program in 1989, these funds have been treated almost like grants that are made on a regular basis to certain qualifying providers. In the 18-year history of the program, close to $15 billion in DSH has been spent. Louisiana ranks 19th in actual numbers of uninsured, ninth in percentage of uninsured and fourth in size of DSH allotments. DSH spending compared to the size of the indigent population in Louisiana is far above the national average, ranking second in the nation at $1,032 per uninsured person (Table 4, page 14). The high level of spending and the low level of safety net performance is strong evidence of the need for program accountability.

Rather than treat DSH dollars as grants, the state should strive for an accountability standard in payments for care of the uninsured similar to that already in place for regular Medicaid, which is comparable to what most insurance companies require. As changes are contemplated to reform health care, a system that can track dollars and assure they are properly spent is a necessity. The recommended accountability standard should apply to all recipients of DSH payments including charity hospitals.

Private hospitals currently benefit from a temporary allotment of about $120 million for costs incurred related to Katrina. In order to be paid, those hospitals submit patient-specific information for both inpatient and outpatient services. Charity hospitals are not required to provide the same level of detail and historically have never submitted patient-specific data to receive payment. State law (Act 906 of 2003, RS 47:2761) requires hospitals and other providers to present patient-specific data on the amount and type of uncompensated care provided as a condition of reimbursement, or a portion of payments can be withheld until such information is provided. This provision of law is not being enforced.

The Medicaid fiscal intermediary has established a system for processing claims for uninsured care submitted by private hospitals that could be expanded at little cost to cover other providers who receive DSH payments. Minimum data for claims payment should include: patient name, Social Security number, date of birth, patient address, sex, provider ID, dates of service, billed charges, patient paid amount and diagnosis. Federal law requires strict protection of patient-specific health data. With consistent collection of this type of data, it is possible to analyze system performance and costs and compare hospitals to state or national benchmarks. Without this data, comparisons are not possible and the state has little idea about system performance.

Recommendation 7: Health care recovery and reform planning should be accomplished by the Department of Health and Hospitals in consultation with the Louisiana Health Care Redesign Collaborative, or a similar entity with broad representation of health care, business and consumer interests. The process should be statewide in scope and include all LSU hospitals and medical schools in addition to the services and programs included in the 2006 Health Care Redesign Collaborative planning effort.

Discussion: The Louisiana Department of Health and Hospitals (DHH) in consultation with a re-energized Health Care Redesign Collaborative should continue and expand the health care reform planning still underway for the New Orleans region. Efforts should be refocused to develop a statewide plan that includes the charity hospital system and medical schools in lieu of an exclusive planning process for LSU.

The 40-member collaborative essentially has stopped its work and at this point no future meetings are scheduled or goals set. However, the perspective of the dedicated and diverse set of stakeholders involved is as relevant as ever to the future of health care in this state. The redesign is far from complete and, in fact, was never attempted in a comprehensive way. While DHH ultimately must take responsibility for planning and implementation, the reforms should be developed in consultation with the collaborative to achieve transparency throughout the process.

The collaborative grew out of the Louisiana Recovery Authority, which was established soon after Hurricane Katrina. An earlier statewide effort was the Governor's Task Force on Health Care Reform, which was launched in 2004 with much fanfare. Two years later that effort was halted after the focus had shifted to planning for four parishes in the Orleans region. A planning process for the five-parish Southwest Louisiana area, which was devastated by Hurricane Rita, finally was initiated in November 2006, but with a new panel and different members. Largely excluded from the planning process were 55 other parishes and two-thirds of the state's population.

Clearly, New Orleans deserves top priority in the recovery and restoration effort, but almost every part of the state was affected by the hurricanes or the diaspora from New Orleans. Furthermore, the need for comprehensive health care reform statewide persisted prior to the storms. The state should seize the momentum created by the storms and use the original collaborative to continue building on the reform plans developed for the New Orleans region.

VII. CONCLUSION

Louisiana stands at a crossroads in the effort to rebuild and reform its health care system. The state needs to focus on a comprehensive plan that produces results and is financially feasible and sustainable. Reorganization should be a top priority for a system that continues to isolate uninsured patients into a structure that lacks capacity to provide good access. Yet, Louisiana has provided a two-tiered planning process to accompany—and perpetuate—its two-tiered delivery system for New Orleans.

With its high number of uninsured patients, Louisiana is one of the top four states in terms of the amount of federal funds paid annually to cover the costs of their care. These funds can be a valuable resource to expand the infrastructure of care for the uninsured if spread to

a wider network of non-state hospitals and ambulatory care provided by private physicians and clinics. The state is not getting maximum benefit from these dollars by using them to subsidize the charity hospitals. Breaking the welfare cycle for the state hospitals will encourage better management and a higher level of efficiency and quality.
The hospitals in New Orleans, Baton Rouge Shreveport and Monroe should be operated as academic teaching hospitals that serve as centers of excellence in their areas of specialization to complement the total health care infrastructure in their communities. The remaining charity hospitals should be transitioned over time to a community-based system of care with public and private community hospitals and clinics appropriate for their own geographic and demographic markets.

Federal funding for care of the uninsured should be distributed according to a dollars-follow-the-patient model in which both public and private providers can receive reimbursement. It is not acceptable for the private sector to provide increasing amounts of health care to the uninsured population without compensation for their services. Full transparency and accountability of health care spending should be established to allow the state to better track and improve how its dollars are being spent.
Taken as a whole, the recommendations in this report should serve as a guide toward a system that expands access to health care for the uninsured population. Continued improvements in quality of care should be demanded in both public and private health care settings. Louisiana can and should dismantle its dual health care system.

Changing the system will require clear guidance from the top levels of government to overcome the entrenched power structure of the current system. Short of that leadership, the state will continue to stand out as an example of an ineffective health care system always on the verge of financial collapse.

Funding for this report was provided by the Community Foundation of Shreveport-Bossier, the Rosalind and Leslie McKenzie Fund, the Juliet Singletary Dougherty Fund for Education, Health and Health Research, the Wilbur Marvin Foundation, the Will and Leona Huff Family Fund, the R. Gordon Kean, Jr., Family Fund, the Alvin and Louise Albritton Memorial Fund, the Baton Rouge Area Foundation, the Ella West Freeman Foundation and the Keller Family Foundation.

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