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Hurricanes and Health Care Reform

Can Louisiana turn a disaster into an opportunity?

EXECUTIVE SUMMARY

Nearly eight months after Hurricanes Katrina and Rita swept through Louisiana, the public health care system still lies in disarray. Important decisions regarding the future of that system have yet to be made, though it is expected that some action on financing and rebuilding of facilities may be taken in the near future. This report considers three critical areas of health care delivery that profoundly impact the cost and effectiveness of health care in Louisiana. The report also includes policy goals intended to outline broad directions that the public and private sectors should consider in order to improve health care access, quality and cost-effectiveness.

Charity hospitals and the uninsured. Louisiana is unique among the 50 states in its approach to providing health care for the uninsured population. Whereas most states rely on local community hospitals, academic medical centers and community health clinics to provide indigent care, Louisiana depends almost solely on a state-owned and operated network of 10 hospitals, some constructed during the 1930's under Governor Huey P. Long. In addition to patient care, these hospitals are used for training physician residents.

A key question in planning the rebuilding of Louisiana's health care system is whether to continue to rely on a costly hospital-centered system of care or design a new delivery model that would shift the focus to maintaining health and preventing chronic disease. A related question is whether or not the charity hospitals can become financially self-sustaining. On average, U.S. public hospitals in 2003 received 63 percent of their revenue from private insurance, Medicare and self-paying patients. LSU hospitals received only 18 percent of their revenue from those sources, with the remaining 82 percent coming from Disproportionate Share Hospital (DSH) payments (about two-thirds) and Medicaid (one-third). It appears unlikely that the charity system, even if rebuilt, will attract paying patients in sufficient numbers to exist without substantial DSH subsidies.

Primary and preventive care. Primary care refers to a "medical home" that provides continuity and integration of health care for patients. The aims of primary care are to provide a broad spectrum of care, both preventive and curative, over a period of time and to coordinate the care the patient receives. Ideally, this care would be provided in the most cost-effective setting, which would typically be a primary care physician's office or a free-standing community health center. Louisiana's near total reliance on the charity hospital system to provide health care for the 900,000 uninsured means that many do not have reliable and ready access to a primary care physician. Because waiting lists for appointments at charity hospital outpatient clinics are intolerably long, patients frequently use emergency rooms for non-emergency primary care services. Louisiana has the fourth highest rate of ER usage of the 50 states, with charity hospitals receiving a major share of the ER visits.

This is the first report in an ongoing series of PAR health care policy briefs highlighting major issues that impact health programs and state and federal spending in Louisiana. This report provides an overview of the state's health system and its deficiencies, as well as the challenges and opportunities presented by Hurricanes Katrina and Rita. Future briefs will focus on specific issues, including the need for primary and preventive health care, the challenge of providing for the uninsured, long-term care for the elderly and persons with disabilities and state Medicaid spending. Each brief will provide specific recommendations for system change and improvement.

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Long-term care system. Spending on long-term institutional care (nursing homes and facilities for persons with disabilities) continues to increase, though demand for those services continues to decline. Meanwhile, growth in home and community-based services for these populations is far short of demand, and 10-year stays on waiting lists for services are commonplace. The imbalance between institutional and non-institutional care has improved over the past decade. The proportion of long-term care dollars spent for home and community-based services increased from $50 million in 1996 to $240 million in 2003 to $370 million in 2006. However, there is still a significant disparity between the proportion of spending on non-institutional care for the elderly (17%) compared to persons with developmental disabilities (40%).

Reform Opportunities. Reform measures are rarely implemented absent a crisis. Now that the state has endured an unprecedented disaster that destroyed much of the health care system in south Louisiana, the conditions for reform appear to be in place. Numerous studies of the post-hurricane health crisis have been completed and added to dozens of research projects amassed from the decades prior to the hurricanes. Almost without exception, these studies call for an extreme makeover of the Louisiana health care system.

The consensus is that the expensive, often inaccessible, hospital-centered, state-operated model of health care delivery should not be preserved. Instead, health care in 21st century Louisiana should emphasize primary and preventive care that can be easily accessed in order to maintain good health and prevent disease. Home and community-based services for the elderly and persons with disabilities should be available, accessible and cost-effective. Expensive specialty, hospital and institutional care should be high quality and provided only when necessary. The new model of health care should be cost-effective and financially sustainable.

This report lays the foundation for a series of PAR analyses that will identify specific reforms for the state to adopt to improve the efficiency and outcomes of the health care system.

INTRODUCTION

In August and September 2005, Hurricanes Katrina and Rita devastated a health care system that was already dysfunctional. Scores of hospitals, nursing homes, doctors' offices and clinics were damaged, many beyond repair. The unprecedented evacuation from coastal areas displaced hundreds of thousands of residents, many of them to other states throughout the country. The health care workforce was decimated, leading to predictions that physician and allied professional staffing would be reduced to levels inadequate to operate facilities and services. (See Table 1.) A potential complication is that erosion of the state's tax revenue base may cause serious budget problems for health care in the future, depending on whether population and commerce are restored to pre-hurricane levels.

Table 1. Health Care Capacity in the Greater New Orleans Area* – Before and After Katrina

	Pre-Katrina	Post-Katrina	% change
Staffed hospital beds**	4,083	1,984	-51%
"Safety net" clinics***	90	19	-79%
Physicians – Orleans Parish only (est.)***	2,664	1,200	-55%
Licensed nursing home beds****	6,414	3,159	-51%

*Orleans, Jefferson, St. Bernard and Plaquemines parishes **U.S. GAO report, March 28, 2006 ***DHH Bureau of Primary Care and Rural Health: Orleans/Jefferson and St. Bernard health system status report, March 2, 2006 ****DHH Health Standards licensure database. Louisiana Nursing Home Association estimates 2,616 beds operational at mid-April.

Louisiana faces numerous uncertainties about how it will rebuild its infrastructure, protect its citizens, restore its economy and re-establish and maintain its programs and services. But these extraordinary challenges are accompanied by extraordinary opportunities to transform the state's economic and political climate. Health care should be a top priority. It remains to be seen whether Louisiana can embrace change and enact reforms that will help it compete in the global economy with a 21st century health care delivery system.

HIGH SPENDING, POOR OUTCOMES

For decades prior to the hurricanes of 2005, Louisiana's public health care system was relentlessly described as expensive, inefficient and antiquated, a throwback to the 1930s when Governor Huey P. Long established the statewide charity hospital system. Though times have changed, the health care system has not kept pace with most other states.

When it comes to health care, Louisiana is a high spending, low performing state. This fact is painfully reinforced each year when the results of the latest annual surveys of "healthiest states" are released. The two best known surveys are conducted by Morgan Quitno Press and United Health Foundation. Both surveys have consistently ranked Louisiana as one of the three worst states in health care performance over the past 15 years.

Table 2. Louisiana Health System Characteristics and Status

	United States	Louisiana	Louisiana Rank in U.S.
Overall performance rank for Louisiana health system			
Morgan Quitno – Health Care State Rankings 2006			48
United Health Foundation – America's Health Rankings 2005			49
Demographics (Kaiser Family Foundation State Health Facts)			
Total population 2003-04	290,286,350	4,409,810	25
Population at or below 100% of federal poverty level 2003-04[1]	17%	22%	5
Population at or below 200% of federal poverty level 2003-04[1]	36%	45%	3
Selected performance indicators and health outcomes (Morgan Quitno 2006)			
Percent of population lacking access to primary care 2005	11.5%	21.6%	7
Births of low birth weight as percent of all births 2004	8.1%	10.9%	2
Total mortality – age-adjusted rate per 100,000 in 2003	831.2	1007.4	2
Infant mortality – rate per 1,000 live births in 2004	6.6	10.0	1
Cancer mortality – age-adjusted rate per 100,000 in 2002	193.5	222.9	2
Diabetes mortality – age-adjusted rate per 100,000 in 2002	25.4	42.1	1
Heart disease mortality – age-adjusted rate per 100,000 in 2002	240.8	269.8	10
Population without health coverage (Morgan Quitno 2006)			
Total uninsured 2004	45,820,000	761,000	19
Percent of population uninsured 2004	15.5%	18.8%	5
Percent change in persons uninsured 2000 to 2004[2]	+18.4%	-6%	47
Percent of children uninsured[2]	11.2%	8.0%	33
Private insurance coverage (Morgan Quitno 2006)			
Persons with private insurance coverage 2003-04	169,746,800	2,324,630	25
Percent with private coverage 2003-04	59%	53%	42
Percent of private companies offering coverage 2003-04	56.2%	50.0%	
Percent of companies with 50 or fewer employees offering coverage 2003-04	43.2%	34.9%	40
Employer-sponsored health plan premiums 2003 (KFF State Health Facts)			
Single policy – employee	$606	$633	25
Single policy – employer	$2,875	$2,684	41
Family policy – employee	$2,283	$2,587	8
Family policy – employer	$6,966	$6,148	44
Government-sponsored coverage and spending (Morgan Quitno 2006)			
Medicare total spending 2004	$245.2 billion	$4.6 billion	18
Medicare enrollment 2004	41,729,000	629,000	24
% of population enrolled 2004	13.9%	14.0%	34
Spending per capita 2001	$854	$998	9
Spending per enrollee 2001	$6,223	$7,354	2
Medicaid total spending 2002	$258.2 billion	$5.02 billion	16
Medicaid enrollment 2004	44,596,338	944,438	15
% of population enrolled 2004	14.9%	21.0%	5
Spending per capita 2004	$886	$1,059	11
Spending per beneficiary 2002	$5,235	$5,588	19

Sources: Kaiser Family Foundation State Health Facts and Morgan Quitno Health Care State Rankings utilize mainly federal data, such as U.S. Bureau of the Census, Centers for Medicare and Medicaid Services and the Centers for Disease Control to provide most recent statistics. Information is also furnished by other governmental and reputable private organizations.

[1] Persons in poverty are defined as those making less than 100% of federal poverty level which was $15,067 or less for a family of three in 2004. Those "near poverty" made between 100% and 200% of FPL, or $15,067 to $30,134 for a family of three.

[2] Uninsured population in Louisiana according to U.S. Bureau of the Census. The number of uninsured was reduced during the period 2000 to 2004 by 6% attributable to gains in coverage through Louisiana Children's Health Insurance Program. The state's 6% reduction ranks 47th or 4th best nationally, compared to an increase of 18.4% in number of uninsured for the U.S. as a whole.

The two national surveys and other data used in this report paint a disturbing portrait of health care in Louisiana. The state's poor showing is usually underscored by a host of alarming statistics in various disease mortality rates and system performance failures (see Table 2).

The state's low health rankings and poor performance are often excused by citing high poverty levels and a lack of financial resources. The fact that other southern states with similar economic profiles and rates of poverty have better health outcomes points to the need to reorganize the way Louisiana delivers health care (see Table 3). Shifting the focus from an institution-centered organizational structure to a patient-centered model will permit new opportunities for consumer choice, better accessibility to care and higher quality. Judging by Louisiana's historically lofty spending patterns compared to many other states, this new paradigm should not require substantially higher levels of funding.

HEALTH CARE POLICY GOALS
(PUBLIC AND PRIVATE SECTORS)

The following are policy goals intended to outline broad directions that the Louisiana health care system should follow in order to improve access to care, quality and cost-effectiveness. In future policy briefs, PAR will make specific operational recommendations to achieve implementation of these policy goals.

1. Promote delivery of primary and preventive care to include:

- *financial and other incentives to attract and retain primary care physicians to practice in Louisiana, especially in rural and other underserved areas in the state*
- *an increase in cost-effective alternatives for non-emergency care to reduce unnecessary use of emergency rooms*
- *an expansion in numbers of community health clinics so that Louisiana conforms to national norms in terms of numbers of site locations and patients served*
- *an increase in school-based health centers to ensure access to care in all school districts.*

2. Utilize private sector expertise and capacity wherever possible. For example, private hospitals already provide significant indigent care and a limited degree of graduate medical education. These roles could be expanded to supplement state-operated hospitals, particularly if either more cost-effective or higher quality specialized care is available locally.

3. Pursue opportunities to establish regional or national centers for excellence through public/private partnerships with leading private hospitals for patient care, medical education and research.

4. Structure alternative payment and delivery systems to provide care for indigent patients. Such systems could include use of existing state & federal funds to purchase limited benefit health plans that emphasize primary care and to provide premium subsidies for small businesses to maintain or begin coverage of employees.

5. Promote establishment of a broad continuum of services for the elderly and for persons with disabilities, to include home and community-based care as alternatives to institutional care in scope and amount so that Louisiana conforms to national norms.

6. Promote transparency in health care information to enable consumers and others to review cost and quality performance measurements and compare outcomes for various service providers.

7. Use health information technology to reduce costs and facilitate administration of programs. This would include implementation of a Web-based, electronic medical records system.

8. Use reimbursement systems to provide incentives for providers to achieve state policy goals. This could include added payments for providers that meet key quality standards or performance measures.

Table 3. Health Care Spending and Outcomes in Comparable Southern States

	Pop. in or near poverty*	Per capita state/local spending**	Health performance ranking 2006***
Louisiana	45%	$6,180	48
Arkansas	43	5,381	36
N. Carolina	40	6,237	30
Kentucky	41	6,073	26
W. Virginia	45	6,609	22
U.S. avg.	36	7,115	n/a

*Percent of population below 200% of federal poverty level, about $33,200 income for family of three
**Total state & local spending per capita for government services 2002
***Morgan Quitno 2006 health rankings, based on data for 2002-2005

CHARITY HOSPITALS AND THE UNINSURED POPULATION

Some of the most significant devastation caused by Katrina was the damage to the charity hospital system. The storm rendered inoperable the Medical Center of Louisiana at New Orleans (MCLNO), which includes the 70-year-old "big charity" hospital and the newer

University Hospital. Currently, the charity system in the New Orleans area operates at greatly reduced capacity and revenues. The hospital facilities are marginally usable at best but would cost as much as $750 million to replace, according to LSU Health Care Services Division (HCSD). Employment was terminated for some 2,600 employees in the last days of 2005. Temporary mobile clinics are now being run by HCSD, and two floors of the University Hospital component of MCLNO are being renovated for inpatient services.

There have been dire warnings of what will happen if sufficient capital outlays and operating funds are not provided to reconstruct and run the New Orleans facility and some of the other nine hospitals in the statewide charity system. (Earl K. Long Hospital in Baton Rouge is also planned for replacement at a cost of $300-$400 million and Huey P. Long Hospital in Alexandria will need $200-$250 million to be rebuilt.) Charity hospital officials have long insisted that there are no viable alternatives to the type of health care delivered by the charity hospital system, and that indigent health care, medical education and research will suffer irreparable harm if other options are attempted.

Clearly, the state faces a tremendous challenge in reconnecting patients with good health care and medical residents with proper training facilities. It will take years to put the state's public health care system back on a stable footing. But a review of charity hospital operations and finances shows that the system was in decline long before Katrina made landfall.

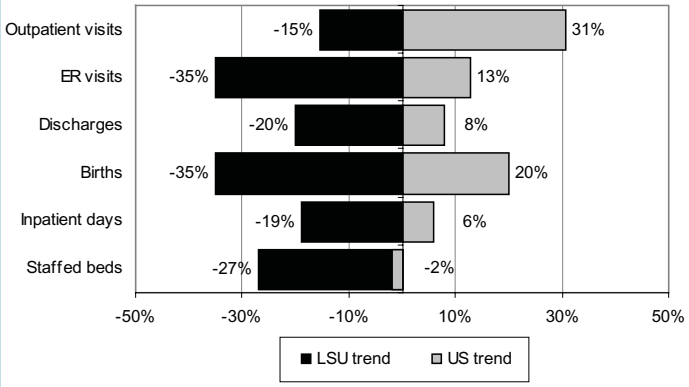
The problem of how to proceed with rebuilding health care in south Louisiana has crystallized around two very different schools of thought. The essential question that must be resolved is: Should the state attempt to (1) resurrect the pre-Katrina status quo and launch a massive and expensive rebuilding campaign to establish a state hospital system that can compete with the private sector or (2) redirect funding and resources toward a fundamentally different model that partners with private hospitals and other providers to assist in graduate medical education, care for the uninsured and biomedical research? The second scenario does not rule out a more limited reconstruction effort aimed at smaller hospitals with fewer beds. This plan is more in concert with uncertain demographic projections and the doubtful financial viability of large charity hospitals with scant ability to generate revenues other than liberal subsidies of Medicaid DSH funds and state dollars.

Making the transition from the current dysfunctional and, in many areas, non-existent health care system will test the expertise, financial resources and political commitment of Louisiana for many years to come. In the months ahead, policymakers will weigh the difficulty of constructing a sustainable, more accessible and high-quality public health care system against the cost of perpetuating a high-cost, low-performing system.

SERVICE AND REVENUE DECLINE

According to national surveys, Louisiana's charity hospitals are none too healthy compared to other public hospital systems around the country. 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. Inpatient and outpatient statistics are shown in Figure 1.

Figure 1. Public Hospital Service Delivery Trends LSU HCSD Compared to U.S. Average 1998-2003



Source: Natl. Assn. of Public Hospitals 2005, 1998-2003 data.

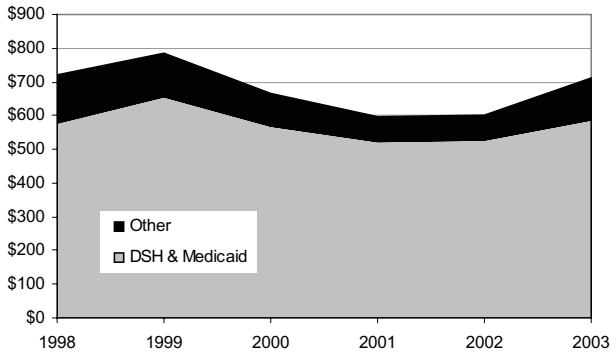
Total revenues declined by 1% for LA charity hospitals during the 1998-2003 period compared to an increase of 40% for U.S. public hospitals. (See Figure 2.) Furthermore, the Louisiana system is nearly totally dependent on Medicaid and disproportionate share hospital (DSH) payments to pay its operating expenses. Medicaid and DSH account for 82% of revenues by 2003, compared to 37% for U.S. public hospitals, which have a more diversified revenue base. (See Figures 3 and 4.) This dependence results from the decline in numbers of paying patients, i.e., those with Medicare and private insurance, that access the charity system for medical care.

Total revenues for the eight HCSD hospitals for 2003 were $713 million, slightly less than the $719 million collected in 1998. Of that amount $587 million (82%) came from Medicaid payments and DSH. For the current state fiscal year (2005-06), the amount of Medicaid and DSH has grown to $708 million, with most of the increase due to a two-year federal windfall that expired June 30, 2005.

Excessive reliance on federal funds has been a chronic problem in the state's health care system, especially for the past two decades. During the early 1990s an influx of federal money from an expanded Medicaid disproportionate share hospital (DSH) program produced several billion dollars for Louisiana. The questionable practice of billing the federal government three times the cost for charity hospital care, then using the surplus

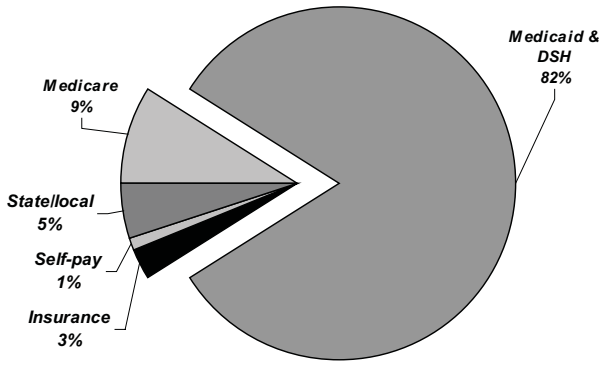
federal dollars for state match to draw down more federal dollars was ended by Congress in 1995. Before Congress intervened, Louisiana's actual state match rate for Medicaid was less than 10%, compared to the federally required rate of 32%.

Figure 2. Medicaid and DSH Payments ($ in millions)



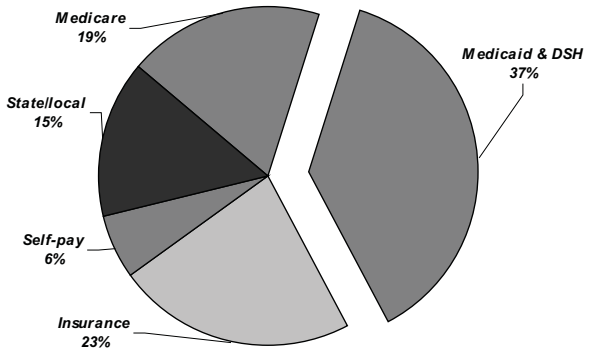
Source: Natl. Assn. of Public Hospitals 2005

Figure 3. LA Charity Hospitals



Data for 8 charity hospitals under HCSD, Shreveport and Monroe excluded.
Source: Natl. Assn. of Public Hospitals 2005, based on 2003 data.

Figure 4. Public Hospitals Nationwide



Data for 89 public hospitals nationwide.
Source: Natl. Assn. of Public Hospitals, 2005, based on 2003 data

Without the constraint of having to appropriate real state dollars for matching funds, the state Medicaid budget ballooned from $900 million in 1988 to $4.6 billion by 1994, a phenomenal average growth rate of 31% per year. State general fund dollars used for match or other health purposes were shifted elsewhere in the state budget. Health care remains reliant on the Medicaid financing scheme *du jour* to pay for a substantial part of day-to-day operations.

Not only does this leave health care programs at the mercy of congressional and state appropriations, but it removes considerable flexibility from program managers. Whereas a state general fund dollar might be spent on cost-effective physician or clinic care in an underserved area, a federal DSH dollar appropriated for the charity hospital system is tied to the institution. According to Mercer Consulting, a national authority on health care, approximately 55 percent of the 114 million emergency room visits in 2002 were for low-acuity non-emergent conditions. Treatment of those conditions in an ER typically costs at least two to three times as much as treatment in a doctor's office or clinic.

Likewise, hospital-based outpatient clinics, such as those currently used at charity hospitals, are more costly than free-standing clinics or doctor's offices. In an effort to shift routine care from expensive institutions to more cost-effective clinics and doctor's offices, some states have been able to get federal permission (waivers) to use DSH dollars to pay for non-hospital care for the uninsured. Louisiana is awaiting approval from the federal government of a waiver it applied for in 2005.

Louisiana ranks in the top five states in the nation in terms of DSH funding, with appropriations totaling nearly $900 million per year, pre-Katrina. These are normally not 100% federal funds and therefore require the current 30% match rate. The questionable device of using the state charity hospital system as a cash cow to generate massive sums of federal money in the early 1990s locked the state into a method of financing those hospitals that still remains to this day.

Now, 11 years after Congress plugged the loopholes and triggered a financing crisis in Louisiana, the health care budget still suffers from instability and uncertainty. A habitual distraction in each legislative session is the search for non-recurring or other revenues to plug holes in the budget for one more year and avoid any and all cuts. This activity diverts state government from the all-important task of finding ways to stabilize health care financing and yet provide an affordable and effective system that delivers improved health outcomes. The ongoing health care financing "crisis" that looms over the state capitol each spring can be traced directly to the ill-fated policy hatched in the early 1990's to extract maximum federal dollars from the disproportionate share program.

GOVERNANCE TRANSFER TO LSU

In 1997 LSU proposed statutory changes to transfer control of the charity hospital system from the Louisiana Health Care Authority to the LSU Health Sciences Center. LSU committed to management improvements for the hospitals in order to improve revenue generation and make the system less reliant on Medicaid and Disproportionate Share payments. It was hoped that changing the image from charity hospitals to university medical centers would enable close competition with local private community hospitals to attract more paying patients.

While there have been improvements in medical care, such as disease management for a limited number of chronically ill patients, the decline in paying patients and the reliance on state and federal funds has accelerated since 1998. Annual increases in the system budget are financed primarily by Medicaid and DSH payments, while revenues from paying patients have significantly declined. With its competent and committed medical staff, it would be unfair to blame LSU for failing to bring about the reforms it promised. The problem lies with an ill-designed, hospital-centered health care delivery system that lacks a community-based primary care presence, particularly in rural Louisiana. The system also suffers from its growing dependence on state/federal subsidies in the form of DSH payments for financial support in the absence of sufficient numbers of paying patients.

Louisiana charity hospitals compare unfavorably to the trend established by other public hospitals throughout the country. (See Figure 1.) Numbers of uninsured persons have increased dramatically all across the country over the past few years and public hospitals have generally seen an increase in their service levels and revenues. That has not happened in Louisiana, but there may be countervailing forces, which help to account for the charity hospital decline.

First, the facilities are poorly maintained and in some cases understaffed. For example, patients seeking appointments in the fall of 2003 at outpatient clinics at the New Orleans charity hospital were told there would be an 18-month waiting period, which is now reported to be even longer in some cases. This level of inconvenience may have been too much for even the most faithful clients of the charity system. The adage that "treatment delayed is treatment denied" would seem to apply here and would partly explain why the state continues to lead the nation in mortality and morbidity levels for many diseases.

Second, many patients are indeed going elsewhere. The Louisiana Hospital Association estimates that its members (not including LSU hospitals) provided $100 million in uncompensated care last year for the uninsured. If those patients had received care in the charity system, the statistical trends for the system would look more like other U.S. public hospitals.

Third, the system is ill-designed to serve the indigent population in Louisiana, many of whom live outside a reasonable radius from one of the 10 charity hospitals. Persons living in rural areas who are not insured often delay or avoid care altogether, but when they elect to go to a distant charity hospital they typically pass any number of community hospitals, clinics and doctors' offices along the way. Also, lack of transportation for many indigent patients is a problem that makes care less accessible.

Fourth, the current trend in health care nationwide is to bring routine primary care to the patient as a cost-effective means of early diagnosis and treatment. Examples of that trend in Louisiana's public health care delivery system include the expansion of school-based health centers, community health clinics and rural health clinics. Another example is increasing Medicaid coverage to more than 300,000 children through a LaCHIP outreach program, then linking them to local primary care physicians through CommunityCARE. The charity hospital system, on the other hand, has adhered to the same flawed premise of "let the patients come to us" on which it was founded many decades ago.

REFORM EFFORTS

In the year prior to hurricanes Katrina and Rita, the Governor's Health Care Reform Panel developed a number of initiatives to reform Louisiana's health system, including a federal waiver for a pilot project to expand coverage for the uninsured. A federal HIFA (Health Insurance and Flexibility Act) waiver application was submitted in 2003 and again in 2005, but approval has not yet been issued. The federal government has approved, however, a time-limited use of DSH funds for private hospitals, clinics and physicians related to uncompensated care incurred during the post-hurricane period ending January 2006.

In each case, the proposal would use a portion of disproportionate share hospital funds to provide statewide coverage for a segment of the low-income uninsured population and would have provided incentives for small businesses to maintain or expand coverage for employees. The 2003 proposal relied primarily on private sector resources augmented by the public hospital safety net.

MEDICAL EDUCATION FINANCING

Under the current organizational structure in Louisiana, graduate medical education is inextricably entwined with the charity hospital system. Significant funding for the LSU Medical School and its training sites at charity hospitals (excluding Huey P. Long Hospital, which is used for training Tulane residents) is provided

through the Medicaid disproportionate share program. A major source of funding for graduate medical education in most states is the Medicare program. Medicare revenues in Louisiana charity hospitals amount to only 9%, compared to 19% for public hospitals in other states. This low level of Medicare revenues means that Louisiana forfeits significant federal dollars available for graduate medical education.

The charity hospital system is organized to give high priority to the needs of the medical schools. Furthermore, uninsured patients are captive to a system that provides only limited points of access to medical care in the form of 10 hospitals. This emphasis on expensive tertiary care and medical education overlooks the need for convenient access to inexpensive medical care in local clinics and doctors' offices. For the past five years the federal government has encouraged states to apply for waivers that would enable them to shift federal dollars away from hospital care and toward primary and preventive care. Thus far, Louisiana has not been able to take advantage of this opportunity.

Louisiana ranks 24th in total population among the 50 states, but 12th in numbers of physicians it educates. Just prior to Katrina in July 2005, the state reported 1,787 residents in training or approximately 40 residents per 100,000 population. This is significantly higher than Florida (17.5 per 100,000), Mississippi (18), Georgia (23) Alabama (25) and Texas (29). It is unclear if Louisiana retains most of these physicians or if they move to other states to practice medicine. It is clear, however, that nearly all that remain in the state choose to practice in population centers, thereby contributing to the disparity in numbers of physicians practicing in urban vs. rural areas that has existed for decades.

PROPOSED SOLUTIONS

At least two national consulting firms (RAND and The Lewin Group) have studied the post-Katrina situation in the New Orleans area and have outlined options for the state to consider in designing a new health care delivery system. Based on their knowledge of hospital closures elsewhere and how communities and states dealt with those situations, both firms have offered valuable insight into how Louisiana might deal with its own challenges. While the New Orleans disaster is unprecedented in its severity, there are nevertheless some templates that can be applied. Selected comments from their studies are shown on page 15.

Price Waterhouse Coopers is assisting Governor Kathleen Blanco's Louisiana Recovery Authority in its deliberations and is expected to release a health care recovery plan soon. The Louisiana Public Health Institute has been working with the Bring New Orleans Back Committee (BNOB) commissioned by Mayor Ray Nagin. BNOB's Health and Social Service Committee has released its final report, and portions of it are highlighted herein.

Governor Blanco and LSU announced on February 22 that an agreement between the Veteran's Administration (VA) and the Health Care Services Division (HCSD) was being negotiated. Preliminary information about the agreement indicates that HCSD and VA will each build new hospitals in close proximity and will share certain administrative and support functions that will be housed in a common building that will connect the two hospitals. No details are available concerning the number of beds to be housed or estimated costs of the HCSD hospital. PAR will cover these developments in a later policy brief and will make specific recommendations when details are made public.

The most far-reaching health coverage proposal comes from the Louisiana State Medical Society and is called Health Access Louisiana. The proposal would create a statewide system of personal and portable health insurance available to all who live or work in Louisiana. Subsidies would be available to help purchase coverage for low-income persons using existing DSH funds in the charity hospital system. Statewide adoption of this proposal would completely transform the way public health care is financed and delivered in Louisiana.

PRIMARY AND PREVENTIVE CARE

The most prominent concerns about the health care delivery system, whether in Louisiana or elsewhere, relate to access, cost and quality. Rapidly escalating costs and insurance premiums are making health coverage unaffordable for more and more people. The ballooning health care budgets of small and large businesses, cities and states and the federal government threaten fiscal solvency and spending priorities other than health care. Despite the high level of spending on health care, quality continues to be an ongoing problem and medical errors continue to plague the practice of medicine.

Almost everyone agrees, however, that there is a simple strategy that can reduce costs (or at least reduce cost increases) while improving quality: provide access to primary and preventive care for more of the population in order to detect and treat disease early to avoid costly medical procedures and hospitalizations and help maintain good health. Implementing this simple strategy for vulnerable populations, however, has been an elusive goal throughout the nation. In Louisiana, for example, a fondness for institutions and time-honored traditions has encouraged the citizenry to think of the charity hospital system as a provider of all aspects of medical care, including primary care services. One can visit any charity hospital ER and notice that most of the visitors are there for non-emergency care. Indigent

patients have come to view the ER as the place to go to see a primary care physician.

It is not surprising, therefore, that Louisiana ranks in the top ten states in ER visits per capita and is one of the states with the worst access to primary care. (See Table 4.) A recent series of essays in *Boston Review* on health care reform noted that Louisiana was one of the two worst states in the country in terms of primary care access, because only one of every three people have access to a regular primary care provider. Barbara Starfield, professor of health policy at Johns Hopkins, described some of the benefits of primary care as follows:

> "A nationally representative survey showed that adults who reported having a primary-care physician rather than a specialist as their regular source of care had lower subsequent five-year mortality rates, regardless of their initial health or various demographic characteristics. Furthermore, areas with higher ratios of primary-care physicians to population had much lower total health-care costs than other areas, possibly because of the preventive care and lower hospitalization rates that accompany good primary care."

According to a 2001 study by the American Medical Association, an average physician's office visit costs $60 compared to $383 for the average visit to an emergency room. There are more than 11 million visits annually to emergency rooms for non-emergency care. Unnecessary ER visits waste billions of dollars and delay emergency care for those who really need it. Even hospital outpatient clinic costs are significantly higher than a freestanding clinic or physician's office.

However, clinics and doctor's offices are not available to most of the uninsured population. The only option for many Louisiana citizens is to go to one of 10 charity

Table 4. Accessibility and Cost: Primary Care vs. Hospital Care

	United States	Louisiana	Louisiana Rank in U.S.
Public & private hospital services and spending (KFF State Health **Facts)**			
Emergency room visits per 1,000 population 2004	383	548	4
Utilization trend 1999-2004	+4.7%	+9.8%	
Outpatient visits per 1,000 population 2004	1,946	2,303	16
Utilization trend 1999-2004	+7.1 %	+5.8 %	
Inpatient hospital days per 1,000 population 2004	673	856	9
Utilization trend 1999-2004	-4.4 %	+7.8 %	
Hospital ownership (Kaiser Family Foundation State Health Facts)			
Percentage of total hospital beds per 1,000 population 2004	2.8	3.8	9
State/local ownership – percent of total 2004	15.8%	30.6%	6
Not-for-profit 2004 – percent of total 2004	70.3%	39.0%	47
For profit 2004 – percent of total 2004	13.9%	30.4%	6
State/local spending on hospital vs. non-hospital care (Morgan Quitno 2006)			
Spending on hospital care per capita 2004	$303	$685	3
Percent of total spending	5.0%	12.6%	2
Spending on non-hospital care per capita 2004	$205	$124	40
Percent of total spending	3.4%	2.3%	36
Ratio of spending on hospital care to non-hospital care 2004	1.5:1	5.5:1	
Federally Qualified Health Centers (Kaiser State Health Facts)			
Total FQHCs in 2004	914	17	37
Service delivery sites 2004	5502	44	37
Patients served 2004	13,127,811	101,278	32
Patients per 1,000 population 2004	45.2	22.9	
Physicians (Kaiser Family Foundation State Health Facts)			
Nonfederal physicians per 1,000 population 2004	821,911	11,820	24
Nonfederal primary care physicians as % of total physicians 2004	40%	38%	45

hospitals, which are often miles from the individual needing care and frequently crowded — factors that act as deterrents to seeking care. When medical care is delayed, conditions may worsen and costs may increase.

Unfortunately, Louisiana data for the period 1999-2004 show that state trends are running counter to the rest of the nation (see Table 4). Utilization of relatively low-cost outpatient visits are increasing in Louisiana at lower rates than the national average, while high-cost inpatient hospital care and emergency room visits are growing at roughly twice the national average. This high-cost model of health care delivery consumes dollars that could otherwide be used to expand coverage or improve access to primary care for the uninsured.

A January 2006 report by the American College of Physicians indicates primary care in the United States is in danger of collapse, because the number of physicians choosing to go into primary care is declining. The problem may be even more acute in Louisiana. The state ranks 45th in the country in the percentage of primary care physicians, though it ranks 23rd in physicians of all types per 1,000 population, indicating an imbalance of primary care and specialty physicians.

Numerous studies have shown that health systems with high ratios of primary care physicians tend to have better health outcomes and lower costs. It makes sense, therefore, to ensure that incentives are in place to attract and retain primary care physicians.

Louisiana provides proof of the low cost, high performance correlation by being at the opposite end of the spectrum. With the worst health performance in the country and above-average costs, the state is overdue for a system makeover. Changing the focus from high-cost hospital and specialty care to primary and preventive care can achieve better health outcomes while reducing the rate of spending increases.

STRATEGIES FOR REFORM

In addition to coverage options such as HIFA waivers (see "Reform Efforts," page 7), there are other ways to improve access to care for the uninsured. One important option has had only limited success. Community Health Clinics, or Federally Qualified Health Centers (FQHCs), are intended to provide medical care to the uninsured population, as well as to those with private insurance, Medicare and Medicaid. A full menu of services in addition to primary medical care is provided, including mental health and dental services. A federal grant is provided each year to assist in providing services for indigents.

Historically, there have been substantial barriers to expanding these clinics throughout the state so that people will have convenient health care nearby. Table 5 shows that Louisiana has only 44 community health center sites while Mississippi, with 40% less population, has 144 sites. West Virginia, with 60% less population, has 132 sites. Factors that may account for the low rate of clinics in Louisiana are the cumbersome federal application process, the general reluctance of existing providers to tolerate new competition and the failure of policymakers to make this a priority until recently.

Another means of delivering primary care is through a Rural Health Clinic. These entities are similar to an FQHC, but there is no mandate to cover the uninsured, nor is there a federal grant for that purpose. Nevertheless, they can be useful in extending access to care throughout rural areas. Louisiana has 56 RHCs, compared to 63 for West Virginia and 137 for Mississippi.

Until recently, the Louisiana Medicaid program lacked a structured means of ensuring that most of its enrollees had access to primary care and utilized it to the fullest. In 2001 a statewide, 24-month phase-in of the CommunityCARE program began with the goal of ensuring that Medicaid recipients had access to a "medical home" with a primary care physician (PCP) that would act as a gatekeeper for use of specialty services, hospital care and ER visits. In part, this was also intended to put an end to "doctor shopping," so that a single PCP would be available to the patient, thereby ensuring continuity of care. Today 700,000 Medicaid patients, mostly children, are enrolled in CommunityCARE. An independent audit in 2003 showed that the program would save $150 million annually starting in 2004 by reducing unnecessary ER visits, specialty care and hospital visits.

In the post-Katrina environment, the need for primary and preventive care is even more essential. It provides a structured approach to early disease detection and treatment and places a strong emphasis on maintaining good health. With the safety net in disarray in the wake of Katrina, a more decentralized health care system that relies less on hospital care makes sense. Using existing private hospital capacity for inpatient care and emergency services would take advantage of resources that are already built and in operation.

Table 5. Federally Qualified Health Centers in Comparable Southern States

	Sites	Patients	Patients per 1,000 population
MS	144	310,807	109
WV	132	270,775	152
AR	56	104,889	39
LA	44	101,278	23

SOURCE: Kaiser State Health Facts, 2004 data

Equally important, using community health clinics and private physicians would allow a cost-effective means of expanding primary and preventive care to the low-income population.

LONG-TERM CARE SYSTEM

Nowhere is Louisiana's institutional bias more evident than in the systems of care for the elderly and for persons with disabilities. Louisiana currently has over 300 nursing homes and 37,500 nursing home beds, making it the state with the highest rate of nursing home beds in the nation and the highest rate of residents receiving nursing home care. But it also has one of the worst occupancy rates in the nation, leaving 25 percent or 9,000 beds empty. Despite small gains in recent years, Louisiana lags well behind the national average in moving to a delivery system that will provide a continuum of institutional and in-home services for those who need long-term care.

The picture is somewhat different when looking at the choices available for persons with developmental disabilities. Although more progress has been made in providing non-institutional options, there remains a waiting list estimated at over 10,000 persons who do not wish to be institutionalized and have asked for a community-based alternative. Louisiana has one of the most extensive systems of state-operated developmental centers in the country, housing some 1,500 residents. In addition, private residential care for persons with developmental disabilities is among the largest in the nation with over 5,000 residents. Most other states have achieved a better balance between institutional and non-institutional care for both the elderly and for persons with disabilities.

Louisiana will spend in 2006 nearly $1.4 billion, about 28% of all Medicaid spending, on long-term care services for the elderly and persons with disabilities. A breakdown of the $1.4 billion shows that 27% of those funds go toward home and community-based services and 72% toward institutional care. This represents an improvement compared to 2004 when 78% of long-term care dollars was spent on institutional care, ranking Louisiana 5th in the nation for institutional spending (see Table 6). However, the proportion of home and community-based spending for each system of care shows substantial differences. In 2006, about 17% of long-term care funds for the elderly are spent on home and community-based services, compared to 40% for persons with developmental disabilities.

CARE FOR THE ELDERLY AND PERSONS WITH PHYSICAL DISABILITIES

Louisiana depends heavily on nursing homes to provide long-term care services, while other states have moved steadily toward home and community-based services over the past two decades. Although other options exist, such as assisted living facilities, Home and Community-Based Services (HCBS) and home health care, Louisiana still relies heavily on nursing homes to provide long-term care services to the elderly and persons with disabilities.

In the Medicaid program, nursing home expenditures account for $630 million in the current fiscal year and until recently consumed the greatest portion of total Medicaid spending in Louisiana. Per capita, Louisiana has more nursing home beds and residents and some of the lowest occupancy rates of any state in the nation, indicating excess capacity and use. (See Table 6.)

Louisiana Legislative Auditor Performance Audit Report: Department of Health and Hospitals' Administration of Long-Term Care Services Audit Results (March 2005)

ACCESS TO LONG-TERM CARE SERVICES

- A uniform assessment process would help DHH ensure that individuals receive appropriate, cost-effective placements in long-term care settings. Approximately 5,945 individuals residing in nursing facilities and ICFs/MR* could potentially be served in less costly settings, resulting in a cost difference of between approximately $35 million and $53 million.
- DHH's definition of nursing facility level of care is too broad.
- Inequitable funding has resulted in long waiting lists for home and community-based services. Individuals on the waiting list for the New Opportunities Waiver (NOW)** on June 9, 2004, will have to wait over nine years for services. However, institutional facilities with low occupancy and/or utilization have generally received funding increases each year.
- DHH's Facility Need Review Program*** should be modified or eliminated because it restricts market entry and creates an advantage for existing nursing facility and ICF/MR providers.

MAJOR COSTS OF LONG-TERM CARE SERVICES

- Some provisions of the private nursing facility reimbursement system appear generous as compared to other states. Louisiana could have potentially saved over $44 million in state fiscal year 2005 if it had adopted provisions similar to other states.
- The NOW waiver needs a cost control mechanism. The average annual direct cost per person for the waiver in state fiscal year 2004 was only $251 less than the average cost of private ICF/MR* care.

QUALITY OF LONG-TERM CARE SERVICES

- DHH quality assurance processes could be improved by increasing the minimum staffing requirement from 1.5 to 3.0 hours per resident per day in nursing facilities; assigning investigation priorities for nursing facility complaints in a timely manner; consistently imposing penalties for repeat deficiencies in ICFs/MR*; and removing or increasing the cap on civil money penalties.
- The Bureau of Community Supports and Services' (BCSS) oversight of regulatory processes is insufficient to ensure that waiver recipients receive quality services.

*ICF-MR is a designation for institutional services for persons with developmental disabilities.
**NOW is a federally-approved program that provides home and community-based services for eligible individuals.
***Facility Need Review assesses need for new institutional long-term care services.

OVERCAPACITY, UNDERUTILIZATION OF NURSING HOME BEDS

Louisiana has perpetuated an institutional system to care for the elderly, and it has not progressed toward a diversified system of care like those found in most other states. Utilization of nursing home services has been on the decline for the past 15 years, and Louisiana now has the 39th worst occupancy rate in the country. (See Table 6.) Despite having 9,000 or more empty beds, the state still ranks first in the number of nursing home residents per 1,000 persons 85 and older, 50 percent above the national average. Operating nursing homes below optimum capacity is inefficient and leads to higher subsidies to maintain those homes in operation.

Nursing home budgets continue to grow, despite a downward trend in demand for nursing home care. Although occupancy rates are declining, the Medicaid private nursing home budget was increased by almost $90 million (16%) during the 2004 legislative session to a total of $647 million.

The nursing home industry took steps in 2003 to reduce excess capacity through a program that temporarily retires or "banks" beds until they are needed in coming years. Industry representatives indicate that some progress has been made over the past two years toward reducing empty beds through acquisition and closure of low-occupancy homes. Ownership of those beds, however, is retained so that they can be reopened if it is determined in the future that demand exists.

Many patients and their families have begun to view nursing home care as a last resort, rather than a first choice. Choosing institutional care often means giving up personal assets and independence. Receiving care in a community-based environment, preferably in one's own home, is now the option that most people would select if it were available. In Louisiana that option is not as accessible as in most states, although some improvement has been shown over the past two years.

Recent progress toward the goal of balancing institutional and non-institutional care for the elderly can be attributed to the Barthelemy lawsuit which was settled in 2001. The suit was a class action on behalf of Louisiana plaintiffs seeking home and community-based alternatives to institutional care in nursing homes. The terms of the settlement agreement call for the state to

Table 6. Louisiana's Long-Term Care System

	U.S.	LA	LA Rank
Medicaid spending for long-term care*			
Total spending, 2004	$89.3 billion	$1.3 billion	21
Total spending per capita, 2004	$304	$289	23
Total spending as % of Medicaid spending, 2004	31.6%	25.7%	41
Percentage of total spending for institutional care, 2004	64.5%	77.6%	5
Services for elderly; persons with physical disabilities*			
Nursing home spending, 2004	$46.5 billion	$596.5 million	23
Nursing home spending per state resident, 2004 (c)	$160.19	$135.26	n/a
Nursing home residents, 2003	1,451,672	29,151	18
Nursing home residents per 1,000 age 85 and older, 2003	308	470	1
Home & community-based services (HCBS) spending, 2002	$3.5 billion	$7.1 million	44
HCBS spending per state resident, 2002 (c)	$12.12	$1.62	n/a
HCBS recipients, 2002	487,877	1,098	45
HCBS recipients per 100,000, 2002 (c)	168.1	24.0	n/a
Services for persons with developmental disabilities**			
Residential facility (ICF-MR)****** spending, 2004	$11.9 billion	$419.2 million	9
Facility spending per state resident, 2004	$41	$93	3
Facility residents, 2004	104,526	5,442	6
Facility residents per 100,000, 2004	35.6	120.5	1
HCBS spending, 2004	$15.5 billion	$210.1 million	27
HCBS spending per state resident, 2004	$53	$47	30
HCBS recipients, 2004	424,855	5,199	26
HCBS recipients per 100,000, 2004	144.7	115.1	34

** Kaiser Commission on Medicaid and the Uninsured, "Long-term Care: Understanding Medicaid's Role for the Elderly and Uninsured," November 2005. **Morgan Quitno, "Health Care State Rankings 2006," March 2005; Kaiser Family Foundation, State Health Facts. ***Research and Training Center on Community Living, University of Minnesota, "Residential Services for Persons With Developmental Disabilities: Status and Trends Through 2004," July 2005. ****ICF-MR refers to intermediate care facilities for persons with mental retardation/developmental disabilities. (c) = calculated by PAR using Morgan Quitno or Kaiser data*

expand a number of in-home services and add one not previously offered, personal care services to assist with daily living chores that cannot be performed by the recipient.

Many states, including Louisiana, have begun to experiment with innovative programs such as PACE (Program of All-inclusive Care for the Elderly) that provide a complete continuum of care including hospital, nursing home and in-home and community-based services in return for a rate per person that covers all expenses. The PACE provider negotiates the single all-inclusive rate with the Medicaid agency and is required to supply all services needed by the patient. In Louisiana, this pilot program has not been expanded beyond New Orleans, but may prove to be a promising reform option.

NURSING HOME QUALITY AND SAFETY

Quality of care has improved in nursing homes since 2000. To conform to more stringent federal standards, the state randomized the nursing home inspection process and assigned inspectors to a wider area to assure they did not limit their focus to only a few homes. Performance data generated by the federal government shows that Louisiana had modest or significant improvement relative to national averages in 16 of 24 quality indicators between 2000 and 2004.

Yet, quality remains an issue. A March 2005 series in *The Times-Picayune* pointed out a number of incidents of neglect and abuse that caused patient deaths. It is evident that the improvements already made have not been sufficient to guarantee a high level of patient safety and quality of care throughout the industry.

In 2005, the Legislative Auditor's Office released a report (see the summary on page 11) on nursing home care that made a number of detailed and very specific recommendations regarding changing long-term care for the elderly to provide more in-home and community-based services, as well as to revise current practices in the oversight and regulation of nursing home care. To date, most of those recommendations have not been implemented.

An issue that surfaced during the hurricanes of 2005 involved evacuation of nursing homes. A total of 14 nursing homes in the Greater New Orleans area remain closed eight months after the Katrina disaster. The fact that some 70 elderly nursing home residents died as a result of the storm has attracted widespread attention to the inadequacy of planning and implementation of evacuations. In some cases nursing homes declined to evacuate or could not follow unworkable plans. Redesign of how plans are confected, reviewed and implemented will be the subject of legislation during the 2006 regular session of the Legislature.

CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Steady progress has been made in achieving a balance between institutional and community-based care for persons with developmental disabilities.

From the perspective of state policymakers this shift shows progress, but from the perspective of the many wait-listed persons with disabilities who do not wish to be institutionalized, nothing much is happening. The waiting list for the New Opportunities Waiver (NOW), which is the primary vehicle for in-home supports and services, includes more than 10,000 persons who will wait for an average of nine years to receive services. Advocacy groups indicate waiting periods of as much as 14 years.

Advocates for persons with disabilities are calling for closure of the state's network of nine developmental centers. They argue that financial resources should be aligned with demand, and most people prefer in-home care. Whereas almost 4,600 people receive services through the NOW waiver at a current year cost of $250 million, nine developmental centers serve just 1,500 residents at a cost of over $200 million.

Advocates also note that Louisiana serves twice as many people in developmental centers as the national average. Further, Louisiana is one of only 12 states that have not closed any of their centers. Closure of similar institutions has proceeded nationwide over the past two decades as the demand for in-home care increased. According to information compiled by the Louisiana Developmental Disabilities Council, since 1960 a total of 171 developmental centers were closed in 38 states. Nine of those states closed all centers and 14 states closed more than half.

Louisiana has been successful in reducing the population of its centers from well over 3,000 residents in the 1980s to just over 1,500 today. In 2003 the state initiated a five-year plan to reduce the developmental center populations by offering transition to community placements on a strictly voluntary basis.

Yet, Louisiana's public and private system of residential care is one of the most extensive in the country. It includes the nine centers serving 1,500 persons, plus a private system funded almost exclusively by Medicaid that comprises 450 large and small facilities and houses a total of nearly 5,500 persons.

In 1996, only $40 million was spent on non-institutional care for this population compared with $210 million by 2004. Rapid growth has continued and total spending now stands at more than $250 million in the current fiscal year.

A concern expressed in the 2005 Legislative Auditor's report on long-term care is rapid increases in costs of community-based programs such as the New Opportunity Waiver. The Executive Budget for 2006-07 calls for $265 million for NOW with 4,642 "slots" (placements for qualifying individuals). The same program spent $125 million in 2000-01 for 4,251 slots. Clearly, program spending is growing more rapidly than numbers of persons served, and the Legislative Auditor recommends development of a cost-control mechanism to slow down the rate of spending increases.

Ideally, home and community-based services should benefit from the savings realized in any downsizing or closure of institutions. Maximizing the use of those savings to help move people off the waiting list and into services will require fiscal discipline to keep average costs as low as possible.

REDESIGNING LONG-TERM CARE

The challenge for Louisiana as it attempts to redesign its long-term care system is to improve quality of services, assure patient safety and expand choice of non-institutional services, while at the same time trying to reign in cost increases. The state cannot afford to continue to operate its vast institutional care system and concurrently expand the in-home services that many people prefer. Encouraging and offering incentives for institutional providers to diversify into community-based services is one of many approaches to this problem.

Other states have found ways to successfully balance institutional, in-home and community-based care so that a broad continuum of services is available to meet a variety of needs, depending on individual capabilities and preferences.

CONCLUSION

This overview of Louisiana health care has described the most serious and long-standing shortcomings of the state's medical care delivery system. Hurricanes Katrina and Rita did not cause those problems but made them much more apparent. A bias in favor of expensive institutional care at the expense of low-cost primary and preventive care has shortchanged Louisiana of convenient access to doctors and clinics that can provide diagnosis and treatment to prevent or cure illness early, maintain health and prolong life. The rapidly mounting expense of operating this institutional system has been the major ongoing fiscal problem that the state has had to face. Yet, despite decades of excessive spending on health care, the health status of Louisiana citizens remains the worst in the country.

Many important priorities of state and local government are unfunded or poorly funded because of the need to finance health care at ever higher levels. Rather than curb its appetite for more and more dollars for health care, the state has become overly reliant on what has been viewed in the past as a nearly infinite supply of money to pay the bills — the federal treasury. Although there has been an influx of federal funds to assist with hurricane recovery, the state should not rely on this windfall to continue.

The list of policy goals identified in this report can effectively lift Louisiana off the bottom if they are adopted as part of a long-term health strategy.

- *Promote delivery of primary care to prevent disease and maintain health*
- *Utilize available private sector experience and capacity, rather than recreating and rebuilding additional capacity in the public sector*
- *Establish centers of excellence in patient care, medical education and research through public/private partnerships*
- *Provide choice for indigent patients with new ways to finance and deliver services*
- *Promote home and community-based alternatives to institutional care for elderly and developmentally disabled citizens*
- *Make health care information transparent and user-friendly to allow patients to make informed choices*
- *Establish electronic medical records and other technologies to reduce costs, improve administration of programs and reduce medical errors*
- *Reward service providers that deliver high quality services or meet key performance goals*

Louisiana expects its health care system to become stronger and less vulnerable as it is rebuilt after hurricanes Katrina and Rita. This will be accomplished by making health care more accessible and more affordable. Recreating the expensive and inefficient institutional systems of the past will accomplish nothing.

In future policy briefs, PAR will focus on specific areas and make recommendations for system improvement in each case. These briefs will cover several topic areas, including the need to expand primary and preventive health care, the challenge of providing for the uninsured, long-term care for the elderly and persons with disabilities and state Medicaid spending.

Guidance for Louisiana Health System Redesign and Rebuilding

Selected recommendations and comments from state and local commissions, provider associations and independent consultants

State and local commissions and national consulting firms have studied Louisiana's health care system and the challenges and opportunities that exist in the post-Katrina/Rita environment. Below are selected recommendations and comments from these groups.

Louisiana Hospital Association www.lhaonline.org
The Lewin Group www.lewin.com
State hospitals/long-term planning needs:

- *Reliable demographic and financial projections to determine most appropriate use of public investment.*
- *No public funding to rebuild hospital infrastructure requiring substantial on-going state and federal subsidies.*
- *Focus on forward-looking models and programs that allow community hospitals and physicians access to federal and state funds currently monopolized by charity hospital system. ("Dollars follow the patient.")*
- *Emphasize regional public/private partnerships, reliable funding and community-based primary care and mental health services.*

Graduate Medical Education (GME):

- *Stabilize current GME programs for short term, but "right-size" and/or relocate future programs based on population shifts.*
- *Encourage partnerships between medical schools and hospitals that leverage Medicare utilization and GME funding.*

Primary/Preventive Care:

- *Support deployment of LSU and Tulane faculty and residents, as well as primary care physicians to provide outpatient, community-based primary and preventive care to uninsured patients statewide.*
- *Secure immediate federal resources to develop community-based primary care and mental health clinics.*
- *Explore public/private partnerships utilizing local and regional provider networks to ensure patient access to primary care.*

RAND Health www.rand.org
Disadvantages of rebuilding a charity hospital to replace the Medical Center of Louisiana at New Orleans New Orleans (MCLNO):

- Financing**.** *The MCLNO financing structure was unstable; rebuilding alone would not solve this issue.*
- Patient mix**.** *Rebuilding Charity Hospital as a modern facility would not allow MCLNO to attract the mix of patients that would enhance the hospital's long-term financial stability. Private, for-profit, urban acute care hospitals are more likely to offer profitable services that attract insured patients.*
- Quality**.** *Poor quality of care and medical errors are more common in financially distressed hospitals. If MCLNO is rebuilt without means to assure financial stability, quality of care will not meet expectations.*
- Uncertain demand for services. *Predicting health care demand in post-Katrina New Orleans will be difficult due to population changes. In uncertain times, investing in bricks and mortar solutions risks creating too little supply, resulting in unmet needs among poor and underserved, or oversupply, resulting in high costs, inefficiency, unnecessary medical procedures and troubled medical education.*
- Time. *Considerable time would be required to plan and build a new public hospital. During a rebuilding period, many residents would find alternative systems that provide care, as has been the case in other cities that experienced a similar rebuilding cycle.*

Bring New Orleans Back Commission www.bringneworleansback.org
Louisiana Public Health Institute www.lphi.org
Recommendations for New Orleans health system reform:

- *Prepare hospitals, nursing homes, other providers for future disasters. Include social services to ensure all people are reached.*
- *Link neighborhood primary care centers to hospitals and change payment models to ensure access to care.*
- *Shift focus from institutional care to ambulatory care, wellness and preventive medicine, health promotion and chronic disease prevention.*
- *Maintain a university teaching hospital in New Orleans.*
- *Implement electronic medical records systems.*
- *Focus on environmental health.*
- *Create area-wide health and human services collaboratives.*
- *Initiate demonstration project for universal coverage.*
- *Establish adequate funding to initiate and sustain primary and neighborhood-level health care for New Orleans area.*

Governor's Health Care Reform Panel www.dhh.louisiana.gov
Providing Care for the Uninsured:

- *By July 1, 2006, establish 100% federal financing to provide for Katrina evacuees under 200% of federal poverty level: (1) health coverage with reduced benefit package or (2) a premium assistance program for those with access to employer sponsored insurance.*
- *By January 1, 2007, transition to 80% federal funding with a public MCO (a public managed care organization) that utilizes the safety net system and includes coverage for adults under 200% of federal poverty level. Continue premium assistance.*
- *By July 1, 2007, restore full state financial participation in Medicaid program with 30% state and 70% federal match.*

Reforming the Long-Term Care System:

- *Implement pre-admission nursing home level of care determination for Medicaid-funded supports and services.*
- *Implement single point-of-entry systems for (1) aging and adult-onset disabilities and (2) developmental disabilities.*
- *Implement needs assessment for persons with developmental disabilities.*
- *Expand consumer direction to allow recipients more control over amount and scheduling of services needed.*
- *Downsize public and private institutions for persons with developmental disabilities.*

Maximizing use of Health Information Technology:

- *Continue development of Louisiana Comprehensive Access Record Exchange (LaCARE), a comprehensive network to provide patient information, including medication allergies, medications a person is taking and medical conditions for which a person is being treated.*

Louisiana Recovery Authority www.lra.louisiana.gov
Kaiser Family Foundation www.kff.org
Goals to expand coverage and access to health care:

- *Strengthening the local safety net: Focus on building a coordinated system of care through a rebuilt but smaller public hospital in New Orleans.*
- *Building on Medicaid: Use options and waivers to work toward covering all low-income Louisianans with income below 200 percent of poverty; expand coverage through a managed care organization to improve coordination and quality of care.*
- *Expanding options for employers and workers: Create a subsidized, private group insurance option for low-wage workers and employers.*

The Urban Institute www.urban.org
Next steps for rebuilding New Orleans health system for the low-income uninsured population:

- *Broad coverage expansions financed by federal and/or state funds appear unlikely given the current fiscal situation.*
- *One alternative is to redesign the safety net around a smaller charity hospital repaired or rebuilt with disaster relief funds.*
- *The new safety net could be based on a continuum of care for low-income residents, rather than continue the current hospital-centric system. Ambulatory care would be substituted for costly episodic care in hospitals, especially emergency rooms. This would increase efficiency and quality while reducing costs.*
- *Federal approval should be sought to direct Medicaid disproportionate share dollars away from public hospitals in order to support this more efficient system of care.*
- *Additional federally qualified health centers would be one way to attract federal dollars while expanding non-hospital clinic services.*

HEALTH CARE TERMINOLOGY

CommunityCARE CommunityCARE is a managed care program that assures access to primary care services for nearly 700,000 Medicaid eligibles. The program links patients to a "medical home" with a primary care physician (PCP) who provides continuity and coordination of care and authorizes specialty and hospital services, including ER visits.

Disproportionate Share Hospital payments (DSH) DSH payments are made by Medicare or Medicaid to hospitals that treat a disproportionately high number of low-income patients. Louisiana is fifth in the U.S. in DSH spending at $900 million.

Federal Poverty Level (FPL) The FPL was established to help government agencies determine eligibility levels for programs such as Medicaid. The FPL in 2006 for a family of four is $20,000 gross annual income.

Federally Qualified Health Centers (FQHCs) aka Community Health Centers. FQHCs provide outpatient primary and preventive care, and certain dental and mental health services. A federal grant provides for uninsured care.

Graduate Medical Education (GME) Medical education as an intern, resident or fellow after graduating from a medical school.

Health Care Services Division (HCSD) A division of the LSU Health Sciences Center that operates an eight-hospital "safety net" for uninsured persons. The hospitals also serve as training sites for physician education. LSU hospitals at Shreveport and Monroe are not under HCSD.

Health Insurance Flexibility and Accountability Act (HIFA) Waiver HIFA allows states flexibility to increase health care coverage for the uninsured by using existing Medicaid, DSH and CHIP funds. Louisiana awaits approval of a HIFA coverage expansion.

Home and Community-Based Services (HCBS) Waiver Medicaid HCBS programs give states flexibility to design programs that allow eligibles to live in their homes or a community setting, rather than an institution. Examples in Louisiana are the New Opportunities Waiver (NOW) for persons with developmental disabilities and the Elderly and Disabled Adult (EDA) waiver for those who prefer alternatives to nursing home care.

Long-term Care Includes medical, nursing or custodial care designed to help people who have disabilities or chronic care needs. Services may be provided in a person's home, in the community, in nursing homes and other institutions or in assisted living facilities. Most long-term care in Louisiana is financed by Medicaid.

Louisiana Children's Health Insurance Program (LaCHIP) A state-administered program financed by state and federal funds to expand health coverage for uninsured, low-income children with family incomes up to 200% of the federal poverty level ($40,000 for a family of four in 2006).

Medicaid (Title XIX of Social Security Act) Louisiana Medicaid is a $5 billion state-administered program financed jointly with approximately 70% federal and 30% state funds. It provided coverage for more than 900,000 low-income persons in 2005. Subject to federal guidelines, states determine benefits, eligibility, and provider payment rates.

Medicare (Title XVIII of Social Security Act) Medicare is a federal program that provides basic health care and limited long term care for retirees and certain disabled individuals without regard to income level. Beneficiaries pay premiums, deductibles, and coinsurance.

Primary Care Physician (PCP) Primary care physicians provide a broad spectrum of preventive and curative health care, and coordinate specialty or hospital care for patients. Most health insurance plans require patients to have a PCP, typically a doctor in family practice, internal medicine, pediatrics or obstetrics/gynecology.

Program of All-inclusive Care for the Elderly (PACE) PACE programs coordinate and provide preventive, primary, acute and long term care services so older individuals can continue living in the community. Medicare and Medicaid programs pay single all-inclusive rates to cover any expenses incurred for PACE participants, including hospital, nursing home and specialty care. Basic primary care and other services are provided on-site at the PACE center.

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"PAR is an independent voice, offering solutions to critical public issues in Louisiana through accurate, objective research and focusing public attention on those solutions."

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