A New Safety Net

The risk and reward of Louisiana's Charity hospital privatizations

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EXECUTIVE SUMMARY

In the past year, Louisiana's hospital safety net has been reinvented but not discarded. After a sudden reduction in federal health care financing, Louisiana embarked on a new path by privatizing the operations of its state hospitals while continuing to provide medical education managed by its public universities.

Uninsured adults in Louisiana have long relied on government-subsidized care at the state-run "Charity" hospitals. Estimates for 2011 indicate 291,000 to 419,000 uninsured adults in Louisiana were at or below 138 percent of the Federal Poverty Level. There were 93,453 more uninsured adults than there were in 2009. The Charity hospital system in 2011 had 1.76 million outpatient encounters and 63,814 discharges from inpatient care, nearly half for uninsured adults.

If viewed as a step toward better health care for the poor, rather than as a grand solution, the state's reinvention of the safety net can seen positively.

For children, Louisiana has embraced a health insurance coverage model rather than a safety net. From 2003-2011, the percent of uninsured children declined from 11.1 percent to 3.5 percent, translating into 101,162 fewer uninsured children.

The reinvention of the charity hospitals is a significant departure from the former operating system but continues to uphold the state's safety-net approach to providing health care for uninsured adults and the indigent. The new system affects health care institutions in nine regions. For each community, the state has a unique contract with a new operator, which in most cases is a private partner. Each deal is described in Appendix A.

Perhaps the best way to look at the recent changes is not to see them as a single statewide reform, but as a varied collection of reforms among the metro areas. Therefore, the success of the state's initiative will have to be measured by the financial, educational and health care outcomes in each community as well as statewide. Also, partner hospitals and non-partner hospitals will be affected differently by the recent reforms, causing other local impacts.

The new safety net should accomplish worthwhile objectives previously set forth by PAR. The Louisiana State University System now can focus more clearly on its mission of medical education and be less preoccupied with the business of operating hospitals across the state. The new managers, using their private sector hospital management expertise, are expected to perform more efficiently and to modernize the facilities and equipment.

Quality specialty and hospital care appear to be a potential result of the partnerships. The New Orleans and Baton Rouge partners have highlighted early successes, such as reduced wait times in emergency rooms and an increased number of surgeries. This new arrangement will continue to offer disease management and injury care through extensive outpatient services and clinics, which are a critical and often overlooked role of the Charity system.

But for those adults without health insurance who rely on free care at Charity hospitals, the new Charity system still does not make primary and preventive care a high priority. Whatever the advantages of the reinvented safety net, it is still basically a safety net. Urgent care will continue to be a principal avenue of health care service for uninsured adults both at the partnership and non-partner hospitals. Also, the reforms do not emphasize regional and community networks.

The financial structure of the new safety net carries potential rewards as well as risks and uncertainties. The new partnerships have relieved the state of some expenses for renovations and new buildings. Direct government payroll and long-term retirement system obligations have been reduced, though with some mixed fiscal side effects.

Some state and partner costs are being shifted under the new system. These include cost-shifts to the federal government, to non-partner hospitals and to local governments in the form of prisoner care. (See prisoner care analysis on page 23.) Some partners have enhanced their commitments by front-loading their lease payments, but this action also results in a financial boost to the state in the short term at the expense of the longer term. The lease payment system, which uses federal money to reimburse the partners for their sizable lease costs, has not been approved by federal regulators.

Uncertainty has become an unfortunate fact of life for public health care financing, no matter what plan or scenario might be proposed. Still, the considerable uncertainties of the new safety net should be noted: The long-term impact of decreased federal funding for uncompensated care costs could have a major impact on the system's revenue model. A recently created "upper payment limit" mechanism of federal financing, which has supported a number of hospitals in Louisiana, is not an assured revenue source over time. The state's real obligation to cover the partner hospitals' expenses will not be known until some point in the future when the final bills, or cost reports, are completed.

The new safety net might not be financially feasible in later years. Looking ahead and considering the potential risks of the current federal funding streams, the state must evaluate the comparative costs of moving to an insurance model for those adults without coverage rather than a safety-net reimbursement model based heavily on urgent care.

Some communities have had more time than others to examine their new safety nets. For example, the replacement of services previously provided by the state's Earl K. Long Hospital in Baton Rouge has been debated publicly for years and much is known about that new arrangement. Overall, however, the track record for the state's and the LSU System's handling of the reform has been a reflection of an old-style Louisiana approach to government contracting and transparency: Long-term, multi-million dollar decisions were made without a publicly competitive process and with evasions to hand over relevant public documents. A crisis mode of deal making is not a time to set aside open governance.

From here on, the public and the Legislature should demand transparency and accountability in the new operations. The public ought to see clear measures of health and financial outcomes. The new arrangements are quite different from one another, and so we might expect results to vary from region to region.

The state will almost surely have to readapt some of these arrangements as the financial and regulatory environments evolve. The state must remain flexible in the long run and keep under consideration changes that would accommodate a more robust participation of the local communities. If viewed as a step toward a better health care system for the poor, rather than as a grand solution to the problem of Louisiana's large population of uninsured, the state's recent reinvention of the safety net can be seen positively.

INTRODUCTION

Historic change in Louisiana public health care is under way. Louisiana's long-standing approach of providing state-funded and centralized administration of health care to the uninsured and those on Medicaid is undergoing transformation. The state's move away from a university-operated charity hospital system to one of a partnership with private providers is momentous and is under implementation in most areas of the state.

This report will describe the traditional approach Louisiana has taken to health care for the uninsured and contrast it with the new model. Changes in financing, administration and service delivery will be described broadly and the specifics of each local agreement will be explained. This report will highlight key policy aspects of the transition.

The state's move away from a university-operated charity hospital system aligns generally with PAR's prior policy recommendations. PAR's 2007 report on the charity hospital system provided a series of recommendations related to transitioning to a new model of public health care. In that report, PAR outlined the list of challenges the state faced in providing quality and timely medical care through the charity system, including long wait times for appointments, inability to utilize nearby health services, limited availability of current diagnostic equipment and poorly maintained hospitals.

Changes in the public hospital system must also be evaluated by the overall impact on each community's health care infrastructure, including those medical facilities not involved in the new public-private partnerships. The new program's architects describe the transformation as creating a broader statewide safety net that includes the new partners as well as all nonprofit hospitals in Louisiana. As part of receiving a tax-exempt designation, all nonprofit hospitals have a duty to serve the uninsured. While the partner hospitals are under contract with LSU to provide the public purpose, the reform envisions nonprofit hospitals generally sharing in the care of the indigent and uninsured.

A true evaluation of the new system should include assessments of health care outcomes, business efficiencies, education strategy, community impacts and cost, including the financial effects on patients, the institutions and the state. Many believe that even though the charity hospitals were inefficient, the quality of care was higher than is typically described, and so health care outcomes in particular should be monitored under the new system. Because the current reform is only just under way, a full assessment of these factors is not yet possible. However, this report can shed light on how the system has changed and can offer early indications of its progress.

CHAPTER ONE

The Old Charity System

Health care for the indigent and uninsured has long been a struggle for local, state and federal governments. The most common approach in other states for providing care for this population is at the local level, often with nonprofit community hospitals and sometimes with large public institutions such as Cook County Hospital in Chicago. When treating those who cannot pay, local hospitals are reimbursed in part for their uncompensated care costs from local, state and federal funding sources.

Louisiana, however, administers and funds its indigent care at the state level. These state services depend heavily on federal dollars. Louisiana historically is an outlier in caring for the uninsured because it has used a highly centralized, 10-hospital charity system operated by the state government. This system is typically described as the "charity" hospital system.

The charity hospital system can trace its beginnings to 1736 when the first charity hospital opened in New Orleans. New Orleans has seen five subsequent charity hospitals, and public health care is currently being provided by the "Interim LSU Hospital" while a new building is being constructed.

THE LSU ERA

Responsibility for managing the charity hospitals was transferred in 1997 from the Louisiana Health Care Authority to the Louisiana State University System, which also operates the state's only public medical schools. At that time, the operation of the charity system was placed under the jurisdiction of the LSU System Board of Supervisors, although much of the complex financing of the system involved funding streams through the Department of Health and Hospitals. This transfer was touted as a strategic move to combine graduate medical education and public health care.

The state-operated public hospitals in the southern part of the state have been run by the LSU Health Care Services Division (LSU HCSD). The LSU Health Sciences Center in Shreveport has operated the hospital in that city, as well as E. A. Conway Medical Center in Monroe and Huey P. Long Hospital in Pineville. Until the reforms implemented in 2013, the state employed approximately 9,940 people in the charity hospital system.

Louisiana historically is an outlier in caring for the uninsured because it has used a highly centralized, 10-hospital charity system operated by the state government.

The state public hospitals will treat anyone who resides in Louisiana regardless of ability to pay. The system has no local residency requirement and no pre-enrollment process. The services traditionally have included inpatient care, outpatient specialty clinics, OB/GYN services and care for prisoners. (See prisoner care analysis on page 23.) Patients with private insurance can seek care at a charity hospital, although few do.

Louisiana law entitles any resident at or below 200% of the federal poverty level (FPL) to receive free care at the state hospitals and associated specialty clinics. For example, that threshold would amount to $1,915 per month for an individual and $3,925 per month for a family of four. This is a state-created entitlement. Charges are reduced by 40% for those without insurance who earn more than 200% of the poverty level.

An uninsured person with an urgent condition may go to any hospital emergency room, whether in or out of the state-operated system. A private hospital's obligation for treatment of such conditions ends as soon as the uninsured patient is stabilized and the patient is transferred to a state public facility for continued care, if needed. In practice, patients in need of further care are rarely transferred.

THE SAFETY NET

The state public hospital system offers care for acute conditions but provides fewer options for preventive care for the uninsured. Not all of the 10 state public hospitals in Louisiana offer a broad array of services. Many uninsured in Louisiana live far from a state public hospital that offers the specific services needed. These factors lead to an overutilization of expensive emergency care. The uninsured often seek help for health problems in hospital emergency rooms. Most private hospitals receive little or no payment for these emergency services for the uninsured.

Although attention is typically focused on the traditional brick and mortar charity hospitals, an integral aspect of care provided through this system is the outpatient specialty clinics. These clinics do not typically provide preventive care but provide patients with primary and specialized care for complex conditions. Many complex conditions are treated within the LSU clinics and these clinics serve as a critical point of access for high-need Medicaid patients and for the uninsured.

LSU has long lacked a strong primary care base. Its Graduate Medical Education program is tied to specialists who teach at the medical schools. In fact, LSU sees most of its patients in its clinics, not in its hospitals. In 2011, it had 1.76 million outpatient encounters, of which 402,920 occurred in an emergency room, compared with 63,814 discharges from inpatient care.

GRADUATE MEDICAL EDUCATION

LSU's foremost mission in health care is to provide medical education, a role that will be given greater focus under the new privatization plans. The transformation of the public hospitals must be seen in light of this educational goal and not just as a matter of new management. Patients with special medical needs provide a prime opportunity to help train new physicians.

Most of the physicians practicing in Louisiana today were trained in LSU hospitals and clinics. Since 1997, about 69 percent of doctors in Louisiana received their medical school or residency training from LSU. Graduate Medical Education (GME) also generates revenue for the hospitals that are assigned medical residents. Traditionally, Louisiana medical residents were overwhelmingly assigned to LSU hospitals.

In the past, LSU has provided approximately 984 residents to its charity hospitals (Appendix B). Graduate medical slots are highly sought after by many hospitals for multiple reasons, including the government money that follows them. Also, institutions can benefit from the vitality of young residents, who may choose to locate permanently in the community. The placement of residents throughout the state and the training of those physicians in complex medical procedures are a major plus for hospitals and the communities in Louisiana.

ASSESSMENTS OF CHARITY HEALTH CARE

For many years the charity system has confronted significant questions about whether it has been the best health care policy for Louisiana. Among the policy alternatives were recommendations for expanded insurance coverage or redirecting indigent care to private hospitals. One suggestion was for the state to diversify the patient mix across all hospitals, with private hospitals receiving compensation for their uninsured care and charity hospitals attracting paying patients to reduce reliance on government monies.

Any changes in the Louisiana public safety net hospitals will likely have an impact on private hospitals, especially those with emergency care. Private hospitals must treat critically ill uninsured patients and are typically compensated very little, if anything, for this care. Thus, insured patients usually experience higher costs to compensate for the unreimbursed care provided in private hospitals. However, private hospitals in Louisiana historically have enjoyed very low uncompensated care expenses compared to their counterparts across the country because the uninsured were mostly seen in the state public hospital system.

Many prior policy assessments, including those by PAR, concluded that the charity model was neither efficient nor effective in delivering health care in a state with such high levels of uninsured persons.

PAR published a report in 2007 that described Louisiana's charity health care system as "on life support." In general, PAR concluded that the charity model was neither efficient nor effective in delivering health care in a state with such high numbers of uninsured persons.

The challenges faced by the traditional charity system included the fact that Louisiana's uninsured have a separate but unequal health care delivery system that does not attract paying or insured patients. Thus, the charity system was overly reliant on state and federal subsidies. The care provided by the charity hospitals was considered by many to be very good, but the system suffered from poor access to services and long waits for clinic visits.

Many, including PAR, recommended that an ideal replacement safety net would be locally governed and administered. A local system would provide better choices and better accessibility to primary, specialty and hospital care. This change could also bring about an end to the "two-tiered" system of care – one for the insured and the other for the uninsured. The historical "two-systems within a system" detrimentally impacts the quality of health care for all, both the insured and uninsured, in Louisiana primarily because of funding challenges for the uninsured system.

END OF AN ERA

Hurricane Katrina in 2005 set in motion a series of circumstances that affected the state hospital system. The storm damaged "Big Charity" in New Orleans and the building was closed. This heightened the sense that reform of the entire charity system was possible and even imminent. Care was provided by other New Orleans hospitals until an "Interim LSU Hospital" was established to provide indigent care in the region.

Much analysis was conducted in the wake of Katrina, including an in-depth redesign proposed by consultants for the Louisiana Recovery Authority. The state decided to place a new charity teaching hospital next to a Veteran's hospital the federal government was planning to build in New Orleans. Those massive construction projects are now under way. But at the time of its conception the new Charity did not represent a significant departure from LSU's past policy.

Then in the summer of 2012 Congress suddenly made a $523-million reduction to Louisiana's Medicaid funding, the latest in a series of controversial federal funding changes since Katrina. The state applied nearly $329 million of those cuts to the public health care system. The Jindal administration said the cuts would force the LSU hospitals to modernize, become more efficient and partner with private hospital operators.

CHAPTER TWO

The New Charity System

The state has relied on the private sector for many years for various government functions and services, and health care is no exception. For example, the Department of Health and Hospitals and its predecessor agency have used a private partner for processing Medicaid claims since 1977. When the administration announced plans in the summer of 2012 to utilize private partners to address the charity hospital reductions, it was unclear what precisely would be privatized, with whom specifically, and at what cost.

In October 2012, the LSU system announced a reduction plan that included the layoff of 1,500 employees to be implemented in early 2013. The plan called for deep service cuts to charity hospitals and a reduction of inpatient beds, some to as few as 10 beds.

"LSU Health has long been on an unsustainable path that threatens the strength of our medical training programs," Dr. Frank Opelka, LSU System Executive Vice President for Health Care, said in an LSU press release at the time. "Decreasing inpatient volumes and continued isolation from the evolving health care market have resulted in a system in decline. This transformation helps us focus on our core competencies by maximizing public-private partnerships in local communities that will help cover critical services and strengthen our medical education programs."

A CLOSED PROCESS

The process of selecting the public-private partnerships took place largely in private. The state did not use its usual contracting process and did not issue a Request for Proposals. LSU officials said they spoke to nonprofits and for-profits during the deliberations. Communities, stakeholders and legislators were concerned about how public health care would be provided. Efforts by the media to review the records related to the budget cuts and privatization were rebuffed by LSU's legal counsel, which followed the advice of the governor's general counsel, as part of the "deliberative process privilege".

The process of selecting the partners took place largely in private. The state did not use its usual contracting process and did not issue a request for proposals.

On December 10, 2012, three such partnerships were announced: the University Medical Center in Lafayette would be leased to the Lafayette General Medical Center; the Interim LSU Hospital in New Orleans and its successor, the new University Medical Center, would be leased to the Louisiana Children's Hospital; and the Leonard J. Chabert Hospital in Houma would be leased to Ochsner Health System and Terrebonne General Medical Center. Ultimately for Chabert, an intergovernmental transfer of funds to the Medicaid program was arranged in lieu of a lease payment as with the other partners.

Memorandums of Understanding were presented to the LSU Board of Supervisors for approval on December 14, 2012. These agreements specified immediate lease payments from the private partners and said the other financing and operational details would be worked out in the Cooperative Endeavor Agreements, which are the formal contracts between the various state agencies and private partners. The board approved the memorandums unanimously. The legislature, stakeholders and the media asked for more details repeatedly over the next six months about the legal, financial and service delivery mechanisms of the proposed public-private partnerships. The administration appeared before various committees to offer testimony on the transition. More detailed discussions with the proposed partners took place, and the LSU Board later amended the initial memorandums to distinguish them as being only conceptual in nature.

Aside from the Board of Supervisors approval, other approvals needed by government entities to complete the partnerships depended on the specific nature of the agreements. The Legislature must approve the closure of a public hospital. Both Earl K. Long Hospital in Baton Rouge and W. O. Moss Hospital in Lake Charles were slated to be closed. The Attorney General opined that the leasing of the state hospital facilities did not require legislative approval, although the Joint Legislative Committee on the Budget was required to review the Cooperative Endeavor Agreements. The partnership deals required – and received – funding through the 2013-14 state budget. The state Civil Service Commission was required to weigh in on the layoffs of LSU employees, even though many of the state's staff were presumed to be rehired by the new private managers.

A milestone in the release of information to the public was reached in June 2013 when more details about the partnerships were provided to the joint budget committee and the Civil Service Commission, which had demanded a more in-depth analysis demonstrating that layoffs were the more efficient and effective route. The commission ultimately determined that the information provided to them warranted approval of the layoffs. Several of the agreements took effect on June 24, 2013.

THE NEW DEALS: WHO DOES WHAT

To privatize services currently provided directly by the LSU hospital system, at least five entities have entered into each Cooperative Endeavor Agreement: 1) the LSU Board of Supervisors; 2) a new hospital operating entity, which in most cases is a nonprofit, private hospital; 3) the affected LSU hospital and its associated clinics; 4) the Division of Administration; 5) and the Department of Health and Hospitals.

In general, the private hospital partner leases the physical plant and the furniture, fixtures and equipment used by the LSU hospital and its associated clinics. The private hospital partner then assumes responsibility for operation of the LSU hospital and its affiliated clinics. The private partner also

purchases all consumable inventory on hand and commits to support the LSU hospitals' academic, clinical and research missions. In areas where there is not a physical hospital to rent, the partner may be leasing the outpatient clinics or in some cases opening new clinics.

The CEA requires the private partner to fulfill the obligation placed on the LSU hospital system by providing a safety-net system of care and to support medical education. The public purpose is for graduate medical education and to care for the uninsured, high-risk Medicaid patients and public offenders.

Embedded in these agreements is a brief accountable-care services paragraph that focuses the partnerships on support of the LSU clinical data warehouse. The terms of the CEAs differ but all are long-term agreements. One CEA does not require the private partner to provide care to prisoners. Partners do not have to provide obstetrical care or certain gynecological procedures if they conflict with the provider's religious orientation.

THE NEW DEALS: FINANCIAL OBLIGATIONS

The new operating partners will be compensated mainly with the same state and federal dollars that had been supporting the state-run charity hospitals. Adequate funding from the state to the private partner is one of the keys to a sustainable partnership. The CEAs stipulate that if adequate funding is not provided, the private partners may voluntarily withdraw from the agreements. All CEAs have dispute resolution and wind-down clauses in case of cancellation of an agreement.

The Cooperative Endeavor Agreements require the private partner to fulfill the obligation placed on the LSU hospital system by providing a safety-net system of care and to support medical education.

The methodology for the funding appears designed to constrain costs. On the other hand, some agreements, such as in New Orleans, have no caps on state reimbursements, which could allow higher state costs. The Legislative Fiscal Office has provided detailed analyses of these complex agreements. These financial arrangements will require Medicaid State Plan amendments that must receive federal approval from the Centers for Medicare and Medicaid Services, or CMS. The Medicaid State Plan amendments for the Our Lady of the Lake agreement in Baton Rouge were approved by CMS. Four other State Plan amendments are pending federal approval. A decision by the federal government on these State Plan amendments not anticipated before early 2014. Plans for the other deals will be submitted to CMS.

The operating partners will be paying the state for leases of LSU's assets, which were independently evaluated for their fair market value. These facility and equipment rental payments will go into the state general fund. Significantly, a large

portion of these dollars can be recovered by the private partners through the Medicaid reimbursement process. For partners who are guaranteed their costs, they can recover much of their rental lease payment. The administration says this arrangement will not require advance federal approval.

The state's expenditures for fiscal year 2013 to run the entire charity hospital system were approximately $1.37 billion including administrative costs. The administration told the legislature in June 2013 that for fiscal year 2014, approximately $1.05 billion would be spent for support of the nine LSU partnership hospitals, of which about $400 million is state support. By September 2013, additional agreements had been made and PAR computes the 2014 expenditure amount to be approximately $1.09 billion for the nine LSU hospitals affected. LSU will continue to have administrative costs above and beyond that figure. Lallie Kemp Regional Medical Center, which is not being privatized, will remain open and also incur state costs.

The private partners will be paying the state for leases of LSU's assets, with much of that money indirectly going back to the partners.

TRANSPARENCY PROMOTES GOOD PUBLIC POLICY

Public health care is a vital government function, even when provided by a private entity. The public should have open access to government records and meetings regarding this function. A balance can be struck. Patient privacy and proprietary information may be protected while allowing the public and stakeholders access to information that assures accountability for the financial, programmatic and health outcomes of the new hospital system.

Historically, the Louisiana State University System has done a good job of making information available about each of its hospital operations. Information about performance that was public record when these vital healthcare services were provided by publicly owned facilities should continue to be public record under these new agreements.

The Department of Health and Hospitals has provided lists of data for improved service delivery by Our Lady of the Lake in Baton Rouge, where the state-run Earl K. Long Hospital has closed. The information about improved wait times, decreased backlogs and other milestones were encouraging, not just because of the improvements but also because they appeared to demonstrate robust data collection and disclosure on the delivery of services.

More recently, Dr. Frank Opelka of the LSU System has said that LSU, along with the private partners, are in the initial stages of identifying what "meaningful actionable data" should be collected to track and improve patient outcomes. He said the data and benchmarks must be agreed upon, publicly shared and improved.

Performance measures that were public record before the privatizations should continue to be public record under these new agreements.

These are positive signs. It is incumbent upon LSU to make sure these partnerships operate in a manner in which the public can be assured the goals of medical education and safety-net health care are met. The administration's assertion that data about the private partners' operations will be available in cost reports is insufficient. Cost reports are designed for accounting purposes and routinely take years to finalize. More timely public information is needed.

The Legislature has asked for a monthly report from DHH on disbursements to each private partner according to the specific funding sources. This data will provide insight about the amount of care being provided and the funds expended throughout the year.

Another transparency concern is the selection process for partners to run the hospitals. A couple of these deals were years in the works and had been subjected to considerable public debate. But most were conducted in the past year and a half in a closed process. The administration has described its contracting process as engaging in a dialogue with the "natural partner" in each of the communities. There was not a public bid or request for proposals delineating what the state was seeking or details about partner qualifications. While there might have been an internal evaluation of competitive factors, that part of the state's selection process was conducted neither formally nor publicly.

The administration justified the pace and style of the transition as being due to the sudden nature of the federal health care funding reductions and the state's desire to maintain an adequate level of services in the communities where charity hospitals are located. Also, the majority of the partners are long-standing, credible members of their communities. But it is also true that most of the communities have other long-standing, credible potential partners.

CHAPTER THREE

Following the Money

The traditional charity hospital system revenue mix is heavily dependent on DHH's state and federal reimbursements for uncompensated care and Medicaid payments. The "patchwork quilt" of funding for the traditional charity system is complicated but worth a detailed explanation as it is the basis of the new partnerships. Currently, the overall LSU hospital system revenue mix is approximately 46% from uncompensated care dollars, 25% Medicaid, 10% Medicare, 7% state general fund, 7% self-generated and 5% from transfers from other state departments.

This section explains the various funding streams, some long established and some new, and the implications for the partnerships.

MEDICAID PER DIEM PAYMENTS

The Medicaid per diem rate structure has been in place for more than 20 years and serves as the primary source of payment for Medicaid hospital services. Hospitals are paid a daily rate – a per diem – for Medicaid patients. The per diem payments for LSU's hospitals and the new partners should be understood as an advance payment that will be reconciled later against actual costs. Private hospitals in general do not qualify for reimbursement of costs for Medicaid services from DHH. This is a major distinction between the new partner hospitals and the non-partner private hospitals.

Taking into account savings from lower per diem payments and expenditures from other higher per diem payments, Louisiana will spend about $17.5 million more overall in per diem payments across all partners.

Public hospitals, such as LSU's, receive a higher Medicaid per diem rate than a similar size private hospital. Additionally, a facility designated as a "major teaching hospital" receives a higher reimbursement rate. The LSU hospitals will convert to a private, not public, "peer group" rate for Medicaid per diem payments. In most cases the new per diem rate for the partner hospital is lower than LSU's former per diem rate, but not always.

In sum, most of the new partner providers are receiving less in per diem rates than what LSU received, which creates some up-front savings for the state. The state will save about $14 million dollars annually on reduced per diem rates to some partners. However, with the closure of Earl K. Long Hospital in Baton Rouge, the state is making a higher per diem payment to the new partner, Our Lady of the Lake, that amounts to about $3.7 million more annually for inpatient care. The higher per diems for certain partners will cost the state about $31 million annually, by PAR's calculation. Taking both the savings from some lower per diems and expenditures from higher per diems into account, Louisiana will spend about $17.5 million more overall in per diem payments across all partners.

It is important to note that most Louisiana hospitals that treat Medicaid patients have experienced significant cuts to their reimbursement rates since 2009. The lower rates reimbursed for inpatient and outpatient care have resulted in a revenue decline of approximately $533.8 million for hospitals from 2009 to 2013. However, during that same period DHH made additional supplemental payments including LINCCA payments (described below) to hospitals totaling approximately $1.19 billion, for a net gain of about $655 million in revenue. The distribution of these supplemental payments was not uniform, resulting in significant differences in revenue for various hospitals.

The compensation received by the new partners for subsuming LSU's obligation, however, will be similar to what the public LSU hospitals were previously reimbursed by Medicaid. That means the compensation paid to these partners for services under the agreements will be significantly higher than the compensation paid to other non-partner hospitals treating Medicaid patients for the same conditions. Furthermore, the partner hospitals will likely be more protected from future rate reductions.

UPPER PAYMENT LIMIT (UPL) FUNDING

These payments authorized by the federal government allow states to reimburse hospitals for certain uncompensated care provided under Medicaid at an amount equal to what Medicare would have paid for the same service. Medicare services are typically reimbursed at a higher level than Medicaid. UPL is financed with local, state and federal matched funds.

UPL financing is not new to Medicaid, but a new program that began about three years ago greatly expanded its use and the revenue generated for hospitals. The program is called the Low Income and Needy Care Collaboration Agreement, or LINCCA (pronounced Link-uh). These are agreements between some combination of government entities, private hospitals, public state and local hospitals and hospital districts. The program allows private hospitals to take on services for low-income and needy patients, a move that alleviates the financial strain on the government entities. The state government can then utilize those funds to supplement the Medicaid program and draw down federal financial participation.

In fiscal year 2013 DHH made about $458 million in LINCAA payments to hospital operators that have become private partners in the charity hospital deals. A DHH official has testified that LINCCA payments were given consideration in establishing payment arrangements for the new LSU partnerships. However, DHH also has indicated that LINCAA payments are not tied to the partnership reimbursement methodology.

LINCAA payments made in fiscal year 2013 to several hospitals now involved in partnerships with the state:

- $109.3 million to Touro Infirmary in New Orleans
- $189.8 million to Children's Hospital in New Orleans
- $45.4 million to Lafayette General
- $6 million to Lake Charles Memorial
- $34.5 million to Woman's Hospital in Baton Rouge
- $73.6 million to Our Lady of the Lake in Baton Rouge

UNCOMPENSATED CARE PAYMENTS (UCC)

Uncompensated care financing of hospital services is a long-established and key source of public funding to mitigate some of the cost borne by hospitals for treating the uninsured. UCC is the overall measure of hospital-provided care for which no payment is expected to be received from the patient or an insurer. This includes the "Medicaid shortfall," or the difference in what Medicaid pays for a service and the actual cost of the service. A federal Disproportionate Share Hospital (DSH) supplemental Medicaid payment is used to cover these costs.

Under the new public-private partnerships, the change in UCC payment methodology must obtain federal approval. The charity hospitals will move from the "State" category into the "Private" category for UCC payments, which is primarily a housekeeping task.

The administration told the legislature in June 2013 that it had budgeted $659 million dollars in UCC payments for fiscal year 2014 for the nine partnership hospitals. This figure is a 1.4% increase over the LSU reported UCC revenue for 2011 of $650 million for all 10 LSU hospitals.

An important distinction between Louisiana and other states is that uncompensated care funding in other states is typically distributed among private hospitals that treat the uninsured. However in Louisiana, the bulk of this funding stream in the past has been directed to care through the Charity hospital system.

Federal uncompensated care and DSH funding through Medicaid will likely decline in the future. The Affordable Care Act requires the federal health secretary to implement a plan to reduce federal uncompensated care expenditures for the nation. From 2015 to 2020, $18 billion of uncompensated care funding will be reduced nationally, although the impact on individual states is undetermined. These federal funds are matched by the states to cover some of the uncompensated costs.

Federal uncompensated care and Disproportionate Share funding through Medicaid will likely decline in the future due to slated reductions in the Affordable Care Act.

This potential reduction is particularly important for Louisiana. The state is among the most significant users of uncompensated care funds, at approximately $750.2 million (both federal and state funds) budgeted in fiscal year 2014. The current UCC match rate is approximately 62% federal money and 38% state money.

Historically, financing of the safety-net LSU hospital system was highly dependent on such funding, which accounted for approximately 78% of the $664.5 million of the state's UCC expenditure in fiscal year 2012. A government analysis has not been made of how this pending reduction will impact Louisiana in general and the LSU hospital system in particular.

Other states currently drawing federal uncompensated care funds possibly will need less in the future as they expand their adult Medicaid enrollments under the Affordable Care Act. In all states that implement the Medicaid expansion, uncompensated care costs incurred by providers should decline, because more individuals will have health care coverage. Fewer states will need the same level of UCC dollars due to their participation in the Medicaid expansion. How the new UCC pool of funding will be allocated is unknown. A prudent forecast would assume a decline in this funding for Louisiana.

PAR estimates there will be sufficient room under the state's UCC allocation cap to fund the private partnerships through federal fiscal year 2017 without major adjustments to the UCC payments. However, a hypothetical model shows that if the federal health secretary were to implement a plan that caused an across-the-board reduction in UCC allocations to the states, Louisiana would face a UCC funding shortfall of about $129 million in 2018, $182 million in 2019, and then a lesser amount of $39 million in 2020. This shortfall would be even greater if the Medicaid and uninsured costs of services increase above the state's projections for those hospitals without a cost cap.

If these shortfalls materialize, the state would need approximately $350 million in additional state funds during that three-year period to support the LSU partners and other UCC recipients at the same level as the 2014 budgeted amount. These figures are meant as an illustration, not a prediction, of the potential magnitude of the impact.

GRADUATE MEDICAL EDUCATION

Public funding for Graduate Medical Education (GME) has been long established in the hospital payment system. Most of the GME revenue comes from Medicare. The Medicare GME payments are based on a complex formula, which is enhanced if the Medicare patient percentage is higher within the overall hospital payer mix. The new partners are anticipated to attract a higher percentage of Medicare patients than was traditionally served in the LSU system, but that is yet to be seen.

Eligible hospitals in Louisiana received limited GME payments from Medicaid for a total of $5 million in 2011, $7.1 million in 2012, and $12.6 million in 2013. In addition, higher per diem payments are made to major teaching hospitals and this is a significant source of Medicaid revenue. The traditional charity hospitals received increased funding from graduate medical education as well as a higher per diem rate because they were major teaching hospitals. The new local partners may benefit from this revenue stream as well. Lafayette General, by receiving GME slots from UMC, will receive a higher Medicaid per diem in addition to GME payments.

The private partners in the new charity system will have residents training in their facilities. Some private hospitals have been receiving residents and related revenue for some time, while for others, this is a new opportunity. LSU will lose some revenue because the GME slots now will be at private hospitals. The private partners who traditionally have not had access to residents will potentially see new revenue through the GME slots.

LEASE PAYMENTS FROM PARTNERS

Lease payments paid by the private parties are new and will provide significant revenue to the state. In most cases, the private partners are leasing the facilities from the state. A public entity is involved with the hospital deal in Houma. Appraisals were conducted to determine the fair market values of the leases.

Lease payments by private partners will provide significant revenue to the state. Partners will make the payments and then recoup most of their lease expense through the Medicaid reimbursement process.

In the first year the leases of the public hospitals are expected to generate about $140 million, which will go to the state general fund. Prepayment in rental fees was directed to support the LSU budget and mitigate the fiscal year 2013 budget shortfall. This includes Children's Hospital in New Orleans agreeing to pay two years' worth of lease payments in fiscal year 2013. After the first year, lease payments are made on a regular schedule, according to each CEA. Prepayments of leases serve to prop up the state budget in the short term and it remains to be seen whether further prepayments will be discussed.

The lease payments are made up front to the state and then a portion of these payments can be recovered by the private partners through the Medicaid reimbursement process. For partners who are guaranteed their costs, they can recover most of their rental lease payment. The repayments are matched with federal funds and, at the current match rate, the state will net about 62 percent on the allowable cost of each rental transaction.

The lease payment system

Here is an explanation of how the lease payments result in federal dollars that are circulated back to the private partners. The private partner pays a dollar to the state. The partner claims the allowable portion on the Medicaid cost report. The state then pays the private partner back using federally matched funds. The federal government picks up 62 percent of the Medicaid payment. The private partner is made nearly whole on its lease payment and the state nets 62 cents on the dollar transaction. In fiscal year 2013, some partners made advanced payments of $272.5 million on which the state will net up to $169 million. This is how the state avoided making some of the announced cuts to the LSU hospitals. The state shifted much of the budget shortfall caused by Congress back to the federal government.

OTHER SOURCES

A variety of other revenue sources are available to the hospital system. The legislature can and does appropriate state general funds that are not matched by federal funds to support the operation of the hospitals, such as for prisoner care.

Another source is known as "certification of match." States may match federal Medicaid dollars with state dollars or with certain expenditures that can qualify as a match. For example, community public hospitals may certify qualified

uncompensated care costs, which are in turn used as a match to finance the Medicaid program. Certification of a match is a long-established practice that provides significant revenue to the state's Medicaid program.

A major future source of revenue could be in store for many hospitals across the state. Passed in the 2013 Legislative Session, House Bills 532 (Act 438) and 533 (Act 439) are proposed amendments to the state constitution. A simple majority approval by voters in a statewide referendum slated for Fall 2014 is required for these bills to become part of the constitution.

The bills provide for fees and assessments from certain categories of hospitals, nursing homes, intermediate care facilities and pharmacies. The money from these assessments would be used as a match for federal Medicaid dollars. If the system is designed effectively to meet federal standards, the federal matching dollars would flow to the health care providers, who ultimately would receive substantially more money than the original assessments.

The purpose of the program is to compensate providers that are not fully reimbursed for the care they give to Medicaid patients. If approved by voters, the constitutional amendment affecting hospitals would provide a potential source of funding for the private partners in the Charity deals, either directly or indirectly.

CHAPTER FOUR

New Costs and Savings

The administration has been eager to claim that the hospital privatization has resulted in savings for the state. In fact, the real bottom line is not yet known. A number of factors can be taken into consideration in figuring the ultimate financial impact. The short-term impact may be different from the long-term outcome. An especially important question is, whose costs and savings are being considered? One state agency or all state agencies? The new partner hospital or all hospitals in a community?

As discussed in this report, various factors affect costs and savings. The state is accepting front-loaded lease payments that skew in favor of short-term savings. The funding mechanism of the leases could be questioned by federal regulators in the long run. The true extent of the state's obligation to cover hospital expenses will become more apparent at some point in the future when the hospital cost reports are completed. The long-term effect of decreased federal funding for uncompensated care costs could have a major impact on the system's revenue model.

Also, increased Medicaid and uncompensated care costs for non-partner hospitals should be taken into account as an impact of the state reform. Cost shifting of state expenses onto non-partner hospitals might be another factor to consider. In the big picture, we should ask how much it costs to support the overall system as well as how much it costs the state.

POTENTIAL COSTS

Overall, the state appears to have provided adequate funding for the startup of the private partnerships. Fiscal year 2014 includes a 5% utilization increase or about $32 million in additional state funding over the 2013 budget created prior to the Congressional Medicaid cut for Louisiana. Some minor mid-year adjustments might be needed, which would have been common even under the old system.

Some of the partnerships have cost caps on expenditures. In theory, if a private partner provides more care than it is funded for in the state agreement, the partner would have to absorb those costs.

Some of the partnerships, but not all, have a cap on the overall amount of costs that the state will cover to care for the uninsured. These caps were established considering all the funding used from various mechanisms to pay for uninsured care in Louisiana, including the LINCAA payments to the private partner, as well as Medicaid and UCC payments. Utilization of services at the new private partner managed facility was also a consideration in establishing cost caps.

The cost caps are relevant given that the state's charity hospital law has not been modified and any Louisiana resident at or below 200% of the federal poverty level (FPL) is guaranteed free care at the LSU facility being operated by a private partner. This is a state-created entitlement the private partner will be obligated to meet, regardless of the cap.

Hypothetically, if a private partner provides more care than it is funded for in the state agreement, the partner would have to absorb the additional costs. One of the private partners expressed concern at the Joint Legislative Committee on the Budget meeting in June 2013 about the potential for increases in utilization as care improves. The partner was also concerned about the obligation to provide care regardless of the cap in the agreement. State officials said the agreement could be amended through negotiations if needed.

The administration rejected the Affordable Care Act's Medicaid eligibility expansion to 133% of the FPL, which would have been financed in large part by the federal government. The expansion would have provided Medicaid coverage to low-income adults, many uninsured. The federal government would pay 100% of the expansion cost until 2017, when the federal share would begin to decrease until reaching a 90% match in 2020.

The administration rejected the Medicaid eligibility expansion to 133% of the federal poverty line, which is financed largely by the federal government, and opted instead to utilize the LSU safety-net system and its more generous free-care threshold of 200% of the federal poverty line.

The state opted instead to utilize the LSU safety-net system and its more generous free-care threshold of 200% of the FPL. This free care is financed by federal funding of 62% and a state match of 38% of the care. However, the federal government is curtailing this funding stream in coming years as a part of health care reform.

IMPACT ON NON-PARTNER HOSPITALS

The partnership in the Baton Rouge region has been in place the longest and is the most mature. Early reports indicate that non-partner hospitals are experiencing significantly increased costs for the uninsured related to the downsizing and subsequent closure of the state's Earl K. Long Hospital. For example, an uninsured patient who would have gone to Earl K. Long might now choose to go to Our Lady of the Lake or Baton Rouge General. The cost consequences for the government and the hospitals will be quite different depending on which institution the patient selects. That's because the government money does not always follow the patient. The state's partner agreement provides OLOL with greater government compensation for that patient's care than would be afforded to Baton Rouge General.

Baton Rouge General's Mid-City facility has seen significant cost increases related to uninsured patients. The hospital's emergency department has seen the number of encounters increase from about 1,500 in 2010 to 2,300 over the past year, with 40% of those patients uninsured. The percentage of uninsured patients admitted to the hospital has increased from 15% to 24%. Baton Rouge

General's Mid-City facility has seen a 44% increase in uncompensated care costs over a recent six-month period after the closure of the state's Earl K. Long Hospital in April 2013.

DHH has rules regarding uncompensated care payments to hospitals that are not part of the partnership agreements. Under these rules and because of these increased uninsured costs, Baton Rouge General Hospital now qualifies for a 5% increase in its Medicaid per diem payments, although increased payments by DHH have not been made to date.

The administration's projection of overall savings to the state will be negatively impacted if more hospitals qualify for higher Medicaid per diem rates because of their increased uninsured costs. These additional costs could be relatively minor in the big picture. Still, the administration should factor such increased Medicaid expenses, which are outside the partnership arrangements, into the overall projected costs and savings.

POTENTIAL SAVINGS AND MIXED IMPACTS

One area of savings for the state will be the avoided costs of renovating or building new health care facilities. For example, by closing the aging Earl K. Long hospital in Baton Rouge and moving services to the local private partner, the state avoided building a new facility at a cost of $400 million.

The state will save between $25 million and $30 million that had been allotted for renovation of the hospital at England Air Park near Alexandria. The state has said that approximately $15 million of that will be used to build new outpatient clinics in the area. In the future, the private partner will be responsible for maintaining the facilities. Meanwhile, the state will finance capital improvements already approved by the Legislature for some state hospitals. Approximately $46.7 million in improvements will be made by the state at existing LSU facilities.

It is not known how federal Medicaid regulators will view these rental payments.

The administration says the private partners will pay the state about $140 million annually in lease payments that will go to the state general fund to support higher education. Advance lease payments of $272.5 million were made in fiscal year 2013. It is not known how federal Medicaid regulators will view these rental payments with regard to providing matching federal funds. The Centers for Medicare and Medicaid Services (CMS) will have to determine whether the payments violate regulations prohibiting donations from providers. There is potential for a significant disallowance in Louisiana's Medicaid program if CMS determines any portion of these rental payments is not permitted. It is anticipated that CMS will scrutinize the fair market value of the rental payments, the relationship between the parties and the timing and use of the payments made in advance. CMS might also examine the timing of LINCAA payments to hospitals making advance lease payments.

The privatization of Louisiana's hospital operations has moved thousands of state employees out of government jobs and into private employment, retirement and, in some cases, unemployment. The impact of these public-sector layoffs includes both costs and savings for the state. In fiscal year 2013 alone, approximately 3,669 LSU employees were laid off, 849 retired, and 31 transferred to other agencies. The state employee retirement system reported in November 2013 that nearly 8,000 state hospital workers had been laid off.

So, the state government payroll is shrinking as the local partners take over employment of hospital staff. Also, the state employee retirement system's unfunded accrued liability has been reduced. On the other hand, most state agencies will have to allocate annually a larger percentage of their contribution to the state retirement system. In the short run, the state will be responsible for transition costs of approximately $38 million related to the layoffs. The state will be responsible for paying out accumulated leave, unemployment insurance and retirement benefits for retirees.

The administration anticipates a recurring savings of about $100 million when all costs are considered across all the partnerships. These savings are based on the current financial projections for the partnerships. If the state ends up paying more or less than projected, the savings could grow or erode.

HEALTH CARE FOR LOUISIANA PRISONERS ENTERS A NEW ERA

The former LSU hospitals and clinics provided both primary and non-primary care for local and state prisoners, who in general received the care for free. Now, offender health care has been transformed through the public-private partnerships. While inmates are still entitled to health care, the place where an inmate receives care and who pays for it depends on what system the inmate belongs to and where he or she is housed.

In the past, LSU mostly paid for prisoner care through its state general fund appropriation. If inmates received inpatient care for more than 23 hours, their care could be covered by Medicaid if the prisoner was Medicaid-eligible. Very little recoupment through Medicaid occurred. LSU cannot use federal uncompensated care dollars for inmate care.

Some local jails relied heavily on the LSU charity system for free care for local and state offenders. Others provided and funded their own health care on-site or through a local private provider. For some local jails that were a long way from an LSU charity facility, other arrangements may have been preferable.

With the transition to public-private partnerships, rather than LSU providing for prisoner care out of its budget, prisoner care will be paid through an appropriation to the Department of Corrections for emergency care and by the local governments for primary care. Under the new system, neither LSU nor Corrections will be responsible for primary care services for those who are incarcerated in local jails.

Local law enforcement is now responsible for the primary care of their inmates. For those local law enforcement agencies that were providing primary care to their inmates independently of the LSU system, this may not be a new expense. For those local agencies who relied on the free care through the LSU system, this is a new expense with little baseline data to use for budgeting purposes. Since there are approximately 2,740 parish offenders in local facilities and another 21,200 pre-trial offenders in local jails, this cost could be significant.

The Department of Corrections will provide non-primary care services for local inmates. During an emergency, inmates will be sent to the nearest emergency room until they are stable and then transferred to the nearest facility contracted with Corrections to provide inmate care. All but one of the new private partners are negotiating with Corrections to care for inmates. The corrections agency may pay for the care at an LSU hospital or clinic or another local private provider if that is easier to reach. Corrections is implementing new programs to provide some non-primary care services, such as bringing diagnostic equipment to local facilities where the need warrants it.

Corrections received funding of $50 million for prisoner care and payments will be made directly to the service providers, in many cases the new LSU private partners. This funding is intended to cover the non-primary care of local inmates, juveniles in custody, patients of East Mental Hospital, Corrections Department offenders in state prisons and parish prisons and pre-trial offenders. The corrections agency anticipates that about 20% of the prisoners needing care outside its facilities will be eligible for Medicaid coverage, thus relieving Corrections of some of the cost of care.

Memorandums of Understanding are being executed between Corrections and the private partners (except Our Lady of the Lake) for the continued provision of prisoner care. Among the services that will continue to be supplied by private partners to both local and state prisoners and financed by Corrections are emergency services, inpatient hospitalization, surgery, outpatient specialty services, diagnostic tests, cancer treatment and inpatient OB/GYN services.

In addition to the local prisoners cited above, the Department of Corrections holds about 18,723 prisoners in state facilities and another 21,327 in local jails. The Office of Juvenile Justice has about 436 children in custody. The total prisoner population both state and local is approximately 55,422.

Of note, the inpatient care for both state and local prisoners would be covered by Medicaid and financed mostly with federal funds if Louisiana elected to expand its Medicaid eligibility under the Affordable Care Act. The Department of Corrections does not have an estimate of how much this inpatient care could cost. However, an estimate can be made by using figures for the cost of Medicaid program private provider inpatient care as compared to acute care and pharmacy costs. In that estimate, Louisiana could potentially save about 29% or $14.5 million annually in state general funds on prisoner care costs with a Medicaid expansion.

The Department of Corrections is anticipating that the reforms may yield some efficiency by eliminating redundancies in care and focusing on medically necessary care. With Corrections being directly responsible for the administration of health care costs for state prisoners and for the non-primary care of local prisoners, the agency may be able to identify more cost-effective ways to provide care. Corrections is already taking steps to bring more health care services on-site within its prisons and to enhance the use of telemedicine.

The opportunity exists for efficiencies in operations with the new private partners, with better health care for those incarcerated, and savings to the taxpayer. But it remains to be seen whether these advantages will be realized.

CHAPTER FIVE

Policy Questions

The provision of charity care in Louisiana has been a hotly debated public policy issue for some time. This general direction taken by the administration aligns with recommendations of a number of health care analysts, including the Public Affairs Research Council. PAR had urged that the state embark on a five-year plan to transform the system using private partners.

Little action was taken in this direction until Congress caused a large decrease in federal funding for the Louisiana Medicaid program last year. The state then found itself in the financial position of urgently needing to enter into agreements with private partners. This urgency was the justification given for moving swiftly. As a consequence, the state did not utilize a bid process or full transparency in the partner selection and contract process.

While this reform is still in an early stage, PAR offers the following observations and policy questions.

Are the partnerships financially sustainable in the long term, both for the state and the health care providers in the various communities?

At this time, the administration has chosen not to expand Medicaid under the Affordable Care Act to those residents who earn up to 133% of the federal poverty level. Louisiana continues to offer free care to any Louisiana resident earning up to 200% of the federal poverty level. In general, health insurance coverage that offers preventive and primary care is preferable to safety-net care. Louisiana's funding strategy for providing a safety net is heavily dependent on federal uncompensated care dollars. Also, the state pays a larger share of the match with federal funds to support the safety-net system.

The unanswered question is whether the administration's plan to provide the uninsured with safety-net care – instead of health insurance coverage – will be financially feasible in later years. The future of the federal funding is uncertain. It is essential that policymakers track costs and future federal financing of the funding streams. The state also should continue to evaluate the comparative costs of moving to an insurance model for those without coverage rather than a safety-net reimbursement model based heavily on emergency room care.

Because each state hospital in Louisiana now has a different operating arrangement depending on the partner and the community, the financial status of the health care providers in each region must be monitored and considered separately. Perhaps the best way to look at the recent changes is not to see them as a single statewide reform, but as a varied collection of reforms among the major metro areas of the state. To determine the real success of these changes, the financial stability of each community's private

partner and overall health care infrastructure must be considered. Likewise, the health care outcomes for the population of those communities must be tracked. Partner hospitals and non-partner hospitals and associated clinics could be affected differently by the recent reforms. Each community will have its own profile of finances, hospital bed capacity, clinics, indigent coverage and effective care.

Former PAR policy recommendations advised that regionally integrated systems of care should be established by local authorities and health care providers. The prior recommendations stated that a better model of care would be regional and community-based networks that emphasize primary and preventive care, as well as quality specialty and hospital care. The new systems eventually could evolve more in that direction.

Will the partnerships change the "separate but unequal" nature of the traditional charity hospital system by providing better care that attracts a diverse patient mix?

The traditional Charity health care in Louisiana has been described as providing a separate but unequal health care delivery system for the uninsured that did not attract paying or insured patients. This was the chief reason the charity system was overly reliant on state and federal subsidies.

The new partnerships include a local private partner or partners who have, in some instances, created a new governing nonprofit or governing organization. Although a local private partner is involved in each agreement, this does not necessarily mean a regionally integrated system of care was established by local authorities and health care providers. The state sought out a partner for each community and it is not evident that other health care providers or local authorities will be deeply involved in the state system of care except in some medical specialties and other circumstances.

It is uncertain whether the new model will largely maintain a separate health care delivery system for the uninsured. In some communities, like Baton Rouge and Lake Charles, the uninsured will receive care at the private provider's existing hospital, thus almost assuring a more diverse patient mix. In the other communities, the uninsured will receive most care at the site where the former charity hospital operated, although the care will be provided by the private partner. Whether care provided by the state will be more integrated with the care received by insured patients remains to be seen. This will be driven in part by the quality of care provided by the private partner.

Although a local partner is involved in each agreement, this does not mean a regionally integrated system of care was established by local authorities and health care providers.

Prior research indicated that the hospital safety net offered poor access to services and long waits for clinic visits. The public-private partnerships do not, at this time, appear to be increasing the number of places the public can seek services, although this was mentioned as a possibility with the Alexan-

dria and Monroe areas. Access to care and waits for clinic visits are two areas that should be monitored. The reforms do not appear, at this time, to include regional and community networks that emphasize preventive care, although LSU indicates that early steps are under way to establish a preventive care infrastructure. Reports like the one of increased mammogram screenings at Chabert in Houma are certainly encouraging.

New Orleans and Baton Rouge have highlighted early successes in their partnerships, such as reduced wait times in emergency rooms, an increased number of surgeries and a reduction in a backlog of prescriptions. Quality primary, specialty and hospital care do appear to be a potential result of the partnerships.

Will policymakers and the public be able to answer these and other policy questions with timely and appropriate data?

Louisiana's Bayou Health managed care plans for Medicaid report quarterly on the number of appeals, complaints, denied claims, paid claims, prompt pay and prior authorization statistics, physician participation and emergency room use. The new state agreements for the public hospitals do not delineate what reporting measures shall be provided from the new providers aside from cost data. While legislative testimony from the administration assured legislators that the partners would have to comply with audits and provide cost data, it is unclear what additional data would be provided to policymakers and the public. Ideally, the performance or outcome data expected from the partner would be delineated in the cooperative endeavor agreements as with other state contracts. Aside from cost data, it is not specified what data the partners must provide.

The state needs to formalize data sharing agreements and benchmarks and routinely share the reported metrics on the performance of the various partnerships. Louisiana residents who depend on the private partners deserve no less.

Louisiana Health Secretary Kliebert testified at the legislature in September 2013 that significant improvements in the delivery of care by private partners to former LSU patients had been made and Dr. Opelka of LSU has said his agency is working to define measurable outcomes and a data collection system.

These are encouraging statements from the administration. The state needs to formalize data-sharing agreements and benchmarks and routinely share the reported metrics on the performance of the various partnerships. The taxpayers who finance the agreements and the Louisiana residents who now depend on these private partners for their health care deserve no less.

The administration has hailed the move to public-private partnerships as providing better patient care, improved performance and outcomes at a lower cost. While the financial data should be readily transparent, it remains

to be seen what measures the administration plans to utilize to determine whether the new system and each specific partner have improved care, performance and outcomes.

Conclusion

The transition to a state hospital partnership model is an historic move for Louisiana health care policy. Although the contracting process has lacked transparency, the model holds potential to improve the quality of access to care for those served by the charity system. Fiscal estimates do not project savings in the actual provision of care for the population served, but recurring savings are anticipated in shifting the responsibility for building maintenance and construction to the private partners, as well as reduced government payroll and retirement system liabilities due to the termination of state workers in the charity system. Many of those former state employees now work for the new private partners.

This model is heavily dependent on a federal funding stream that is slated for eventual reduction. Thus, it is important to recognize the potential risk in the long-term sustainability of the partnerships if the current funding model remains in place. The advance lease payments also have created a fiscal risk for the state. The financial model for the partnerships appears sound for this fiscal year, but there are serious questions about how workable the revenue and reimbursement model will be in the future. Another factor impacting the health care environment is the implementation of the Affordable Care Act. While some other states are expanding their Medicaid coverage for adults, Louisiana's model does not incorporate increased insurance coverage. The state should continue to compare and evaluate the potential impacts of the different models.

In most of the new hospital deals, the state has partnered with a long-standing health care provider with operating experience in the community. The partner for the Shreveport and Monroe hospitals is the exception, and this arrangement needs to be further evaluated as more information becomes available. Overall, there is good reason to be optimistic that care and access to services will improve. The administration and the LSU System should hold fast and formalize their commitment to track timely service delivery and outcomes for health care provided through the partners.

The state will almost surely have to readapt its partnership agreements as the financial and regulatory environments evolve. The state must remain flexible in the long run and keep under consideration changes that would accommodate regional networks and a more robust participation of the local communities. If viewed as a step toward a better health care system for the poor, rather than as a grand solution to the problem of Louisiana's large population of uninsured, the state's recent reinvention of the safety net can be seen positively.

APPENDIX A

LOUISIANA'S NEW CHARITY HOSPITALS: A DEAL-BY-DEAL BREAKDOWN

The following is an overview of each Cooperative Endeavor Agreement between the state and the private or local partners to operate the respective LSU hospital and affiliated clinics. Each CEA calls for a contract monitor to perform data collection, review and reporting. LSU will retain ultimate authority over its academic programs, policies and procedures, while the partner will maintain ultimate authority over business, management, policies and operations.

Five of the hospitals were fully transitioned to the new partners during fiscal year 2013, which ended June 30, 2013. The state's Earl K. Long Hospital in Baton Rouge has closed and its services were taken over by Our Lady of the Lake on April 15, 2013. Louisiana Children's Medical Center assumed operation of the Interim LSU Hospital in New Orleans on June 24, 2013. Ochsner Health System and Terrebonne General Medical Center assumed operation of Leonard J. Chabert Hospital. Lafayette General Medical Center assumed operation of University Medical Center. Lake Charles Memorial Health System assumed operation of W.O. Moss.

Four more hospitals are transitioning to private partners during fiscal year 2014. The LSU Medical Center in Shreveport and E.A. Conway transitioned on October 1, 2013. Bogalusa Medical Center is scheduled to transition in March 2014 and the transition of Huey P. Long hospital in Pineville is scheduled to be complete by June 30, 2014.

FIVE AGREEMENTS EFFECTIVE IN FY 2013

Earl K. Long Medical Center in Baton Rouge

LSU hospital: Earl K. Long Hospital located at 5825 Airline Highway, Baton Rouge, closed on April 15, 2013, and its services were taken over by Our Lady of the Lake (OLOL) and by Woman's Hospital for some women's services. At closure, the hospital had approximately 20 staffed beds, down from 83, and 693 employees were laid off. The estimated cost to replace the old hospital was about $400 million. Rather than building a new hospital, the state reached an agreement with OLOL concerning continuation of core services.

Past Revenue: In 2011 Earl K. Long's revenue mix was approximately 43% uncompensated care for the uninsured, 28% Medicaid, 5% Medicare, 13.5% state general fund, 1.5% self-generated, and 9% inter-agency transfers from other departments.

Partner: The private partner is Our Lady of the Lake Inc., a Louisiana nonprofit corporation. The hospital is part of the Franciscan Missionaries of Our Lady Health System. The health system was organized in 1984 to unite three existing hospitals in Louisiana that were already part of the FMOL mission. The other hospitals include St. Francis Regional Medical Center in Monroe, Our Lady of Lourdes Regional Medical Center in Lafayette, and St. Elizabeth in Gonzales.

OLOL, established in 1923, is one of the largest private medical centers in Louisiana, with more than 700 licensed beds. In a given year, Our Lady of the Lake

treats more than 35,000 patients in the hospital and serves more than 350,000 persons through outpatient locations with the assistance of more than 1,000 physicians and 4,000 employees.

Earl K. Long inpatient services were transferred to the OLOL hospital campus on Hennessy Boulevard and some women's services to the new Woman's Hospital on Airline Highway opened in August 2012 in southeast Baton Rouge.

Terms: The term of the agreement is 10 years with automatic renewal in one-year increments after five years for a rolling five-year term.

Partner's obligation: The private partner is leasing the former Earl K. Long outpatient clinics. The total rental due to the state is $3.8 million annually. It is important to note this lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to the Centers for Medicare and Medicaid Services regulation. Since OLOL is guaranteed a reimbursement of 100% of their UCC costs and 95% of their Medicaid costs, the hospital stands to be repaid by DHH for these rental costs.

State's obligation: The state's obligation is to pay OLOL 100% of their UCC cost for caring for patients who earn less than 200% of the federal poverty level and 95% of Medicaid costs. The CEA budget worksheet calls for an estimated total payment of $185.7 million for fiscal year 2014. There is no cost cap on this CEA, so if OLOL's expenses for care exceed this amount, the state is obligated to pay their costs.

OLOL Hospital assumed additional financial risk by entering into the first private collaborative with Louisiana State University. A component of this public/private partnership was the closure of inpatient services at Earl K. Long (EKL) Hospital. Due to the high-cost populations that EKL served, Medicaid started making supplemental (non-UCC) payments to OLOL to help with the financial burden. For fiscal year 2011, Medicaid rates only reimbursed about 76% of OLOL's Medicaid inpatient costs without these supplemental payments. During fiscal year 2011, Medicaid paid supplemental payments to OLOL in the amount of $129 million for inpatient and outpatient services.

Of special note: Since the legislature approved closure of Earl K. Long Hospital, both inpatient and emergency services will be subsumed by OLOL.

OLOL Hospital will not be providing women's services that are in conflict with the mission of the organization, such as dispensing birth control. Women needing these services will access them through an alternate provider. Nor will OLOL provide prisoner care outside of emergency services and inpatient care resulting from emergency services. Non-partner hospitals in the Baton Rouge area will assist with emergency prisoner care.

And, the per diem rate paid to OLOL increased by $724.36, or 68%, post-partnership transition, from a rate of $1,062.63 to a rate of $1,786.99 per day. The Earl K. Long former per diem rate was $1,194.55. This per diem increase results in OLOL being paid approximately $3.5 million dollars more per year for Medicaid inpatient care than was paid to Earl K. Long.

As an outcome of the partnership with LSU, OLOL has achieved certification as a Level II Trauma Center which offers 24-hour immediate coverage by general surgeons, as well as health care in the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology and critical care. In addition, OLOL is investing $19 million in a medical school building on its campus.

Interim LSU Public Hospital in New Orleans

LSU hospital: The Interim hospital was operating 185 staffed beds at transition and had 1,997 employees. Construction is underway on the new University Medical Center (UMC), scheduled for opening in 2015. The Interim hospital replaced what was referred to as "Big Charity," which closed post-Katrina.

The new, 424-bed UMC, operated by a non-profit governing board, will encompass a wide range of services. Equally important, the new hospital will serve as a major training center for the education of medical professionals.

The new hospital is situated on 34 acres bounded by Canal Street, South Galvez, Tulane Avenue and South Claiborne Avenue. The $1.2 billion medical center will become the cornerstone of a biomedical district and will house a Level I Trauma Center.

In addition to inpatient services and trauma care, the center will host a cancer program, including radiation therapy and a chemotherapy clinic; outpatient surgery; outpatient imaging; and rehabilitation services. Treatment areas are being designed to maximize collaboration with the adjacent Veterans Affairs Medical Center by creating efficiencies through the location of adjacent diagnostic services and parallel outpatient services.

Updated financial projections were prepared and submitted by University Medical Center Management Corp.'s contractor Kaufman Hall on June 2, 2011. That report estimated that to operate, UMC would require state general fund support of $73.1 million for the year ending June 30, 2015, rising to $96.1 million by 2020. Meanwhile, services will have moved from the Interim hospital to the new UMC, which will have more than double the beds. Additional cost increases are possible within the larger capacity.

There appears to be sufficient revenue under the state's CEA obligation to finance operations of the new UMC in the near term. The state will continue to own the new hospital and the private partner's lease payments are for the use of the facility only.

Past Revenue: The Interim hospital's 2011 revenue mix was approximately 45% uncompensated care for the uninsured, 26% Medicaid, 8% Medicare, 6% state general fund, 6% self-generated, and 9% inter-agency transfer from other departments.

Partner: The private partner is Louisiana Children's Medical Center, Inc., a Louisiana non-profit corporation. Children's Hospital is a 247-bed, not-for-profit medical center offering the most advanced pediatric care for children from birth

to 21 years. In 2012, Children's Hospital recorded more than 200,000 patient visits, with children coming to the hospital from 63 of the 64 parishes in Louisiana, 37 states and 5 foreign countries. In all, 48,245 children received care from the hospital in 2012.

Term: The term of the agreement is 42 years with automatic renewal for three consecutive 15 year periods, for a total of 45 additional years.

Partner's obligation: The private partner is leasing the facility of the Interim Hospital and will lease the new hospital upon completion. The total annual rental payment for the Interim Hospital is $33.9 million according to DOA. This lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to CMS regulations. Thus, the private partner stands to recover most if not all of these rental costs. Once the new hospital is open, the lease payments will increase to $69.4 million.

State's obligation: The CEA budget worksheet calls for an initial UCC payment by the state of $184.5 million and additional supplemental payments of $44.1 million in fiscal year 2014. A total of $280.7 million is budgeted for the CEA in fiscal year 2014. There is no cost cap on this CEA.

Of special note: $110 million in lease payments was prepaid in fiscal year 2013 by Children's. which represents a two year prepayment on the old facility and a portion of the new facility. Plus, $143 million was prepaid by Children's toward the construction of the Ambulatory Care Building and parking garage at the new hospital site. The rental payment will vary between the old and new facilities, thus the difference in the annual rental amount and the prepaid amount.

University Medical Center in Lafayette

LSU hospital: University Medical Center located at 2390 West Congress, Lafayette, had 32 staffed beds, down from 87, and 726 employees at the time of transition. The hospital has traditionally served as a safety-net facility for south central and southwest Louisiana.

Past Revenue: In 2011 UMC hospital's revenue mix was approximately 45% uncompensated care for the uninsured, 29% Medicaid, 9% Medicare, 6% state general fund, 3% self-generated, and 8% inter-agency transfer from other departments.

Partner: The private partner is Lafayette General Health Systems, Inc., a Louisiana nonprofit corporation.

Term: The term of the agreement is five years with automatic renewal after the first year in one-year increments to create a rolling five-year term.

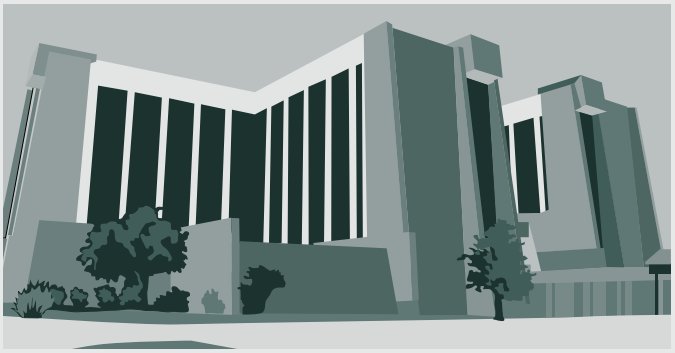
Partner's obligation: The private partner is leasing the UMC hospital and affiliated clinics. The total rental payment is $15.8 million annually. This lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to CMS regulations. Thus, the private partner stands to recover most if not all of these rental costs.

State's obligation: The CEA budget worksheet calls for an initial UCC payment of $48.5 million and additional supplemental payments of $46.1 million in fiscal year 2014. A total of $125.4 million is budgeted for the CEA in fiscal year 2014. There is a cost cap of this amount.

Of special note: Lafayette General Medical Center will pick up 18.25 GME resident slots which will qualify the hospital as a major teaching hospital, with a higher per diem reimbursement rate. Correspondingly, UMC resident slots will be 46.89. This change in teaching status will result in at least $2 million dollars in additional Medicaid revenue to Lafayette General Medical Center and no change for UMC.

Leonard J. Chabert Medical Center in Houma

LSU hospital: The Chabert hospital is located at 1978 Industrial Boulevard, Houma, and began operation in 1978 as a teaching hospital. The hospital has 63 staffed beds at transition, down from 96, and 802 employees. In 2008, a hospital-based, accredited Internal Medicine residency program was started.



Past Revenue: In 2011 Chabert hospital's revenue mix was approximately 47% uncompensated care for the uninsured, 29.5% Medicaid, 13% Medicare, 5.5% state general fund and 6% interagency transfer from other departments. Self-generated revenue was -1%.

Partner: The partner is Southern Regional Medical Corporation Inc., a Louisiana nonprofit corporation. Southern Regional is a public entity whose sole member is Terrebonne General Medical Center (TGMC), which is overseen by a public service district. The partner will manage Chabert with assistance from a company affiliated with Ochsner Health System. TGMC opened its doors in 1954 with 76 beds, 16 physicians and 58 employees, and has grown to 321 beds, more than 150 active staff physicians and over 1,300 employees. Ochsner is Louisiana's largest private not-for-profit health system, with eight hospitals and over 38 health centers in Louisiana.

Term: The term of the agreement is five years with automatic renewal after the first year in one-year increments to create a rolling five-year term.

Partner's obligation: The private partner is leasing the Chabert hospital and affiliated clinics. Southern Regional is not required to pay rent. The Terrebonne Parish Hospital Service District No. 1 will make an annual intergovernmental transfer of $17.6 million in public funds to the Medicaid program for Southern Regional and its affiliates.

State's obligation: The CEA calls for an initial UCC payment of $45.2 million. A total of $85 million is budgeted for fiscal year 2014, of which $45 million will be UCC and $9 million in Medicaid payments to the former Chabert, and $31 million in supplemental payments made directly to the private partner, Ochsner.

W.O. Moss Regional Medical Center in Lake Charles

LSU hospital: W.O. Moss Hospital operated for over 50 years prior to its closure in 2013. At the time of closure it had 10 staffed beds, down from 32, and nearly 331 employees. The hospital's operations were taken over by Lake Charles Memorial Hospital.

Past Revenue: In 2011 Moss hospital's revenue mix was approximately 40% uncompensated care for the uninsured, 19% Medicaid, 7% Medicare, 18.5% state general fund, 5.5% self-generated, and 10% inter-agency transfer from other departments.

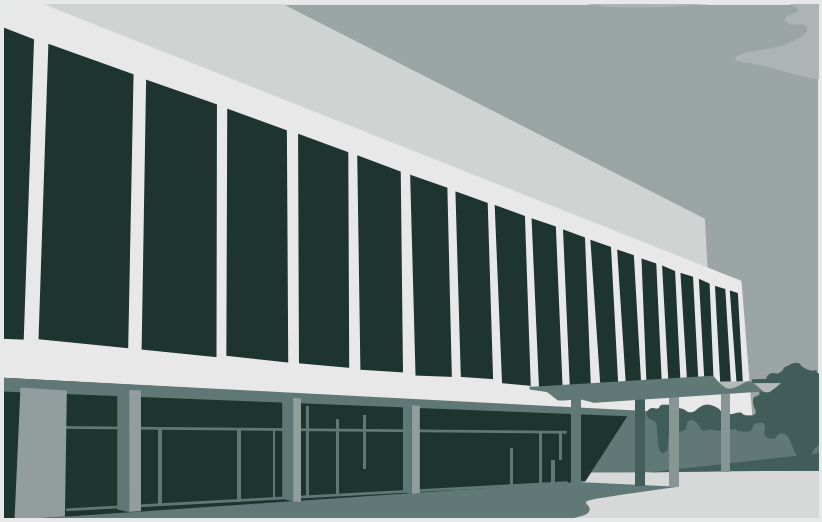
Partner: The private partner is Lake Charles Memorial Hospital, Inc., a Louisiana nonprofit corporation. Lake Charles Memorial Hospital was established in 1952 and consists of a 368-bed healthcare system with a 301-bed acute care facility at the main campus on Oak Park Boulevard; Memorial Hospital for Women, a 38-bed women's facility at Gauthier and Nelson Roads; and a 29-bed long term acute care Memorial Specialty Hospital.

Term: The term of the agreement is 10 years with automatic renewal after the first five years in one-year increments to create a rolling five-year term.

Partner's obligation: The private partner will operate a new outpatient clinic to serve the former Moss patients. The total rental payments to the state are $2.4 annually. This lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to CMS regulations. Thus, the private partner stands to recover most if not all of these rental costs.

State's obligation: The CEA budget worksheet calls for an initial UCC payment of $42.2 million in fiscal year 2014. A total of $54 million is budgeted for the CEA in fiscal year 2014. There is a cost cap of this amount.

Of special note: Since the legislature has approved closure of Moss, both inpatient and emergency services will be subsumed by Lake Charles Memorial Hospital.



FOUR AGREEMENTS EFFECTIVE IN FY 2014

LSU Medical Center in Shreveport

LSU hospital: The LSU Health Sciences Center, located at 1501 Kings Highway in Shreveport, comprises three professional schools and three hospitals including LSU Medical Center in Shreveport, EA Conway Medical Center in Monroe, and the Huey P. Long Medical Center in Pineville.

The LSU Medical Center merged in 1975 with the LSU School of Medicine, which was built adjacent to the facility and had become known as Confederate Memorial Hospital. A year later, the hospital and academic campus merged. The hospital was officially affiliated with LSU and renamed. The Shreveport campus has 452 staffed beds, down from 477, and 2,611 employees.

Past Revenue: The LSU hospital's 2011 revenue mix was approximately 44% uncompensated care for the uninsured, 24% Medicaid, 16% Medicare, 3% state general fund, 13% self-generated, and 0% inter-agency transfer from other departments.

Partner: The private partner is Biomedical Research Foundation of Northwest Louisiana, Inc., a Louisiana nonprofit corporation and BRF Hospital Holdings LLC. The foundation was created in 1986 with a mission to diversify the regional economy after the collapse of the oil industry.

Term: The term of the agreement is five years with automatic renewal after the first year in one year increments to create a rolling five-year term.

Partner's obligation: The private partner is leasing the LSU Shreveport hospital and affiliated clinics. The total rental payment is $44.6 million annually for both the Shreveport and E. A. Conway facilities. However, this lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to CMS regulations. Thus, the private partner stands to recover most if not all of these rental costs.

State's obligation: LSU will operate the hospital for the first three months of the 2014 fiscal year and the partner will operate the hospital for the remainder. Funding details show a total of $242 million is budgeted for fiscal year 2014; of which $21.7 million will be UCC and $29 million in Medicaid payments to LSU, and $78.2 million in UCC and $113 million in Medicaid payments made directly to the private partner, Biomedical Research Foundation of Northwest Louisiana. There is a cost cap for this CEA for fiscal year 2014 of $197.2 million.

Of special note: This private partner does not have prior history operating a hospital. The partner has contracted with a management firm.

E.A. Conway Medical Center in Monroe

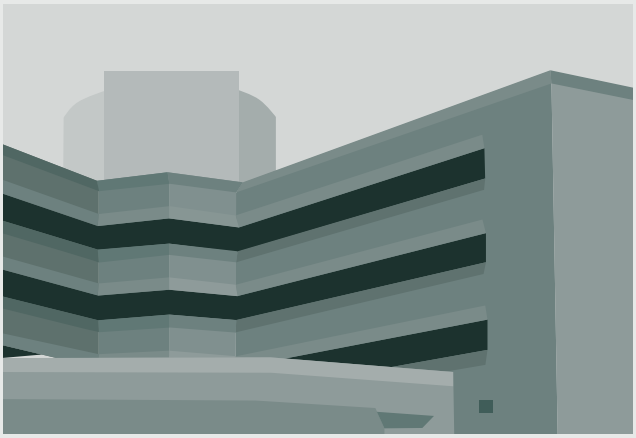
LSU hospital: EA Conway is located at 4864 Jackson Street, Monroe. With a 142 staffed beds and 770 employees it serves a 12-parish area in northeast Louisiana. With services dating from 1941, the current facility opened in 1987. EA Conway also serves the healthcare needs of area corrections facilities.

Past Revenue: The hospital's 2011 revenue mix was approximately 64% UPL funding in lieu of uncompensated care for the uninsured, 20% Medicaid, 6% Medicare, 8% state general fund, 2% self-generated, and 0% inter-agency transfer from other departments. Of note, no UCC payments were made to the hospital through a special financing arrangement where Conway collected and distributed to other LSU hospitals $42,325,716 in excess UPL payments in fiscal year 2012.

Partner: The private partners are Biomedical Research Foundation of Northwest Louisiana Inc., a Louisiana nonprofit corporation, and BRF Hospital Holdings LLC. However, the partner has contracted with a firm, Alverez and Marsal, to manage and operate the hospitals.

Term: There is a joint CEA for both the Shreveport and Monroe facilities.

Partner's obligation: The private partner is leasing the Conway hospital and affiliated clinics. The total rental payment is $3 million annually and is included in the amount above for the Shreveport hospital. This lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to CMS regulations. Thus, the private partner stands to recover most if not all of these rental costs.



State's obligation: LSU will operate the hospital for the first three months of the fiscal year and the partner for the remainder. Funding details show a total of $52.4 million is budgeted for fiscal year 2014; of which $6.8 million will be UCC and $3.7 million in Medicaid payments to LSU, and $22.8 million in UCC and $19 million in Medicaid payments made directly to the private partner. There is a cost cap for fiscal year 2014 of $43.4 million.

Of special note: This private partner does not have prior history operating a hospital. However, the partner has contracted with a firm to manage and operate the hospitals. This partner also agreed to pay 12 months of lease payments in fiscal year 2014, although it will only be operating the hospital for 9 months.

Huey P. Long Medical Center in Pineville

LSU hospital: Huey P. Long Hospital is located at 352 Hospital Blvd., Pineville. Plans were approved in late 2011 to relocate the medical center to a former military hospital at England Air Park in Alexandria in 2014 with renovation costs of between $25 million and $30 million. Huey P. Long is a 36-bed acute care hospital, down from 60 beds, with 350 employees and inpatient services in Pineville and extensive outpatient clinics in Alexandria. The hospital in Pineville was built in 1939, and it provides service for a nine-parish region of central Louisiana. In 1994, when the federal government decided to close the military hospital at England Air Park, Huey P. Long arranged to use the site and planned to move most of its outpatient clinics there. However, the plan to relocate the Huey P. Long hospital to the England Air Park site changed on September 6, 2013, when the LSU Board of Supervisors approved closure of Huey P. Long and the transfer of services to two private partners, Christus St. Francis Cabrini and Rapides Regional Medical Center.

Closure of the Huey P. Long hospital requires legislative approval, which will be sought in the 2014 legislative session. The transition is expected to occur by June 30, 2014, and after outpatient clinics are established based on demographic trends to help bring health care closer to residents.

Past Revenue: In 2011 Huey P. Long's revenue mix was approximately 53% uncompensated care for the uninsured, 18% Medicaid, 7% Medicare, 19% state general fund, 3% self-generated, and 0% inter-agency transfer from other departments.

Partner: The private partners are Christus Health Central Louisiana, a Louisiana nonprofit corporation, and Rapides Healthcare System LLC, a for-profit Louisiana company owned in part by Hospital Corporation of America (HCA).

St. Frances Cabrini Hospital officially opened on April 1, 1950. In 1999 St. Frances Cabrini Hospital became part of Christus Health System as the Sisters of Charity Health System and the Sisters of Charity of the Incarnate Word Health System were consolidated. With its corporate headquarters in Dallas, Texas, Christus Health is one of the 10 largest Catholic health care systems in the country. Today St. Frances Cabrini Hospital is a 255 bed health care center, employing 1,500 people.

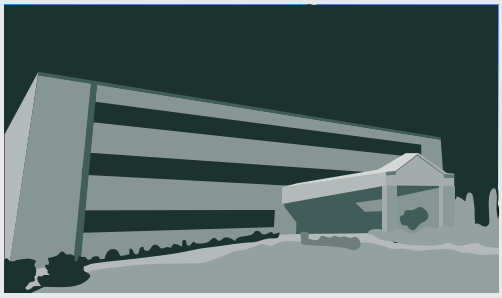
Rapides Regional Medical Center is a 325 bed hospital founded in 1903. In 1993, the operating assets and name of Rapides Regional Medical Center were sold to Central Louisiana Healthcare Systems Partnership. Then, in 1998, the joint venture was restructured as a limited liability corporation - Rapides Healthcare System. Today, HCA continues to own a 74% interest and Rapides Foundation, a nonprofit, owns a 26% interest in the Rapides Healthcare System.

Term: The term of the agreement is 10 years with three automatic five year extensions for a total of 25 years.

Partner's obligation: The private partners will open new outpatient clinics in the Alexandria region to serve the former Huey P. Long patients. The administration told the legislature in September 2013 that rental payments were not part of this agreement.

State's obligation: Funding details are not available, but a total of $42.7 million is budgeted for fiscal year 2014, of which $5.9 million will be UCC and $1.4 million in Medicaid payments to LSU, and $33.4 million in UCC payments and $2 million in Medicaid payments to the private partners. However, going forward the two private hospital partners are guaranteed at least $49 million together per year under the terms of the CEA approved by the LSU Board of Supervisors on September 6, 2013. In addition the state will provide funding via capital outlay for the establishment of the new clinics.

Bogalusa Medical Center



LSU hospital: The Bogalusa Medical Center, 433 Plaza Street, Bogalusa, has continuously served the Northshore for over 100 years. It has 608 employees and is the only full service hospital in a 30-mile radius. This 40 staffed beds, down from 55, acute care hospital also operates 26 primary and specialty outpatient clinics and an inpatient acute psychiatric unit.

Past Revenue: The Bogalusa hospital's 2011 revenue mix was approximately 31.5% uncompensated care for the uninsured, 19% Medicaid, 16.5% Medicare, 7% state general fund, 21% self-generated, and 5% inter-agency transfer from other departments.

Partner: The private partner is Our Lady of the Angels Hospital, Inc. a Louisiana nonprofit corporation, formed specifically for this endeavor by Our Lady of the Lake, Inc. St. Elizabeth Hospital, also a subsidiary of OLOL, will operate the hospital in Bogalusa. St. Elizabeth Hospital is located at 1125 W. Highway 30, Gonzales. The hospital is part of the Franciscan Missionaries of Our Lady Health System. In 2004, St. Elizabeth Hospital became a sponsored hospital under the Franciscan Missionaries of Our Lady Health System which also includes St. Francis Regional Medical Center in Monroe, Our Lady of the Lake Regional Medical Center in Baton Rouge, and Our Lady of Lourdes Regional Medical Center in Lafayette.

Term: The term of the draft agreement is 10 years with automatic renewal for five-year terms.

Partner's obligation: The private partner is leasing the Bogalusa hospital and affiliated clinics. The total rental payment is $3.6 million annually. However, this lease expense will be treated as an allowable cost in the filing of the Medicaid cost report, subject to CMS regulations. Thus, the private partner stands to recover most if not all of these rental costs.

State's obligation: Funding details are not available, but a total of $34.7 million is budgeted for fiscal year 2014, including $10.6 million of UCC and $3.1 million in Medicaid payments to LSU. Also, there will be $15.6 million in UCC payments and $1.7 million in Medicaid payments to the former Bogalusa Hospital, with $3.7 million in supplemental payments made directly to St. Elizabeth Hospital.

Of special note: Our Lady of Angels Hospital will not be providing women's services that are in conflict with the mission of the organization, such as dispensing birth control. Women needing these services will access them through an alternate provider.

NO AGREEMENT ANTICIPATED

Lallie Kemp Regional Medical Center in Independence

Lallie Kemp is a federally designated critical access hospital located at 52579 Highway 51 South, Independence, in Tangipahoa Parish north of Hammond. The hospital has 21 staffed beds and 405 employees.

LSU will continue to operate this hospital and no private partner is contemplated at this time. The anticipated UCC revenue for fiscal year 2014 is $21.5 million.

Of note, this facility will be used for some prisoner inpatient care and a prisoner ward has been constructed at the hospital for this purpose.

APPENDIX B
Charity Hospital Services

Charity Hospitals Inpatient Care - 2011

The state-run hospitals annually handled more than $1 billion in business for inpatient care for the poor and uninsured.

Hospital Name	City	Revenue	Beds	Discharges	Patient Days
LSU Medical Ctr.	Shreveport	$357,973,801	477	20,902	125,304
Interim LSU Hosp.	New Orleans	$368,684,627	224	12,417	70,712
E.A. Conway	Monroe	$124,030,852	142	6,648	36,338
University Med. Ctr.	Lafayette	$110,664,187	87	4,837	24,976
Leonard J. Chabert	Houma	$102,871,499	96	5,266	25,608
Huey P. Long	Pineville	$52,128,436	60	2,353	14,710
Earl K. Long	Baton Rouge	$144,745,418	83	5,422	21,732
Bogalusa Med. Ctr.	Bogalusa	$63,855,830	55	3,569	16,048
W.O. Moss	Lake Charles	$44,984,624	32	1,278	8,654
Lallie Kemp	Independence	$40,447,704	18	1,122	4,273
Total		**$1,410,386,978**	**1,274**	**63,814**	**348,355**

Charity Hospitals - Outpatient Services - 2011

The state-run hospitals also operated extensive outpatient services, which will be continued by the private partners.

Hospital Name	City	Encounters	Clinic Visits	ER Visits
LSU Medical Ctr.	Shreveport	422,733	362,308	60,425
Interim LSU Hosp.	New Orleans	271,664	149,688	53,462
E.A. Conway	Monroe	141,280	105,662	35,618
University Med. Ctr.	Lafayette	182,256	100,319	44,562
Leonard J. Chabert	Houma	175,403	69,334	41,950
Huey P. Long	Pineville	75,262	41,954	37,758
Earl K. Long	Baton Rouge	194,553	113,376	46,720
Bogalusa Med. Ctr.	Bogalusa	118,946	58,707	27,843
W.O. Moss	Lake Charles	94,598	49,897	27,211
Lallie Kemp	Independence	81,554	42,401	27,371
Total		**1,758,249**	**1,093,646**	**402,920**

APPENDIX C
LSU Resident Placement

Where Residents Were Placed Before and After the Reform

This chart shows the number of residents assigned to the LSU hospitals before and after the transition to private partner operators. In some cases the LSU hospitals have seen a shift of their residents to other facilities run by a partner hospital. For example, before the transition, residents in Baton Rouge were assigned to Earl K. Long and Our Lady of the Lake. When Earl K. Long closed, all residents were placed at OLOL's facilities. A resident is a doctor who is completing a training program to become board-certified in a specialty field such as internal medicine. For example, a pediatric resident has completed medical school and is completing a three-year training program to become specialized in pediatrics. A first-year-resident is often referred to as an intern.

Hospital Name	City	Pre-transition	Post-transition	Partner Hosp. Pre-transition	Partner Hosp. Post-Transition	Current total
LSU Medical Ctr.	Shreveport	540	540	0	0	540
Interim LSU Hosp.	New Orleans	239.1	241.1	133.4	140.5	381.6
E. A. Conway	Monroe	25	25	0	0	25
University Med. Ctr.	Lafayette	71	46.89	0	18.25	65.14
Leonard J. Chabert	Houma	9.3	7.5			7.5
Huey P. Long	Pineville	0	0	21	21	21
Earl K. Long	Baton Rouge	86.5	0	47.7	126.5	126.5
Bogalusa Med. Ctr.	Bogalusa	13.5	12.6	0	0	12.6
W.O. Moss	Lake Charles	0	0	24.3	24	24
Lallie Kemp	Independence					0
Total		**984.4**	**873.09**	**226.4**	**330.25**	**1,203.34**

APPENDIX D

Top 10 States for Uncompensated Care Allotments

Top 10 States for Uncompensated Care Allotments

Louisiana is one of the Top 10 users of federal uncompensated care dollars, even though the state's population is smaller than the other states in that class. The state's charity hospital system is a major reason for that ranking, and this situation likely will continue under the new safety net.

Location	FY2008	FY2009	FY2010	FY2011	Rank
United States	$10,683,013,818	$11,376,768,510	$11,653,301,427	$11,288,052,532	
Tennessee	$3,054,519,282	$3,054,519,282	$3,054,519,282	$3,054,519,282	1
New York	$1,512,959,000	$1,619,017,426	$1,659,492,862	$1,607,960,722	2
California	$1,032,579,800	$1,104,963,644	$1,132,587,735	$1,097,417,551	3
Texas	$900,711,000	$963,850,841	$987,947,112	$957,268,445	4
Wisconsin	$890,423,551	$952,842,241	$976,663,301	$946,335,031	5
Minnesota	$703,509,451	$752,825,471	$771,646,111	$747,684,221	6
Louisiana	$731,960,000	$750,259,000	$769,015,475	$731,960,000	7
New Jersey	$606,361,000	$648,866,906	$665,088,579	$644,435,620	8
Pennsylvania	$528,652,600	$565,711,147	$579,853,926	$561,847,754	9
Missouri	$446,234,600	$477,515,645	$489,453,536	$474,254,563	10