

Comments on Blueprint Louisiana's Health Care Recommendations

Blueprint Louisiana makes several assertions of fact and recommendations for the future of Louisiana's system of health care access to the uninsured. These principally include:

- The current system has proven "enormously expensive" but provides "inadequate access to care."
- Care for the uninsured should be provided on a "dollar follows the patient" basis, rather than have funding flow "to facilities."
- LSU should focus on health care education and research instead of directly providing health care (recommended for some parts of the state but not others).
- Funding for Graduate Medical Education (GME) should be increased by moving programs to community hospitals
- The current system of safety net hospitals is atypical of the rest of the country and some of the state public hospitals under LSU should be turned over to local or regional governments

The Blueprint perspective closely tracks certain views expressed in the health care reform debate. It expresses understandable sentiments and objectives, but at the same time is based in large part on a flawed understanding of the current system leading to unrealistic recommendations that will not serve the state well. Following are comments on each of the principal positions expressed in the Blueprint.

- **Expensive Care, Inadequate Access.** *"The Louisiana tradition of caring for the uninsured through the charity hospital "safety net" **has proven enormously expensive, yet provided inadequate access to care.**" [Emphasis added]. A "**dollar follows the patient**" system is preferable.*

Response:

Health care is indeed enormously expensive, but it is a distortion of the facts to imply that care for the uninsured through the LSU Hospitals and Clinics is particularly so. The LSU hospitals and clinics expend around \$700 million (not \$1 billion as the Blueprint mistakenly indicates) in providing care for the uninsured **and** in supporting resident physicians and supervising faculty in training programs.

While the state receives excellent value for this expenditure, no one can claim that \$700 million is sufficient to provide **all** the access to health care that our large uninsured population requires and to support residency programs. At the same time, it has never

been demonstrated that access can be increased through expenditure of **the same amount of funding** through an alternative system.

Estimates are that insurance-type coverage would cost, not \$700 million, but upwards of \$2 billion annually. As recently as July 2007, the Kaiser Family Foundation estimated a “total annual cost of approximately \$2.3 billion in additional Medicaid program spending” that would be required to cover the uninsured.

In this context, the assertion in the Blueprint that the safety net provides “inadequate access to care” is simply disingenuous. An insurance-based, “dollar follows the patient” model that expended **three times more funding** naturally would increase access. If additional funding were made available, access could be improved through the current system as well.

The Blueprint repeats a common error in thinking about health care reform in that it associates deficiencies in access with our current safety net hospital and clinic system instead of with the level at which that system has been funded.

- **Funding Should Follow Patients to Private As Well As Public Hospitals.** It is recommended to “redirect state funds from facilities to people.”

Response:

This recommendation reflects a different version of “dollar follows the patient.” Rather than insurance benefits supporting the care of patients, some interests wish to direct existing funds -- not actually from “facilities” to “people” -- but from the LSU hospitals to other facilities in order to cover their own uncompensated care costs.

Understandably, no providers like to deliver care without reimbursement. However, in this less than perfect world, there are several issues with the recommendation to shift dollars from safety net to community hospitals.

First, the existence of the statewide hospital and clinic system with a mission to provide care to the uninsured **is itself a kind of subsidy to community hospitals**. It has resulted in a rate of uncompensated care in community hospitals that has been **less than half the national average** for all hospitals nationwide. Since Katrina, some hospitals have seen a significant increase in the number of uninsured, and special funding has been provided. On a statewide basis, however, the uncompensated care rate for Louisiana hospitals is **still below the national average**. It is fair to ask how much care to the uninsured community hospitals should be expected to provide because of their role in the community or their public, not-for-profit or tax status.

Second, most uninsured patients who access the LSU Hospitals are seen in clinics. Even those who go the Emergency Department can be referred to a clinic for necessary follow-up and can be assigned a primary care or specialist physician for routine or ongoing care. Generally, community hospitals are not imbedded in an integrated

network of physicians willing to provide ongoing care to those encountered in the ED. The LSU Hospitals and Clinics represent a better model of care for uninsured patients than community hospitals lacking a clinic system.

Third, the federal “Disproportionate Share” funding that flows to LSU to care for the uninsured is not a “grant” but instead is compensation received to reimburse for the cost of care that has occurred. Consequently, if the available funding were shifted away from LSU, services would have to be reduced and access would suffer. If the same funding were given to a community hospital, it would not necessarily go to additional care but in part would pay for care already provided as a result of federal requirements. The result will be a net loss in access, and, at best, the Blueprint is a plan to rob Peter to pay Paul.

- **LSU Better Suited to Education Than Care.** *The union of education and health care can “lead to a lack of focused attention in either area.” Our current approach leaves money on the table that could be obtained by dispersing training programs to other hospitals.*

Response:

The dual mission of education and care delivery in the LSU Hospitals provides a means to serve **both** health care access and health care training functions **with the same dollar**. Faculty physicians who teach new doctors are well able to both provide quality patient care **and** to supervise resident physicians in that care. Care delivery is not a distraction, but rather a critical part of the educational process. It may be a challenge to do both, but it is a challenge that academic medical centers successfully meet all across the country.

The Blueprint fails to lay out **both** the financial advantages **and** disadvantages that will result from dispersing educational programs widely. While there is some potential to gain revenues through Medicare as a result of more community hospital involvement, there also is a potential to lose funding from other sources, and this possibility is ignored.

The Blueprint does advocate retaining four academic medical centers under LSU, a recommendation that contradicts the position that education and care delivery detract from one another.

Divest Some State Hospitals to Local Control. *Louisiana’s statewide system of access for the uninsured is atypical, should be broken apart, and “responsibility for providing care to the uninsured should be shared by the private and public sectors, with an emphasis on local governance”*

Response:

- This view is based upon an inaccurate representation of the practice around the country. In virtually **all** states, there are both safety net and medical school hospitals and clinics that exist side-by-side with Medicaid and related insurance-type coverage programs.

- More local support for health care for the uninsured would be a welcome development. However, while there have been a variety of working groups at the local level, no local government, or regional association of local governments, has proposed to take over any of the state public hospitals, to assume responsibility for their funding, or to incorporate them into local or regional government structures. While elsewhere around the country, providing access to the uninsured **evolved** as a local function, in Louisiana there is no experience or history of operating local safety net facilities.
- The fragmentation of the state public hospital system would not only create the kind of residence-based eligibility issues that plague other states, but it would undermine significant accomplishments under LSU to achieve system level efficiencies involving information systems, purchasing, Disease Management and a host of other functions.

The Blueprint includes three recommendations that LSU can fully support.

- Those hospitals remaining under state control should attract more paying patients
- Eligibility for Medicaid should be expanded
- The state should “implement accountability for performance and quality of health care in publicly funded programs,” and this should apply to all hospitals.