

## **LSU Comments on PAR Report** **“Realigning Charity Health Care and Medical Education in Louisiana”**

### **General Comments**

PAR’s draft report recommends closing or divesting seven hospitals and removing them and their clinics from the statewide safety net of care for the uninsured that has been entrusted to LSU. LSU takes its legislated responsibilities for the state public hospital system very seriously, as we do our role in health care education. In crafting any new approach to the state’s health safety net and education functions, there should be assurances that the new system will function as well or better than the existing hospitals and clinics in delivering care and providing training for Louisiana’s future health care providers.

The PAR draft falls far short of this standard. Today people know where they can go for clinic or emergency care if they need it, regardless of their ability to pay. PAR’s Recommendations 2 and 4 would destroy the statewide safety net system in favor of a risky, ill-described venture that is only partly thought through and for which no cost is identified.

Recommendations 2 and 4 are the crux of the entire report because the bulk of the other comments and observations are designed to support them. Regardless of the limitations of the current system for delivering public health care services, it is disingenuous to suggest that it should be abandoned in favor of a model that PAR cannot describe fully and is either unwilling or unable to put into a business plan.

As Milton Friedman observed, “there is no free lunch.” There will be a check at the end of the meal and Louisiana will need to know how it can pay for what it orders. How can the legislators or anyone else genuinely interested in improving public health honestly appraise PAR’s recommendations without cost estimates for the proposed alternatives? If it is not PAR’s responsibility to provide cost estimates for its own proposed alternatives for public health delivery, then whose is it? How can PAR expect anyone to embrace Recommendations 2 and 4 without knowing if it will cost the state \$200 million, \$500 million, or \$1 billion more per year to provide an insurance product to all of Louisiana’s uninsured?

The state cannot afford to provide every health service that everyone might need. In either redesigning or maintaining its health care system, it is imperative that the state come to grips with available resources. The best system for Louisiana when \$700 million is available is not the best system if there is \$2.5 billion to spend. But it would be irresponsible to tear down a limited but working system to pursue a design we could not possibly afford. And based on the financial information it presents, PAR’s recommendations are indeed irresponsible.

The assertion on page 1 that “[R]egardless of the level of federal support . . . the recommendations in this report can be implemented to dismantle the two-tiered system....”

testifies to PAR's failure to attend in any realistic way to the financial basis of the steps it recommends for the state. PAR's recommendations for a different model to provide public health care in Louisiana, without a financial pro forma or business plan to support those recommendations, implies that there might indeed be "free lunch." PAR can dispel this perception by including cost estimates for Recommendations 2 and 4 in its report.

### Specific Areas of Concern

The problems in the PAR draft are not as much with the narrow facts it cites as that the facts do not themselves support PAR's recommendations. The analysis and interpretation of facts appear designed to support a pre-conceived policy direction.

### Origins of the Two-Tiered System

The lead paragraph sets the tone for the PAR analysis.

*The "inefficient union" of medical education and the indigent care through the charity system "results in a two-tiered system of care" (p.1)*

The "two-tiered" system most certainly does **not** "result" from either the actions of the charity hospitals or our educational institutions, but rather is a direct product of the country's employer-based health insurance system, which, in Louisiana, leaves over half the population without coverage. In the face of **two tiers of coverage**, the charity hospitals and clinics offer the best care possible within available resources to those people whom neither employers nor government can afford to insure. To the extent that funding permits, the state public hospital and clinic system narrows the access gap between the insured tier and the uninsured tier.

### Efficiency

The union of education and health care for the uninsured is hardly "inefficient," as the above quote asserts, and it provides a means to **both** deliver care and train physicians with the same dollar.

In addition to characterizing the union of the state public hospital system and GME as "inefficient," PAR on page 1, line 6 cites the current indigent care system as being "inefficient and unfair." Page 3, line 46 refers to "the expensive and inefficient state-operated institutional system of care...."

And yet the report presents no evidence dealing with the matter of "efficiency," either in the state public hospitals or in private facilities. Inefficiency is simply asserted, repeated and emphasized, but with no documentation.

The report does note the distribution of spending across hospitals on page 17, lines 19-20: "The bulk of funding for the uninsured goes to the hospitals that treat the smallest share of the uninsured but are responsible for medical training. The Medical Center of Louisiana at New Orleans and the LSU Medical Center at Shreveport, both headquarters for LSU medical schools, treat a total of 35 percent of uninsured caseload but receive nearly 70 percent of disproportionate share funding." This distribution is indeed associated with medical education but it also represents an effort to conserve scarce resources by making high cost specialty care available at only a few referral centers. It is evidence of efficiency, not inefficiency, in the face of inadequate funding for the safety net mission.

## Access to Care

A major theme of the PAR report is that access to care is insufficient in the charity system.

*“The pervasive lack of ready access to the basic menu of medical services offered by the charity hospitals is the most glaring problem with Louisiana’s current system of care for the uninsured.” (p. 11)*

*What can be noted about quality of care in the charity hospital system is that some tried and true advanced technology procedures, such as cardiac catheterization, angioplasty and heart bypass surgery, are still not offered in most charity hospitals.” (p. 11)*

The root of these problems is repeatedly noted. For example:

Louisiana has “a public sector **with enormous responsibility but inadequate resources**” (p. 20,) and a “two-tiered system of care in which the uninsured are left to seek care in an **understaffed, underfunded** network of 10 charity hospitals (p. 1, emphasis added)

It is inevitable and endemic that access would be restricted in a safety net system funded at a level well below the cost of insurance coverage for the uninsured population. In the ten hospital system, most specialties are available, but access often involves travel. Simply put, the charity system’s funding level results in rationing and inconvenience to some patients in some circumstances.

Given the resources available, it is a fair question whether unavoidable rationing of care could be structured in a more reasonable manner. Certainly, the use of **all** safety net funds to pay insurance premiums for a minority of the uninsured population, as some have proposed, would not be such a rational alternative. That would be the worst possible model for Louisiana.

If underfunding, as PAR argues, is a major flaw in the charity hospitals, it is not a problem associated with a **safety net system** per se. LSU did not elect to be underfunded. The system can provide as much or as little care as the State wishes to support and its resources permit. PAR cites deficiencies of the current system that are due not to the safety net model but to the level at which the model is funded.

One might suppose that a system cited as hamstrung by “underfunding,” as PAR emphasizes, might be recommended for additional support. With access a problem for some, it would be logical to advocate added funding to hire additional physicians, add clinics, reduce wait times, and implement services nearer to patients in order to address what PAR says is “the most glaring problem” with the current system. But instead PAR appears to be in the business of closing down the charity system, irrespective of the viability of alternatives.

## Measurement of Quality Care

PAR asserts that there is little data available to measure quality in the charity system.

*“Little data exist to track quality in the charity system, and what is available measures so few cases as to render it of little use in most cases.” (p. 11)*

Accredited U.S. hospitals have elaborate systems and structures to monitor, maintain and improve quality, as required by the Joint Commission on Health Care Organizations (JCAHO). Beyond this minimum, LSU has developed an extensive system to measure and utilize quality and outcome indicators in conjunction with its Disease and Chronic Care Management program. Statistical comparisons to national and other benchmark standards are made available online to physicians and other professional staff. For over ten years, clinical staff has worked systematically with this information to improve outcomes and to exceed state and national standards.

PAR has not done its homework on LSU's systems of quality measurement, an area perhaps beyond the organization's level of clinical expertise. Information readily available, however, shows that ***quality in the LSU system is generally at or above state, national and professional standards.***

### **“Antiquated” Model**

PAR asserts that the charity hospital system is “antiquated” (page 1, lines 20-23). It certainly is **not** the case that the integrated delivery model linking clinic primary care and specialty physicians with hospital care is out-of-date. System integration, employed by such entities as Kaiser-Permanente and Ochsner, promotes both efficient and high quality care, and it has greatly facilitated the achievements in Disease Management under LSU.

What PAR may refer to with the pejorative “antiquated” is the structure of a “safety net” versus an insurance model. If insurance coverage for all were affordable, it clearly would be preferable to a safety net model. In the absence of an ability to cover the uninsured, however, it is important to help the provider safety net work as well as possible rather than undermine it.

### **Confusion About Funding**

PAR characterizes Medicaid Disproportionate Share funding for the charity hospitals as “grants”:

*“...DSH funds have been used as grants that guarantee the charity hospital system ‘will make budget’ regardless of how efficient the system is.” (p. 23)*

In fact, DSH funding does not represent a “grant” provided to the hospitals, but rather is a reimbursement program in which payments are restricted to “allowable costs.” ***If costs are not incurred by providing care to uninsured patients, no payments are received.*** Payments for care to the uninsured are audited by the federal government through a formal Cost Reporting process. Because some unavoidable costs are not “allowable” under the program, however, there is no way to break even on the provision of care to the uninsured, much less to make a profit.

### **Local Government Role**

PAR cites the possibility that local governmental entities would take over some of the seven targeted hospitals. No information is presented about how this would be financially feasible given the local tax base, what revenue stream would support the facilities, whether local taxes would be affected, or how multiple parish jurisdictions would cooperate to run facilities that serve them all. Nothing was said about who would be responsible for arranging, funding and delivering specialty care not available in the local hospital.

For better or worse, there does not today exist a level of expertise in local governments to manage hospitals and clinics, given virtually no local historical experience with a health care function and especially with a hospital mission to serve several high risk populations, such as those with HIV/AIDS, and those who are difficult to serve in community clinics, such as prisoners.

In other states, the indigent care mission evolved differently than in Louisiana, and perhaps over time it may evolve here. However, PAR presents no basis to conclude that proposed local control is a viable alternative at the present time.

### **Louisiana as an “Outlier”**

Page 6, lines 20-21: “Louisiana is definitely an outlier in caring for the uninsured, with its highly centralized, 10-hospital charity system operated by state government.” PAR contrasts Louisiana with the rest of the country in which “providing for the uninsured tends to be a local responsibility that is shared by a mix of health care interests, which often include municipal or county hospitals, academic medical centers in some locations, Federally-Qualified Health Centers (FQHCs) and other clinics, and sometimes physicians in private practice.” (Page 6, lines 6-10)

As PAR observes, no two states have indigent care systems exactly alike. In fact, all states have safety net hospitals, usually run by local entities or medical schools that resemble the LSU facilities. There are few material differences in this regard between Louisiana and other states, but there are significant advantages to Louisiana’s statewide approach in terms of regional distribution of specialty services and eligibility for care regardless of the parish of residence.

### **Financial Health and Payer Mix**

The draft on page 7, lines 28-33 says: “According to national surveys, Louisiana’s charity hospitals are none too healthy compared to other public hospital systems around the country. Over the past few years, the numbers of patients and services provided have declined at charity hospitals. Meanwhile, indigent care at private hospitals has increased, despite the lack of compensation. Federal rules requiring all hospital ERs to treat patients regardless of ability to pay make it all but impossible for private hospitals to turn away patients.”

This decline in numbers of patients and services is entirely a function of funding, not the operation of the system per se. Service capacity has shrunk as the budget has declined against the rate of medical inflation. This trend does not represent, as PAR suggests, a failure of the system or the model but rather choices made about the resources allocated to it.

Similarly, the low proportion of paying patients cited by PAR (page 8, lines 20-22) is due to capital funding problems and funding rules that prohibit market based decisions. These problems are external not internal in origin.

PAR’s assertion (page 23, lines 5-8) that “the continuing decline in patients, services and revenues and the increasing need for subsidies” means that “the charity hospital system is not financially sustainable for the long term” is only true if the system is not supported. The same would be true of PAR’s alternative approach if it were not adequately funded, and at the much higher level that will be required.

## Relations with Private Sector

Page 8, lines 1-5: “Increasingly, patients are seeking care outside the public hospital system where they can find more immediate attention in more modern facilities. The estimated cost for providing care to the uninsured in non-charity hospitals has exceeded \$100 million annually. The private hospitals, however, are not being reimbursed for this “uncompensated care” with federal funding that is currently reserved mainly for the charity hospitals.”

The Legislature has allocated the preponderance of DSH funds to the charity hospitals, contingent upon incurring reimbursable costs in caring for the uninsured. However, those DSH funds that are allocated to non-state hospitals reduce the \$100 million figure cited above.

All hospitals encounter some percentage of patients unable to pay, however. Prior to Katrina and Rita Louisiana hospitals experienced uncompensated care at ***a rate less than half the average of hospitals nationally, an advantage resulting directly from the support for the bulk of uncompensated care in the charity hospital system.*** As a result, although non-state hospitals have received proportionately less DSH funding than their volume of uninsured patients would suggest, they ***historically have enjoyed a net “subsidy” resulting from the existence of a safety net system.*** This subsidy goes directly to the bottom line of non-state facilities.

This state-federal subsidy of community hospitals through the charity system also has had the effect of diminishing what otherwise would be a greater extent of **cost shifting** to the business sector, which pays most health care premiums. If the charity system were closed as PAR advocates, and federal and state funds were not found to bring patients into an insured status, the result will be a **significantly increased extent of additional cost shifting to business.**

## GME

Page 17, lines 4-5: “Training residents almost exclusively in poorly funded charity hospitals limits students’ exposure to diverse caseloads and limits access to certain types of federal funding to support the research and teaching functions of the medical school.”

Over a third of residency slots exist outside the ten state public hospitals, hardly an “almost exclusive” relationship. Further, the exposure to diverse caseloads in fact is an unparalleled advantage of training in the LSU facilities.

PAR asserts that Louisiana is leaving **Medicare** GME funding “on the table” by utilizing a hospital system with a relatively low Medicare patient share.”

“Dismantling the two-tiered health care system is key to improving the funding structure of the medical training programs.” (Page 17, lines 33-34)

And on page 18, starting on line 45: “Because so few Medicare patients seek care in charity hospitals, the medical school at New Orleans forfeits a source of federal funding for Graduate Medical Education that is widely accessed at other schools around the nation. Some estimates are that an additional \$160 million in Medicare payments annually is left untapped because of the limited patient mix at the charity hospital.”

However, the state gains millions of dollars in **Medicaid** GME funding because of the structure of our safety net system and its relationship with medical education. PAR fails to show the **net**

**of any gain through Medicare and loss through Medicaid in GME funding, if its alternatives are implemented.**

## **Conclusion**

Change in the public health care system is both desirable and inevitable. It must be thought through, however. Catchy phrases, such as “the dollar follows the patient” have serious financial and other implications that have not been fully described or costed out. The same is true for suggestions, promoted by PAR, to remove hospitals now part of an *integrated* statewide system and spin them off to multiple, local governmental jurisdictions with no dedicated revenue stream and no experience in the health care sector.

The PAR report represents a continuation of the traditional tactic. Bash and denigrate the charity system (whose patients have little political voice), reduce political and financial support for it, but come up with no workable alternative. The hospitals under LSU record nearly two million outpatient visits per year, a large majority in clinics. The population without insurance definitely needs much more care than this. The public will expect to know what will replace a system that, above all, assures a place to go for care when it is needed, as well as trains tomorrow’s doctors, dentists, nurses and allied health workers.