

WORKING P A P E R

The Public Hospital System in Louisiana

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WR-314

October 2005

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Key Findings

- The key consideration following closure of a public hospital is to ensure that the level of uncompensated care provided in the community (the safety net) is maintained. Some communities that closed their public hospitals developed local coverage programs to purchase care for the indigent uninsured; these arrangements facilitated continuing care and were associated with expanded ambulatory care and fewer preventable hospitalizations.
- A critical issue for most communities deciding to close a public hospital involved the ownership of facilities that would care for the indigent uninsured; the principle concern was how a change in ownership would affect the facility's mission as a "provider of last resort."
- All ownership models studied appear to have maintained existing levels of uncompensated services following closure of a public hospital when contracts and regulations were designed to address this issue.
- Medical education in the community appears to be maintained following closure of public teaching hospitals.
- Achieving the community goal of providing high-quality care to all citizens depends on careful needs assessment, planning, and consensus building. Planning includes determining the mission of any new facilities, carefully assessing local supply of and demand for health care, understanding local market forces, and determining an appropriate governance, financing and regulatory structure.

The sudden closure of Charity Hospital following Hurricane Katrina represents the loss of the nation's second oldest continuously operating public hospital, one that has provided care for the poor and underserved of New Orleans since 1736. Charity Hospital is part of the Medical Center of Louisiana at New Orleans (MCLNO), which also includes University Hospital (formerly known as the Hotel Dieu). MCLNO is part of a statewide network of ten public hospitals operated by the Louisiana State University Health Care Services Division (HCSD). The Louisiana Department of Health and Hospitals (DHH) and the HCSD must now decide whether to rebuild the MCLNO, and if so, must decide on its structure, function, governance, and financing.

The situation in New Orleans is unique for two reasons. First, MCLNO closed suddenly, with little opportunity for careful planning to address the reduction in hospital services or to make other arrangements for patients. Second, because a significant portion of New Orleans' population relocated following the hurricane, the region may experience much less demand for hospital services, at least in the near term. Despite the uniqueness of the situation in New Orleans, there are lessons to be learned from other cities that have closed public hospitals, and we draw largely from this literature in outlining the options for New Orleans.

Considerations for Policy Design

The Greater New Orleans Health Planning Group has set out its preliminary objectives for future hospital care in the city. These goals include (1) developing a seamless, integrated system of primary, secondary, and tertiary care that assures access to high-quality care for all citizens irrespective of socioeconomic status and (2) sustaining high-quality medical education. In this brief, we describe policy considerations associated with two key decisions regarding the public hospital system in New Orleans and the preferred arrangements needed to meet Louisiana's health care and medical education goals: 1) whether or not to rebuild MCLNO as a public hospital that replicates the pre-Katrina model, and 2) what types of private and public-private arrangements might be pursued if the decision is made not to rebuild MCLNO as a publicly owned center. We also discuss considerations relevant to the decisionmaking process.

Whether or Not to Rebuild MCLNO as a Public Hospital that Replicates the Pre-Katrina Model

Based on the evidence from public hospital closures in other communities as well as New Orleans' public hospital delivery model prior to Hurricane Katrina, DHH and HCSD have several options for meeting the goals of delivering high-quality health care to all citizens and sustaining high-quality medical education. These options include rebuilding MCLNO as comprehensive public hospital, creating public-private partnerships, and allowing the private sector to meet all the medical and medical education needs of New Orleans.

Option 1: Rebuild MCLNO as a Comprehensive Public Hospital

Compared to most cities, New Orleans had a larger percentage of poor and unhealthy residents, fewer residents with private health insurance coverage, and fewer financial resources to meet the health needs of its citizens. Should these demographic characteristics persist, they would support the continued need for a significant health care safety net in the city and throughout the state. MCLNO has been a key safety net provider within New Orleans, and has also served as a major referral center for patients in other treatment facilities throughout the state, including the eight other facilities in Louisiana's public hospital system.

Advantages of Rebuilding:

- **Continuation of tradition.** For nearly 270 years, MCLNO served the City of New Orleans and represented the commitment of the City and State to care for its poor and underserved residents. Rebuilding Charity Hospital could symbolize the city's commitment to care for all citizens as the city rebuilds.
- **State control.** The State of Louisiana would maintain complete control over its public hospital system, including planning, standardizing health care policy for the entire system, and integrating purchasing and resource allocation processes.

Disadvantages of Rebuilding:

- **Financing.** The MCLNO financing structure was unstable; rebuilding alone would not address this issue. The financial instability of many public hospitals is related to inefficient administrative procedures (e.g., personnel management, procurement procedures, budget planning, capital access) and financing mechanisms that place a large burden for uncompensated indigent care on the hospitals. Also contributing to financial problems for public hospitals have been changes in payments for Disproportionate Share Hospital and Graduate Medical Education, both of which have led many public hospitals to restructure.¹
- **Patient mix.** Even the rebuilding of Charity Hospital as a modern facility would not allow MCLNO to attract the mix of patients that would enhance the hospital's long-term financial stability. Private, for-profit, urban acute care hospitals are more likely to offer profitable services of the sort that attract patients with public or private insurance (e.g., cardiac catheterization and sports medicine clinics), while public hospitals tend to focus their offerings on the kinds of services needed by the poor and uninsured (e.g., psychiatric emergency services, and AIDS-related services), many of which may be unprofitable.²
- **Quality.** Poor quality of care and medical errors are more common in financially distressed hospitals.³ If MCLNO is rebuilt without the mechanisms to assure its financial stability, the quality of care that is delivered will not meet expectations.
- **Uncertain demand for services.** Predicting the demand for health care in post-Katrina New Orleans will be difficult because of rapid fluctuations in the population. During this time of uncertainty, investments in bricks and mortar solutions risk creating either too little supply, resulting in unmet needs among the poor and underserved, or oversupply, resulting in high costs, inefficiency, unnecessary medical procedures, and troubled medical education.
- **Time.** Considerable time would be required to plan and build a public hospital that provides comprehensive services; during the rebuilding period, many New Orleans residents would find alternative systems that provide needed care. In all cases of public hospital closure that have been studied—including closures that were not carefully planned in advance—the demand for health care was met by other facilities, including privately owned hospitals and ambulatory care clinics. The movement of patients to other facilities occurred even when a successor public system was not introduced.⁴

¹ Andrulis DP, Duchon LM. Hospital Care in the 100 Largest Cities and Their Suburbs, 1996-2002: Implications for the Future of the Hospital Safety Net in Metropolitan America. SUNY Downstate Medical Center, New York, 2005

² Horwitz JR. Making profits and providing care: Comparing Non-profit, for-profit, and government hospitals. Health Affairs, 24(3): 790-801, 2005.

³ Burstin HR, Lipsitz SR, Udvarhelyi IS, Brennan TA. The Effect of Hospital Financial Characteristics on Quality of Care. JAMA 270(7): 845-849, 1993; Zhao M, Bazzoli GJ, Carretta HJ. Hospital Financial Distress and Patient Outcome: A Panel Study. Presentation at the 2004 Annual Meeting of AcademyHealth, 2004

⁴ Bovbjerg RR, Marsteller JA, Ullman FC. Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion. The Urban Institute, Washington DC. 2000

- **Opportunity costs.** Rebuilding would involve significant lost opportunity costs. Following the closure of a public hospital, most communities have used the money saved to fund other community health and development needs, especially expanded primary health care, disease prevention, and wellness programs.⁵

Option 2: Create Public Private-Partnerships

When faced with the need to restructure their public hospital systems, many communities have turned to mixed models of ownership and financing with the goal of maintaining the service mission of the public hospital while also attracting a mix of patients that would enhance financial stability. There are many successful models for the State of Louisiana to consider, including quasi-public; not-for-profit; and for-profit ownership models, lease arrangements, and joint ventures.

Advantages of Public-Private Partnerships:

- **Efficiency.** Health care delivery in mixed models appears to be more efficient while preserving the level of health care for the indigent uninsured.⁶
- **Flexibility.** Public-private partnerships would provide needed flexibility as New Orleans rebuilds and the sociodemographic characteristics and medical needs of the population change. For instance, DHH would have the option of building a primary and secondary care delivery system, integrating tertiary care from its private partners.
- **Integration and planning.** Establishing relationships and ongoing communication among all the partners responsible for providing care to the indigent uninsured could allow for improved integration and planning, including improved disaster preparedness planning and surge capacity.
- **Proximity to community in need.** Public-private partnerships offer the opportunity to provide care throughout the community from locations in proximity to those most in need. A recent study suggests the importance of living close to needed care; in this study elderly individuals who lived in primary care shortage areas were nearly twice as likely to experience a preventable hospitalization.⁷ Another study found that shorter distance to the nearest hospital was associated with fewer deaths from unintentional injury and myocardial infarction; however, that study was conducted in Los Angeles, which is unique in that many hospitals do not have emergency departments.
- **Support for medical education.** Public-private systems appear capable of supporting medical education needs. The literature on residency training programs indicates that, after closure of public hospitals providing medical education, surrounding facilities absorbed trainees so the number and size of

⁵ Center for Health Policy, Law, and Management. A Guide for Communities Considering Hospital Conversion in the Carolinas. Duke University, Durham, NC. 1998

⁶ Legnini MW, Anthony SE, Wicks EK, Meyer JA, Rybowski LS, Stepnick LS. Privatization of Public Hospitals. Economic and Social Research Institute, Washington, DC, 1999; Bovbjerg et al., 2000

⁷ Parchman ML, Culler SD. Preventable Hospitalizations in Primary Care Shortage Areas. Archives of Family Medicine 8:487-491,1999

programs remained stable. In some cases, training improved because of the broader experiences that could be provided.⁸

Disadvantages of Public-Private Partnerships:

- **Time, attention, and planning.** Mixed public-private models require time, attention, and planning from all segments of the health care system, and they may require statutory and regulatory changes or federal waivers for successful implementation.

Option 3: Allow the Private Sector to Provide New Orleans' Safety Net and Fill Medical Education Needs

New Orleans has several large private hospital systems that also deliver uncompensated care to indigent uninsured individuals, including some that provide medical education, such as Tulane University and the Oschner Clinic. Most studies indicate that higher levels of uncompensated care in public relative to private hospitals are largely due to the greater likelihood of public hospitals being located in urban areas with high levels of need. When both public and private hospitals are located in the same area, differences in levels of uncompensated care largely disappear.⁹ Medical education for LSU students and residents could also be maintained under a private sector option, but GME waivers and others issues would need to be considered.

Advantages of Private Hospital Solutions:

- **Operational costs and quality.** Private hospitals may be more efficient and less costly to operate than public hospitals, resulting in the potential for lower prices, facility modernization, and investment in new equipment that allows the hospital to offer better quality.¹⁰ Some case studies of conversion from not-for-profit to for-profit status have demonstrated improved efficiency associated with cost-cutting, increased access to capital, and debt-burden relief.¹¹

Disadvantages of Private Hospital Solutions:

- **Availability of uncompensated care.** There is no assurance that private hospitals would be willing to provide for all of the uncompensated care that is needed.
- **Mix of services offered.** The types of services offered by private, for-profit hospitals are more likely to be relatively profitable services, while such hospitals might not provide sufficient levels of types of typically unprofitable services needed by the poor and uninsured.¹²

⁸ Legnini et al., 1999

⁹ Center for Health Policy, Law, and Management, 1998

¹⁰ Shen YC, Eggleston K, Lau J, Schmid C. Hospital Ownership and Financial Performance: A Quantitative Research Review. NBER Working Paper No 11662. September 2005

¹¹ Collins SR, Gray BH, Hadley J. The For-Profit Conversion of Nonprofit Hospitals in the U.S. Health Care System: Eight Case Studies. The Commonwealth Fund, publication #455. New York, NY, 2001

¹² Horwitz JR. Making profits and providing care: Comparing Non-profit, for-profit, and government hospitals. Health Affairs, Vol2 24(3), 790-801, May/June 2005.

- **Limits on billing arrangements.** Many private hospitals require pre-admission deposits and limit flexible billing arrangements, such as the ability to make small payments over time. While these business practices do not appear to limit the amount care delivered, they have often resulted in considerable animosity among patients and in some cases, legal action.¹³
- **Higher prices.** Prices are generally higher at private hospitals than at public hospitals.¹⁴ Because the uninsured and underinsured are more likely to have limited education and to be poor, non-white, and otherwise disadvantaged, they are more sensitive to these higher prices.

Private and Public-Private Arrangements for the State to Consider if MCLNO Is Not Rebuilt as a Comprehensive Public Hospital

Private and public-private partnership arrangements can take many forms, each with a different degree of private sector responsibility and risk. The various forms are differentiated by whether or not the private partner manages delivery of health care services, owns or leases the physical facility, employs the staff, and finances any capital investments. If the decision is made not to rebuild MCLNO as a comprehensive center, the State of Louisiana will need to consider various options for public-private partnerships to meet its health care and medical education goals. The option or combination of options selected will depend on the specific market dynamics that develop in New Orleans, state and local capacity to regulate and effectively manage the quality of care that is delivered, and public consensus.

Option 1: Buy Rather than Build New Capacity

In making the decision to close a public hospital, all communities that have been studied have decided to buy health care for their indigent uninsured population rather than build new physical facilities. Each of these communities used various tools of the sort described below.

Option 1A: Expansion of State Programs such as Medicaid or SCHIP

Expansion of existing state programs can be used to expand access to care. These programs do not cover all segments of the uninsured population, however, and must thus be combined with other coverage options if access is being expanded to all citizens.

¹³ Hearle K, Gallese P. Demonstrating and Improving Hospital Accountability for Charity Care. The Lewin Group, Falls Church, VA 2005

¹⁴Claxton et al, 1999; Mark 1997

- **Advantages:** The expansion of state programs would allow the State of Louisiana to expand coverage for children and some adults. This option would reduce the overall burden of care for uninsured among remaining public health care facilities. Better insurance typically leads to better primary care access, which could result in a reduction in avoidable hospitalizations and emergency room use. Expansion of state programs might also reduce the overall cost of care for the uninsured.
- **Disadvantages:** Better access to primary care through better insurance coverage might cause the demand for hospital care to increase as unmet needs are discovered in an indigent population with a high burden of illness.

Option 1B: State Regulation of Hospital Rates

The State could mandate and regulate a statewide hospital care payment rate system that incorporates cost of care to the uninsured. Such a system has been successfully implemented in Maryland over the past three decades.¹⁵ Hospitals have supported Maryland's system because it allows for predictable payment rules, prohibits unapproved cost-shifting, and does not discriminate among payers.

- **Advantages:** Such a system could be seen as more equitable by helping distribute the financing of care for the indigent to all payers. Rate regulation would help ensure that all indigent care is paid for and could reduce overall hospital costs.
- **Disadvantages:** State regulation of hospital rates might not adequately cover the cost of outpatient care. Moreover, such a system would be effective only with the participation of all payers. The system would also require a Medicare waiver.

Option 1C: Establishment of Local Funding Mechanisms to Purchase Care

Louisiana might consider requiring local jurisdictions to set aside local funds to purchase care from local providers. Funding sources might include local tax revenue or use of local or statewide uncompensated care pools, i.e., taxes on hospital admissions. Many local governments have used funds that would otherwise have supported a public hospital to create new coverage programs for the indigent uninsured.

- **Advantages:** Access to care might increase for the uninsured because a greater number of providers would be willing to provide care that would previously have been uncompensated. The increase in providers could also mean better geographic accesses to care as more providers are available in patients' local areas. Local government would also be able to plan the system of care in the short and medium term and to select and pick the best and most appropriate mix of providers. Such a program could reduce administrative costs because the plan would not require government to deal with insurance administration.

¹⁵ Achievement, Access, and Accountability: A Guide to Hospital Rate Regulation in Maryland. Association of Maryland Hospitals. Eldridge, MD, 2002

- **Disadvantages:** The revenue available for the local uncompensated fund would fluctuate with the local economy. Because the size of funds may be small, the range of services provided could also be limited. Moreover, if payment to providers is based on fee-for-service, providers could have the incentive to overutilize the system. In addition, Medicaid-eligible patients might have a disincentive to apply for Medicaid, choosing instead to rely on local uncompensated funds. The involvement of a diverse group of providers may also make it difficult to monitor quality of care.

Option 2: Explore Public/Private Ownership and Management Options

If Louisiana does not rebuild MCLNO as a government-owned and operated facility, the State has two main options. First, the State can retain ownership of the physical facility but transfer management of the facility to another public entity. One alternative would be to transfer management to state or local government through use of a management contract, lease, or joint venture arrangement; our literature review found little evidence regarding the advantages and disadvantages of these specific arrangements. Another alternative would be for the State to transfer ownership of the system to a public subsidiary (such as a public authority or public benefit corporation) governed by an independent body outside of the state government. Second, the State could transfer ownership by awarding a contract to a private, not-for-profit entity that would agree to meet the needs of New Orleans' indigent uninsured population.

Option 2A: Ownership of Facilities by State or Local Government with Management by a Public Health Authority

In this arrangement, Louisiana would use state statute to create a public body or agency of a governmental unit that would be granted the authority to administer the publicly owned hospital.

- **Advantages:** This option would remove many public constraints on purchasing, personnel management, and capital investment that can inhibit growth and competitiveness and promote inefficiency.¹⁶ The State would retain ownership of and ultimate control of the hospital/system, while the hospital would continue to benefit from debt and liability protections granted to public hospitals. This option would also maintain the State's public mission of caring for the indigent uninsured.
- **Disadvantages:** Such an arrangement might be perceived as adding a new layer of bureaucracy. Moreover, time would be needed to make the transition to the new authority. Under this arrangement, the State would remain at risk of a reduced credit rating if the hospital cannot meet its financial obligations. Nor would the State entirely free itself from public constraints; for example, decisions regarding capital investment or joint ventures might still be subject to requirements for public hearings or other forms of governmental oversight.

¹⁶ Bovbjerg et al., 2000

Option 2B: Transfer of Ownership to a Private, Not-for-Profit Hospital Corporation

Although many of its physical assets are now gone, MCLNO still has many other assets, including land, its relationship with the Louisiana State University schools of Medicine, Nursing, etc., and the goodwill of the people of New Orleans. These assets could be transferred to an investor-owned successor organization while structuring contracts to ensure that the safety net mission of the hospital is maintained. In the most common arrangement, the State of Louisiana could require the new, successor facility to provide a specified level of uncompensated care in return for tax-advantaged, not-for-profit status.

- **Advantages:** Under this arrangement, the net value of uncompensated care provided by not-for-profit hospitals would appear to exceed the losses in tax revenue.¹⁷ Transfer of ownership would remove most public constraints that inhibit competitiveness and growth potential. Such an arrangement would also eliminate the potential risk of a reduced credit rating in the event that hospital could not meet its financial obligations.
- **Disadvantages:** This type of arrangement could cause the hospital to behave more like a for-profit entity and thus to stray from its mission to serve the indigent. According to some estimates, most of the uncompensated care is delivered by about 15% of all not-for-profit facilities.¹⁸ In addition, the hospital would no longer benefit from the debt and liability protections granted to public hospitals.

Process for Making Decisions About the Future of the Public Hospital System in New Orleans

Other communities that have successfully restructured their public hospital systems have taken a period of due diligence to assess options to create a system that is responsive to the needs of their indigent uninsured population, that allows the future system to attract a mix of patients that ensures financial stability, and that meets the region's needs for medical education. A waiting period might be particularly important in New Orleans because of dramatic changes in the supply and demand for health care services. The processes described here, while comprehensive, need not be lengthy and can be accomplished in 6 to 12 months.

Build Consensus

The success of the conversion process will depend on early agreement among all stakeholders concerning the continued public mission of the successor facility.¹⁹ The process should take into account the perspectives of all stakeholders, especially minority and ethnic groups, employees, and the indigent uninsured. The State should identify those who could be adversely affected by its policy decisions and include them in plans to mitigate the potentially detrimental effects

¹⁷ Claxton G, Feder J, Shactman D, Altman S. Public Policy Issues in Nonprofit Conversions: An Overview. Health Affairs 16(2): 9-28, 1997

¹⁸ Claxton G et al., 1997

¹⁹ Legnini et al., 1999

Take a Systems Approach to Planning

A systems approach to planning would require the State to consider local market dynamics as well as existing supply and demand. The State should consider surveying the population to project future need based on demographics of current and returning population. The State will also want to assess the statutory and regulatory environment, including the use of waivers.

Use All Available Resources

The State of Louisiana may want to consider establishing task forces to assess issues relevant to the future of the public health system and make recommendations. Such task forces would include representatives from former public hospitals around the country to ensure that success in identifying the full range of options and the most successful models.

Key References

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