

**A PRE-KATRINA LOOK AT THE HEALTH CARE DELIVERY SYSTEM FOR LOW-INCOME PEOPLE IN NEW ORLEANS**

When hurricane Katrina hit the Gulf Coast on August 29, 2005, it caused massive devastation in Louisiana, one of the poorest states in the country. The greatest impact, by far, was felt in the city of New Orleans where massive flooding forced the evacuation of over one million people and crippled or destroyed much of the city's infrastructure. Much of the health care delivery system in New Orleans has been damaged or destroyed including the Medical Center of Louisiana at New Orleans (MCLNO), the largest public hospital serving the New Orleans area. The closure of MCLNO, which included Charity and University hospitals, not only affects the thousands of people who received regular care in the hospitals or at one of their many outpatient clinics, but also severely disrupts the state's trauma care system. MCLNO operated the only Level 1 trauma center along the entire Gulf Coast. The other Level 1 trauma center in the state is located over 300 miles away in Shreveport.

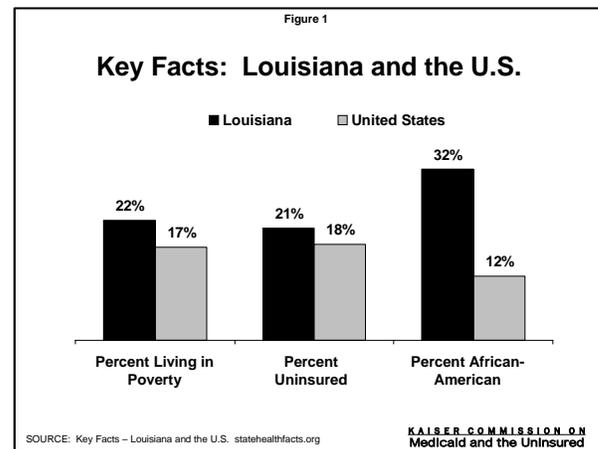
With many hospitals in the New Orleans area still closed and with area residents beginning to return, officials in New Orleans and Louisiana face the overwhelming challenge of rebuilding the health care infrastructure. At the same time, this catastrophe offers an opportunity to rethink and restructure the system of care for the poor. To assist in this effort, this issue brief offers a retrospective look at how care was provided to poor residents in New Orleans before Katrina hit. It describes the structure of the public safety net and briefly discusses the challenges facing the system as it tries to rebuild.

**HEALTH CARE FOR LOW-INCOME AND UNINSURED IN LOUISIANA**

When Katrina struck, about 22 percent of Louisiana residents and 23 percent of New Orleans residents were living in poverty (\$16,090 for a family of three). Over 900,000 people or 21 percent of all residents in Louisiana had no health insurance. Tied to these poverty and uninsurance rates, Louisiana also had some of the poorest health statistics in the country with high rates of infant mortality, chronic diseases such as heart disease and diabetes, and AIDS cases, and lower than average childhood immunization rates. (Figure 1) Large disparities in health status exist for minorities in the state. African-Americans who represent one-third of all residents in the state and two-thirds of all residents in New Orleans are more likely to suffer from heart disease, diabetes, and asthma than their White counterparts.

**Medicaid.** About 19 percent of the population in Louisiana was covered by the Medicaid program. Medicaid covers individuals who are categorically eligible according to federal eligibility rules and who meet income thresholds that are set by the states. Louisiana covers children and pregnant

women up to 200 percent of the Federal Poverty Level (FPL); however, parents are only eligible if they have family incomes below \$3,168 (20 percent FPL) if they are working and \$2,088 (13 percent FPL) if they are not working. The aged and disabled with incomes below \$7,082 are also eligible. Childless adults do not meet categorical eligibility requirements and are not eligible for Medicaid coverage. The federal Medicaid matching rate for Louisiana is 71 percent, so for every \$1 dollar of state general funds spent on Medicaid, the state receives \$2.45 in federal matching funds.

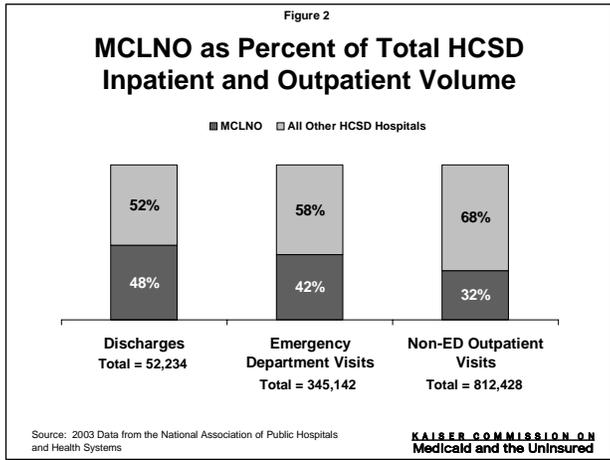


**Safety-Net System,** Louisiana has a unique safety-net system to deliver care to the uninsured. In most other states, local governments shoulder the responsibility for providing care for the uninsured, not the state. They meet this obligation through direct operation of hospital systems, funding uncompensated care in their communities, or in some cases, by developing limited coverage programs that enroll the uninsured. As a result, the safety net system typically represents a broader group of providers.

In Louisiana, Louisiana State University (LSU) operates ten state-funded inpatient hospitals and a network of over 350 clinics that primarily serve individuals in the state without insurance. Eight of the ten state hospitals fall under the administrative responsibility of the LSU Health Care Services Division (LSUHCS) and two are operated by LSU Health Sciences Center in Shreveport. MCLNO was the hub of the LSUHCS. These hospitals fulfill the state mandate that all residents have access to health care services. They provide about 85 percent of the total uncompensated care costs for the state with the remaining 15 percent provided by community hospitals.

Together, the eight LSU hospitals accounted for about 50,000 acute care inpatient hospital admissions, about 900,000 clinic visits and nearly 400,000 emergency room

visits in 2004. MCLNO represented a significant portion of this care, providing about half of the inpatient admissions, over one-quarter of the clinic visits and over one-third of the emergency room visits. (Figure 2) Overall, about 47 percent of the inpatient admissions and 61 percent of the outpatient visits were for patients with no insurance. At MCLNO, 55 percent of inpatient admissions and 65 percent of outpatient visits were for patients with no insurance.



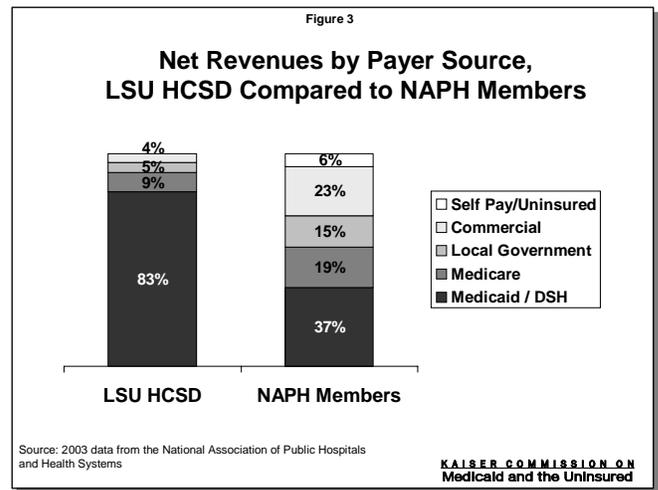
The state budget for FY 2005 included \$848.8 million for LSUHCSD which is comprised of \$177 million in non-federal matching funds, \$517 million in federal Medicaid matching funds and \$27.8 million in state appropriations. Of this amount, MCLNO accounted for 53 percent, the largest share of operating expenses for the system.

The LSU hospitals are funded primarily with Medicaid disproportionate share hospital (DSH) payments. Medicaid DSH payments represented 20 percent of total Medicaid spending in Louisiana, the second highest percentage among all 50 states. Unlike other states where DSH funds are distributed more broadly, in Louisiana three-quarters of DSH payments are made to the 10 hospitals in the LSU system. As a result, DSH payments comprised 67 percent of total net revenues for the system in 2003. While most other public safety net hospitals are very reliant on government sources of financing, their revenue sources are more diverse than that of the LSU hospitals. For members of the National Association of Public Hospitals and Health Systems, state (including Medicaid) and local funding represented just over 50 percent of net revenues in 2003 compared to 88 percent of revenues at LSU hospitals. (Figure 3)

### THE HEALTH CARE MARKET IN NEW ORLEANS

Prior to Hurricane Katrina, the New Orleans area was served by 16 acute care hospitals providing inpatient and outpatient services. In 2004, these hospitals provided nearly 172,000 discharges and over 962,000 inpatient days. The hospitals in New Orleans were marked by excess capacity. With nearly four beds per 1,000 people, the state of Louisiana ranked eighth in the nation in hospital beds, and many of

these excess beds were located in New Orleans.<sup>i</sup> Thirty-six percent of inpatient care was provided to low-income patients (26 percent to Medicaid patients and 10 percent to the uninsured).



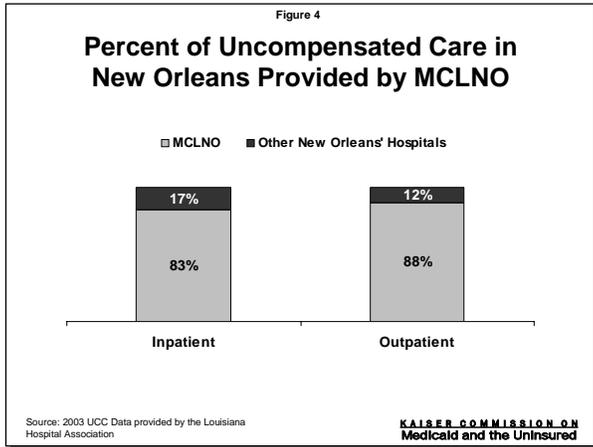
The city was served by physicians in private practice and community clinics. Physician supply in New Orleans was high, in part because two of the state's three medical schools were located in the city. In 2001, the city boasted 300 physicians per 100,000 people, among the highest in the nation.<sup>ii</sup> In contrast, non-metropolitan areas in Louisiana had among the lowest physician supplies in the country. In addition to private physicians, a limited number of community clinics served the New Orleans area, including two federally qualified health centers.

### THE SPECIAL ROLE OF MCLNO

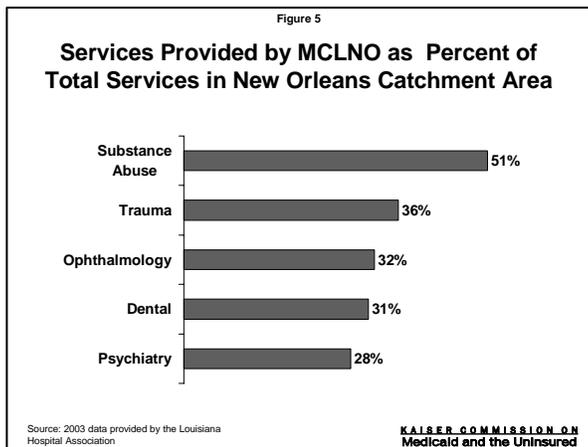
MCLNO, one of the largest hospitals in New Orleans, was recognized as the safety net hospital in the city representing about 14 percent of all admissions, 19 percent of all births, and 23 percent of all emergency room visits for the New Orleans area. MCLNO served a largely poor, predominantly minority population through inpatient care, a network of outpatient clinics and the busiest emergency department in the city. Nearly three-quarters of its patients were African American, and 85 percent had annual incomes of less than \$20,000.

Over half of the inpatient care provided by MCLNO was for patients without insurance, representing two-thirds of this care to the uninsured in the city. In contrast, only four percent of inpatient care at other New Orleans' hospitals was for uninsured patients. MCLNO accounted for 83 percent of all inpatient uncompensated care costs and 88 percent of all outpatient uncompensated care costs in the New Orleans area. (Figure 4) Uncompensated care costs for MCLNO represented over half of the hospital's total costs while uncompensated care costs at other non-state hospitals in Louisiana averaged only two percent of total costs.

While MCLNO was the primary provider for the uninsured, its share of the Medicaid market was lower, representing only 19 percent of the Medicaid discharges for the New Orleans area. Care for Medicaid patients was more evenly distributed across area hospitals because hospitals were reimbursed, at least in part, for the costs of the care they provided.



As a large teaching hospital, MCLNO provided a number of services vital to its uninsured patients, as well as the community at large. MCLNO was a referral center for trauma care, providing 36 percent of trauma discharges in the city. In addition to trauma services, MCLNO provided over 50 percent of inpatient care for substance abuse, 32 percent of ophthalmology care, and 28 percent of inpatient psychiatric care. (Figure 5)



High volumes of substance abuse and psychiatric services reflect the needs of a low-income population burdened by mental health problems and co-occurring substance abuse. The hospital was the largest provider of care for prisoners in the city, accounting for 676 discharges and nearly 13,000 outpatient visits.

MCLNO was also a referral center for other LSU hospitals. About 16 percent of all inpatient discharges at MCLNO were for patients from outside the New Orleans' catchment area. For specialized services, the percentage of patients from

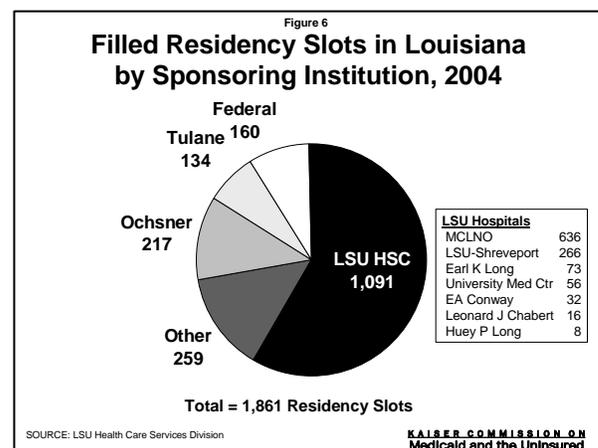
outside the New Orleans area was even higher. About half of the discharges for cardiac, neurology and renal/urology surgeries and over one-third of orthopedic surgery, ophthalmology, and trauma surgery were from outside the catchment area.

Access to primary care for the uninsured in New Orleans was limited. Despite having extremely high rates of poverty, New Orleans was served by only two Federally Qualified Health Centers: Excelth Inc., which operated four sites throughout the city, and a Healthcare for the Homeless clinic. Together these centers provided nearly 57,000 visits. MCLNO was another important source of ambulatory care, providing 350,000 outpatient visits at over 150 primary care and specialty clinics.

MCLNO was also the primary provider of HIV/AIDS care in the city. The HIV Outpatient Program (HOP) Clinic, established in 1987 as a partnership between MCLNO and LSU School of Medicine, had a pre-Katrina patient population of 3,300. HOP provided primary care, specialty care, nutrition, case management, and health education services, and served 850 patients per year in an on-site dental clinic. The HOP pharmacy filled over 250 prescriptions per day and provided free drugs to more than 1,500 patients per year.

#### GRADUATE MEDICAL EDUCATION

In Louisiana, care for the uninsured is intrinsically linked to medical education. Statewide, 59 percent of the residency programs were located in the ten LSU hospitals. In New Orleans, the majority of residency slots were at MCLNO. Staffed by physicians from the state's two medical schools in New Orleans, LSU and Tulane, the hospital utilized medical residents to promote access for the uninsured. In 2004, there were 636 residents in training at MCLNO. Of this total, 31 percent were in primary care residency programs. (Figure 6) The LSUHSCD hospitals also trained nearly 4,000 nurses and other health professionals, many of them based at MCLNO.



## A SYSTEM IN CRISIS

Before Katrina hit, the number of uninsured was increasing, but the volume of services provided by MCLNO had been decreasing over time due to shrinking resources. From 1999 to 2003, the number of discharges decreased by 16 percent, outpatient visits declined by 26 percent, and emergency department visits declined by 17 percent. Lack of resources, not reduced demand, explains the decline in volume.

The uncompensated care burden shouldered by MCLNO was crippling. With 50 percent of its total costs uncompensated, the hospital struggled to secure sufficient revenues simply to sustain operations. The hospital lacked the capital to make much-needed infrastructure improvements. Prior to Katrina, the deterioration of the facility was so severe that the hospital had been threatened with losing its accreditation. Officials had already been exploring options to replace the hospital with a smaller inpatient facility and primary care clinics located throughout the city.

## CURRENT SITUATION

After Katrina, MCLNO was closed along with most of the other hospitals in the city. Three hospitals in Jefferson Parish, East and West Jefferson Medical Centers and Ochsner Clinic Foundation, operated throughout the hurricane and remain open. Other hospitals are slowly reopening albeit with very limited capacity. As they do, they face enormous financial and staffing challenges, fueling potentially explosive battles over funding and staff.

MCLNO is operating a temporary trauma center and a medical clinic in the Convention Center. LSU is in negotiations to lease more permanent space for the trauma center and a limited number of inpatient beds. In the meantime, staff and services have been shifted to other LSU hospitals. Volume at Earl K. Long Medical Center in Baton Rouge has increased by over 50 percent, and some highly specialized services, such as organ transplants, are now being performed at other hospitals within the system. Even with the shift in care to other hospitals, as long as MCLNO remains closed, the LSU system will have difficulty generating enough volume to access available federal DSH funds. In response to the fiscal crisis, LSU has already furloughed 2,900 employees, almost 40 percent of its total workforce, and has requested an additional \$200 million to continue funding its other hospitals.

## FUTURE CHALLENGES

The health care needs of the people returning to New Orleans are immediate, but the larger issues around the best way to rebuild the health care delivery system in the city and the state are looming. A central question is whether to restructure the health care delivery system for the poor and uninsured in New Orleans and in the state. The state-run

charity system in Louisiana has a number of benefits, but also significant drawbacks.

On the positive side, with a mandate to care for the low-income and uninsured, the system provides a safety-net to uninsured residents throughout the state. The integrated, state-wide structure also facilitates continuity of care with an emphasis on ambulatory and primary care. On the negative side, the structure creates a separate system of care for the low-income uninsured. The lack of adequate resources and reliance on DSH funding has made it difficult for LSU to maintain its facilities and the crumbling infrastructure affects efficiency, quality of care and threatens the ability to maintain core teaching programs. The concentration of specialty services at the larger teaching hospitals forces uninsured patients to travel fairly long distances to access specialty care.

As officials and policy makers move forward with developing plans for the future health care delivery system in New Orleans, the question of how best to care for the poor and uninsured must be part of the discussions. Some critical questions are:

- What will the future population of the city look like? How many of the poor will return and when? How many people will have insurance?
- How should care for the uninsured be delivered and financed in New Orleans and in the state? What is the appropriate balance between expanding coverage and promoting access to care through direct support of the safety net?
- Will there be enough and the right mix of health care professionals to staff the new system?
- How will the new system meet the medical education needs of residents and fellows?
- How can other health care services, such as mental health, infectious disease and long-term care be better integrated into the new system?

<sup>i</sup> 2003 AHA Annual Survey Copyright 2004 by Health Forum LLC, an affiliate of the American Hospital Association, special data request, 2005. 2003 population data from Annual Population Estimates by State, July 1, 2003, U.S. Census Bureau  
<sup>ii</sup> GAO, *Physician Supply: Physician Workforce Increased in Metropolitan and Nonmetropolitan areas but Geographic Disparities Persisted*, October 2003.

Data Sources: Data comparing LSU hospitals to other public hospitals from the National Association of Public Hospitals and Health Systems, 2003 Hospital Characteristics Data. Data describing hospitals in New Orleans, including MCLNO, from the Louisiana Hospital Association, LHIN 2004 Database and the American Hospital Association, 2003 Annual Survey. Uncompensated care data from the Louisiana Hospital Association, UCC 2003 Database. Data describing special services at MCLNO provided by LSUHCSD.

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