

Business Plan for University Medical Center

Prepared for the University Medical Center
Management Corporation Board

Prepared By Verité Healthcare Consulting, LLC

September 6, 2011

Table of Contents

Executive Summary	2
Introduction.....	6
Memorandum of Understanding	7
The Proposed Project	8
Project Alternatives.....	10
Business Plan	12
Executive Management.....	12
Non-Profit Corporate Structure and Governance	12
Agreements	14
Clinical and Medical Staff Program Development.....	14
Community Ambulatory Care Initiatives.....	15
Current Program Expansions	16
Destination Programs.....	17
Elimination/Reduction of Capacity Constraints	18
Plan for Participation in CCN/Medicaid Managed Care	18
Health Professions Education	20
Current LSU Programs	20
Training Programs for Tulane and Other Schools	22
Research	23
Role of UMC in Disaster Recovery Efforts.....	25
Financial and Demand Analysis	27
Demand Projections	27
Financial Projections.....	30
Context for the Projected State General Fund Needs	32
Rationale and Anticipated Benefits	33
Risk Factors to be Monitored.....	35
Next Steps	36

Business Plan for University Medical Center

Executive Summary

The UMC Management Corporation’s (UMCMC) Business Plan has focused on addressing the following questions.

What is the project plan for University Medical Center? The plan is to build a new Academic Medical Center (AMC) in New Orleans, named University Medical Center (UMC). UMC will include 424 beds in three inpatient towers, an emergency room and trauma center, an ambulatory care building (ACB), a diagnostic and treatment building, and support structures. UMC will provide high quality patient care and a setting that supports health professions education and research.

The project will cost \$1.088 billion. Project costs will be financed as presented in Table 1.

Table 1: UMC Project Costs and Financing Sources (\$ Millions)

Project Costs and Financing	
Total Project Costs (\$ millions)	\$ 1,088.1
FEMA Funds:	
For Charity Hospital Replacement	474.8
Additional FEMA Funds	155.9
Subtotal	630.7
State Capital Outlay	300.6
Third-Party Financing:	
Ambulatory Care Building	99.6
Equipment Lease Purchase	25.0
Structured Parking	32.2
Subtotal	156.8
Total Financing Sources	\$ 1,088.1

Source: Louisiana Division of Administration and LSU.

An LSU-affiliated entity will issue bonds to finance the ACB, and will agree to provide services and occupancy of the ACB building in support of UMCMC. The total project cost is reduced from the originally estimated \$1.2 billion to \$1.088 billion because

UMCMC revenue bonds will not be issued for construction of the project (saving \$82 million in financing cost) and through continued value engineering of the project.

What alternatives have been considered? A number of alternatives to the planned project have been considered over the years, including building a larger 484-bed AMC, redeveloping Charity Hospital, and building a small research hospital or a smaller 250 bed hospital (and then purchasing Tulane/HCA’s downtown hospital). Another is to defer or exclude the ACB from the project, which would mean no bond issues are needed. Yet another is to continue operating the Interim Louisiana Hospital (ILH). The feasibility and advisability of each of these alternatives has been assessed. After careful analysis and review, the UMCMC Board and its advisors have concluded that the planned project presents the greatest benefits and the fewest risks to the state.

What is the proposed Business Plan? The Business Plan calls for the UMCMC Board, LSU, Tulane, the Louisiana Department of Health and Hospitals, other state agencies, and other universities to proceed as described in the Memorandum of Understanding (MOU) signed in August 2009. The plan is as follows:

- After a three-year construction period, UMC will open in 2015. Clinical, education, and research activities now being provided at the Interim LSU Hospital (ILH) in New Orleans (formerly known as the Medical Center of Louisiana New Orleans, or MCLNO) – and other MCLNO activities that were displaced by hurricanes Katrina and Rita, will be transferred to the new University Medical Center.
- UMC will be managed by UMCMC, a non-profit corporation. The UMCMC Board will retain a CEO as contemplated by the MOU.
- UMC will be the primary teaching hospital of the LSU Health Sciences Center in New Orleans. UMC also will serve as a teaching affiliate of Tulane University School of Medicine and will have other university affiliations as approved by the UMCMC Board.
- By implementing strategic plans, the 424 beds will reach targeted occupancy levels by 2020. These plans include: UMC serving as a primary safety-net facility for Medicaid and uninsured patients, expanding inpatient psychiatric capacity to 60 beds, operating an emergency department with double the capacity now present at the ILH, UMCMC and LSU together enhancing and building community ambulatory care programs that will contribute to referrals, seeing that LSU faculty physicians who were displaced by the storms return to practice at UMC, and developing “destination programs” in identified specialties. UMC also will participate actively in Louisiana’s Coordinated Care Networks (Medicaid managed care), scheduled to begin operating in January 2012.
- As a teaching hospital, UMC will be home for health professions education programs training hundreds of students in multiple disciplines (physicians, nurses,

allied health, and others). UMC’s clinical services will be more diverse (in terms of patient mix and specialties), enhancing the quality of training programs.

- UMC also will be constructed to help New Orleans and southern Louisiana respond to future natural disasters. The facility will be hardened to endure hurricane winds and flooding and will be operated with a mission to provide leadership in the event of disasters.

What are the financial implications of the project for the state? The UMCMC Business Plan includes financial projections that estimate the annual state support (unmatched State General Funds) that would be needed to assure that UMC’s financial requirements are met.

The estimates presented in Table 2 are based on numerous assumptions that have been reviewed by the UMCMC Board and its advisors, including future volumes, public and private reimbursement rates, availability of Medicaid Disproportionate Share Hospital and Upper Payment Limit funds, UMC staffing levels, the amount of professional fees UMC will pay for the services of LSU and Tulane faculty, lease terms for the ACB and equipment, and various expense inflation factors.

Table 2: Actual and Projected State General Fund Appropriations

		State General	
		Year Ended June 30,	Funds (\$ Millions)
Actual ILH	2006	\$	37.5
	2007		36.4
	2008		48.7
	2009		50.6
	2010		26.1
	2011		57.4
Projected ILH	2012		32.5
	2013		33.2
	2014		33.8
Projected University Medical Center	2015		44.1
	2016		50.0
	2017		46.5
	2018		50.5
	2019		61.5
	2020		60.3

Source: UMC financial model developed by Kaufman Hall, incorporating assumptions as of September 2011.

During the six years ending June 30, 2020, state general fund needs are projected to average \$52.5 million. In addition to the amounts in Table 2 and assuming that UMC

starts with a clean balance sheet, UMC may need access to \$120 to \$175 million in working capital in 2015. Options for working capital financing such as a line of credit are under consideration. Costs associated with such working capital financing have not been included in Table 2.

For comparison purposes, financial projections also were prepared to assess the implications of continuing to operate the ILH¹ beyond 2014. **State general funds needed to continue operating the ILH during the six years ending June 30, 2020 are projected to average \$54.8 million – an amount slightly greater than if the proposed project proceeds.** Remaining in the ILH means that awarded FEMA funds would be lost, that certain deferred maintenance costs would need to be addressed, that ILH inpatient admissions would be 25 to 30 percent less than at UMC, that LSU academic and clinical programs would remain dispersed across multiple sites, and that benefits of achieving the vision of the AMC would be lost.

What are the project’s principal benefits? Implementing the Business Plan will:

- Help assure that Louisiana’s needs for well-trained health professionals are met and enhance the educational experiences for trainees who benefit from exposure to diverse patient populations and clinical services.
- Enhance the stature of the state’s medical schools, improving the ability of the schools to attract faculty, students, and research dollars.
- Create immediate and longer-term economic benefits through construction activities, employment at UMC and associated enterprises, and the attraction of incremental research and grant funds.
- Encourage and support development of high quality, specialty health services that will contribute to the health of Louisianans.
- Yield a facility that will enhance public safety in the event of natural or man-made disasters.
- Provide greater financial stability and a governance change for the state’s largest safety-net hospital provider, placing oversight of UMC’s success in the hands of a fiduciary board comprised of leading citizens.

What risk factors will need to be monitored? Risk factors include:

- The cost implications of any delays in constructing the facilities, and the implications of changes in the availability or cost of project financing.

¹ The ILH was renovated using FEMA funds to be the Interim LSU Hospital to provide temporary health services for the region. Under FEMA regulations, these expenditures were allowed with ILH considered a “Category B” temporary facility. The ILH may not continue to be used as a hospital facility after the temporary need is met by permanent facilities. According to the Louisiana Division of Administration, if the ILH continues operating – funds awarded for the permanent replacement facility would be lost.

- Any inability to finance UMCMC’s initial and ongoing working capital needs.
- The implications of any inability of UMCMC, LSU, Tulane, and other partners to reach agreement on the terms of affiliation agreements and how certain decisions will be made.
- Possible competitive responses to plans to develop “destination programs” at the UMC by relocating and recruiting new LSU faculty.

In any scenario, any future cuts to Medicare and Medicaid programs and to Medicaid Disproportionate Share Hospital and UPL funds will need to be monitored.

Introduction

This document describes the Business Plan to develop a new Academic Medical Center (AMC) to replace Charity Hospital, which ceased operating in 2005 due to Hurricane Katrina. The AMC will be named “University Medical Center” (UMC) and will be managed by “University Medical Center Management Corporation” (UMCMC), a non-profit corporation.

This document discusses current plans to:

- Construct UMC in New Orleans on land bounded by Canal Street, South Galvez Street, Tulane Avenue, and South Claiborne Avenue.
- Finance construction, equipment, and initial working capital needs for UMC.
- Seek and hire executive management for UMCMC.
- Develop faculty medical staff and clinical programs that would enable provision of high quality patient care and generation of associated patient revenue to support UMC operating costs.
- Establish UMC as an organization that will play a major role in health professions education and research.
- Ensure that UMC incorporates design features that allow it to play an important role in protecting the public in the event of future natural or man-made disasters.

The Business Plan also provides utilization/volume and financial projections for UMC. The financial projections estimate the range of annual State General Fund (SGF) support UMC will need to fund its financial requirements.

The following key questions are addressed:

- What is the project plan for UMC?

- What alternatives have been considered for the proposed project? What are the implications of these alternatives? Which alternative is preferred?
- What is the plan for UMC's executive management, clinical and medical staff development, participation in Medicaid and health reforms, health professions education and research, and role in public safety?
- What are the financial implications of the project for the state of Louisiana?
- How will the project enhance the stature of the state's medical schools? What other benefits reasonably should be anticipated?
- What risk factors should be monitored?
- What are the next steps?

Memorandum of Understanding

The Business Plan adheres to the vision for the AMC described in a Memorandum of Understanding (MOU) signed in August 2009 among Louisiana State University (LSU), the Louisiana Department of Health and Hospitals (DHH), Louisiana Division of Administration, and Tulane University (Tulane). The MOU describes the need for an AMC that:

- Helps to address physician shortages across Louisiana,
- Enhances the competitiveness of the state's academic and training programs so that Louisiana can attract "the most talented faculty, students, residents and other medical professionals,"
- Can leverage the research capabilities of public and private entities across the state,
- Will continue to play a central role in providing services to the uninsured and tertiary services that are difficult to sustain in community hospital settings,
- Will operate as a major affiliate of Louisiana State University and as part of the LSU System, and will serve as a teaching affiliate of Tulane University School of Medicine, and
- Will have other university affiliations as approved by the UMCMC Board.

The MOU further specifies that building the AMC is not to impede the state's constitutional debt ceiling and will minimize financial exposure to Louisiana taxpayers.

The UMCMC Board is comprised of eleven members, four of whom are representatives of LSU (including the Board Chair). Two other members represent Tulane and Xavier

Universities, respectively. The presidents of Delgado, Dillard and Southern Universities collectively appoint another member. The remaining four members are not affiliated with the above universities.

The UMCMC Board is to employ a qualified Chief Executive Officer, responsible only to the Board. The Board also is to establish graduate medical education contracts according to the MOU (affiliation agreements) with LSU and Tulane, without discrimination.

As a key component of the LSU Health System, the AMC is to participate in mutually beneficial academic, clinical, and business operations, including LSU system-wide information technology, supply chain, and disease management initiatives.

The Proposed Project

Pursuant to the MOU, planning has been underway to construct a new 424-bed facility in New Orleans. Clinical, education, and research activities now being provided at the Interim LSU Hospital (ILH) in New Orleans (formerly known as the Medical Center of Louisiana New Orleans, or MCLNO) – and other MCLNO activities that were displaced by hurricanes Katrina and Rita, will be transferred to the new University Medical Center. The land has been acquired by LSU and the state for the operation of an AMC as envisioned in the MOU.

The plan includes building UMC with 2.2 million square feet and with the following program elements:

- Three (3) inpatient bed towers (550,661 square feet)
- An Ambulatory Care Building (ACB, with 257,660 square feet)
- A Diagnostic and Treatment Building (746,982 square feet)
- Structured Parking (539,789 square feet)
- A Utility Building and LSU Connector (90,552 square feet)
- The project will cost \$1.088 billion, to be financed as presented in Table 3.

Table 3: UMC Project Costs and Financing Sources (\$ Millions)

Project Costs and Financing	
Total Project Costs (\$ millions)	\$ 1,088.1
FEMA Funds:	
For Charity Hospital Replacement	474.8
Additional FEMA Funds	155.9
Subtotal	630.7
State Capital Outlay	300.6
Third-Party Financing:	
Ambulatory Care Building	99.6
Equipment Lease Purchase	25.0
Structured Parking	32.2
Subtotal	156.8
Total Financing Sources	\$ 1,088.1

Source: Louisiana Division of Administration and LSU.

An LSU-affiliated entity will issue bonds to finance the ACB, and will agree to provide services and occupancy of the ACB building in support of UMCMC. The total project cost is reduced from the originally estimated \$1.2 billion to \$1.088 billion because UMCMC revenue bonds will not be issued for construction of the project (saving \$82 million in financing cost) and through continued value engineering of the project.

Construction would last three years. The new AMC would be operational as of July 1, 2014 (the UMC fiscal year 2015). Project construction and equipment costs would be financed as follows:

- Construction costs of \$99.6 million for the Ambulatory Care Building would be financed by an LSU-affiliated entity. Through a lease structure, UMCMC would agree to reimburse that entity for the annual carrying costs of this financing (current estimated to require a cost of funds of approximately 7.5 percent per annum).
- Structured parking (\$32.2 million) also would be financed by a LSU-affiliated entity or by developers.
- Approximately \$25 million of medical equipment would be lease-purchased.

- Based on the most recent information available, total FEMA funds for the project are assumed to be \$630.7 million, or \$38.3 million more than assumed in early June 2011.²
- Sources for UMC's initial working capital needs will be found, including a possible line of credit or the possible transfer of working capital from the ILH.

The total project cost is reduced from the originally estimated \$1.2 billion to \$1.088 billion because UMCMC revenue bonds will not be issued for construction of the project (saving \$82 million in financing cost) and through continued value engineering of the project.

Project Alternatives

In the last few years (and also in recent weeks) alternatives to the proposed project have been considered and assessed. The alternatives include building a larger 484-bed AMC, redeveloping Charity Hospital, and building a small research hospital or a smaller 250 bed hospital (and then purchasing Tulane/HCA's downtown hospital). Another is to defer or exclude the ACB from the project, which would mean no bond issues are needed. Yet another is to continue operating the Interim Louisiana Hospital (ILH). The feasibility and advisability of each of these alternatives has been assessed. After careful analysis and review, the UMCMC Board and its advisors have concluded that the planned project presents the greatest benefits and the fewest risks to the state.

484-Bed Academic Medical Center. Until mid-2008, planning for the new AMC focused on a 484 bed facility. Assumptions regarding the area's population and the AMC's lengths of stay and market shares were adjusted, yielding a final bed size of 424 beds (including 60 psychiatric).

Building a Small Research Hospital. Some advocated a small research hospital; however, the ILH experience has indicated that such a hospital would not fully meet patient care or educational needs.

Building a 250-Bed Hospital and Purchasing Tulane Hospital from the Hospital Corporation of America (HCA). A significant deviation from the MOU and one that would entail a number of new complex assumptions, this option was dismissed when HCA indicated that Tulane Hospital is not for sale.

UMCMC Revenue Bonds for Construction. In this alternative, UMC construction and other project costs would be financed with FEMA funds, state capital outlay funds, and revenue bonds issued by UMCMC.³ Kaufman, Hall & Associates, retained by the

² The Division of Administration indicates that the potential is "good" for \$36.9 million in additional FEMA funds (beyond the currently assumed amount of \$630.7 million). These additional funds would be for certain fixed equipment.

³ The MOU states that capital costs beyond the state capital outlay and FEMA Funds "shall be financed through revenue bonds issued by the Corporation. These bonds shall not be guaranteed by the state of Louisiana, and shall not require the full faith and credit of the State."

UMCMC Board to serve as financial and strategic advisors, recently estimated that the total required bond issue (including a debt service reserve fund and financing fees) would be \$406 million⁴. The alternative financing approach, coupled with greater amounts of FEMA funding, and reduced total project costs reduces the projected state general fund requirement for UMC by approximately \$14 million annually.

Reduced Project Scope. To understand if the project could be financed entirely using equity funds (FEMA and state capital outlay totaling \$931.3 million), LSU and state staff considered options for reducing the total cost of the project. That assessment concluded the following:

- Deleting one of the three inpatient bed towers from the project has been estimated to reduce construction costs by \$55 million.⁵ New construction would be able to accommodate approximately 280 beds.⁶ Psychiatric, rehabilitation, and jail health beds would continue to be operated at the ILH. Some capital investment in ILH would be needed. UMC thus would operate across two campuses. At that reduced level of project cost, at least \$100 million in financing (from an LSU-affiliated entity) still would be required and certain operational inefficiencies would be introduced due to operating two campuses.
- The only way to avoid debt financing would be to defer proceeding with the Ambulatory Care Building. LSU faculty would need to continue practicing at current clinic locations (at the University Medical Office Building and ILH sites). Delaying or deferring this project component would require redesigning one or more UMC buildings and is viewed by many as compromising the ability of the AMC to achieve its strategic goals.

Reuse of the Charity Hospital facility. The UMCMC Board is not responsible for and has no authority over the disposition of Charity Hospital. The state Office of Facility Planning and Control has responsibility for administration of design and construction for capital projects for the State of Louisiana. That office has considered alternatives and options for the project. With expected federal funding, options were required to be considered as part of Section 106 of the National Historic Preservation Act (NHPA), 16 U.S. C. Section 4701, and 36 CFR Part 800 (section 106). Options were considered under the “Programmatic Agreement among the US Department of Veterans Affairs, the Federal Emergency Management Agency, the City of New Orleans, the Louisiana State Historic Preservation Officer, and the Advisory Council on Historic Preservation Regarding the Funding to Repair or Replace Healthcare Facilities Comprising the VA Medical Center and the Medical Center of Louisiana at New Orleans.” That Agreement specified project alternatives for the repair or replacement of the Medical Center of Louisiana at New Orleans.

⁴ University Medical Center – Proposed Business Plan Validation, Kaufman, Hall & Associates, June 2, 2011.

⁵ Detailed project cost information indicates that building the three inpatient towers will cost \$166.7 million.

⁶ The ILH currently staffs 275 beds.

The options were carefully weighed by the federal government and the state. Multiple public meetings were held. The result of the process yielded a determination that the most appropriate option was the relocation to a new site with the construction of new facilities. Revisiting other options may render the entire process null, requiring further analysis to comply with Section 106.

Whether or not reusing Charity Hospital is in the UMCMC Board's purview, the Board has concluded that building a new University Medical Center is by far the preferred alternative.

Continuing to Operate ILH. According to the Division of Administration, the ILH was renovated using FEMA funds to be the Interim LSU Hospital to provide temporary health services for the region. Under FEMA regulations, these expenditures were allowed with ILH considered a "Category B" temporary facility. The ILH may not continue to be used as a hospital facility after the temporary need is met by permanent facilities. If the ILH continues operating, funds awarded for the permanent replacement facility would be lost.

Business Plan

The Business Plan for UMC includes hiring executive management; negotiating and executing several agreements that would further specify the roles and responsibilities of LSU, Tulane, UMCMC, the state, and other parties vital to the AMC's success; developing UMC's medical staff and clinical programs; continuing to build health professions education and research programs; and assuring that UMC plays a meaningful role in the event of natural or man-made disasters.

Executive Management

Pursuant to the MOU, the UMCMC Board is to hire an experienced Chief Executive Officer who will report solely to the Board. The Board is to engage in a procurement process to identify hospital management firms or persons with "documented successful experience in the operation of sophisticated academic and research-oriented health care institutions." Success is defined as achieving "financial and clinical outcomes in institutions operating in competitive environments with significant uninsured populations while also maintaining credible research and training programs."

The UMCMC Board plans to initiate a search or RFP process for the CEO/management firm well in a timely manner.

Non-Profit Corporate Structure and Governance

For decades, public hospitals have served as safety-net health care facilities for poor and indigent populations. A trend has emerged as these hospitals and health systems have recognized that operating under a private non-profit governance structure can enhance their performance.

Grady Memorial Hospital (GMH) in Atlanta, Georgia is one such example. In 2008, health care and state leaders recognized the need for restructuring and created the non-profit entity, Grady Memorial Hospital Corporation to manage the hospital's operations. This significant step in their restructuring was driven by GMH's struggle to remain financially solvent and a desire to attract private investment that was difficult to generate under the previous politically-appointed governance board.

Since the non-profit board has been in place, the hospital has received more than \$300 million in private contributions, had its first profitable year in a decade (2009) and, out of 60 hospitals, was ranked by U.S. News and World Report Best Hospitals as the 10th best hospital in Atlanta in 2010. Due to this success, the hospital was able to invest more in its 2010 marketing campaign, which drove an increase in patient volume and improvement in payer mix. Further, the hospital has seen a rise in patient satisfaction and decrease in infection rates and pharmacy and MRI waits.

A similar debate is occurring in South Florida, where recently a panel of health care leaders in the Miami-Dade area released a report urging the transition of Jackson Health System's (JHS) management to a private nonprofit corporation. JHS has posted losses totaling \$337 million in the past two years alone. Citing similar concerns as Georgia officials, task force members recommended shrinking the board to nine members and imposing term limits, whose initial appointments would be made by County officials. Thereafter, the corporation board would elect its own membership.

Elsewhere in Florida, in a 2010 presentation to Broward Health, Charles Luband of the National Association of Public Hospitals and Health Systems (NAPH) noted some of the other challenges that publicly-managed hospital systems have experienced. He noted that management by a city, county or state bureaucracy can often hinder the hospital's agility by subjecting it to government procurement or civil service systems that are "simply too cumbersome for a hospital". Given the immense changes coming through national health care reform, he noted that public hospitals must have the ability to adjust rapidly. According to NAPH, while half of its members were traditional city or county owned hospitals just 30 years ago, less than 10 percent retain that structure today. There are numerous examples:

- Tampa General Hospital transferred from operation by a county authority to a private non-profit corporation and improved cash on hand from 29 days to 138 days.
- Regional Medical Center at Memphis has been operated by a non-profit corporation since 1981 and has increased independent access to capital through both revenue bonds and joint ventures.
- Boston Medical Center merged with private not-for-profit Boston University Medical Center and significantly decreased public subsidies of its operations and is no longer subject to city civil service and procurement rules.

These health systems underline the value of governance change for the Academic Medical Center in New Orleans. Through all of these transitions, these hospitals have maintained their safety-net mission and continue to serve people of all payers, including the uninsured. They have done so while improving their management effectiveness, depoliticizing their governance structures, and strengthening their financial performance.

Agreements

The MOU specifies that the state (through the Division of Administration and the Department of Health and Hospitals) is to continue funding the cost of services provided by UMC to the uninsured, subject to funding by the Legislature which the relevant state administrative departments will take reasonable steps to obtain.

The Business Plan also calls for UMCMC to enter into several agreements necessary to provide for facility financing and to assure that UMC has the needed support of its academic partners. These agreements include the following:

- Affiliation agreements between UMCMC and medical schools (under which LSU and Tulane would provide services of medical school faculty members),
- Services Agreement between LSU and UMCMC (for other staff, as needed), and
- Services and Funding Agreement between the State and UMCMC (payments for services to be provided for uninsured, underinsured, prisoner care, and others).

Clinical and Medical Staff Program Development

The UMC medical staff will be comprised of faculty from the LSU School of Medicine and the Tulane School of Medicine. The ILH currently has a medical staff of 860 representing a range of disciplines from primary care to medical and surgical subspecialties. The Business Plan calls for thoughtful and strategic expansion of physicians and mid-level providers to meet the needs of UMC and its patients. Plans call for at least 87 new faculty to be recruited over the next few years.

The ILH currently sponsors and supports 308 residents in 30 different specialties. Faculty supervision is provided based on standardized ratios of faculty to residents as defined by the respective Residency Review Committees of the Accreditation Council for Graduate Medical Education. The current ratio of residents to beds in ILH is 1.12. Because most AMCs have 0.7 to 0.8 residents per bed, capacity for increased patient care exists within ILH's current clinical staffing model.

In addition to the physician services directly supported by ILH, the LSU School of Medicine has a not-for-profit faculty practice plan, the LSU Health Care Network, which provides services to ILH on a contractual basis and which also has active practices (outpatient and inpatient) at non-ILH sites.

LSU plans to consolidate existing practices at UMC and to develop new ones, so that the AMC can continue providing the current array of services at ILH, maintain its safety net mission, diversify its programs and payer mix, become regionally competitive for clinical services, and achieve its academic mission.

Recruitment strategies include focusing on trainees who are known to remain in the area where they have trained to pursue their careers. Because faculty spend several years with each of these trainees, opportunities are available to identify desired recruits and to target them for retention at UMC. The schools thus have a distinct advantage in recruiting the best local trainees to become members of the UMC medical staff and to participate in practice plans.

UMC's clinical staff also will grow because LSU also will be adding nurse practitioners and physician assistants to its faculty practice plan. At present there are 55 nurse practitioner students in the LSU School of Nursing. In 2012, LSU will start a new Physician Assistant program in its School of Allied Health, enrolling 35-40 students a year. These two programs will provide a ready source of additional providers that will enhance cost-effective patient access to care and contribute to clinical services growth.

To support the growth of the LSU faculty practice plan and the development of targeted destination programs, the ILH has committed to working in conjunction with the Dean of the LSU School of Medicine to support recruitment and program development around these programs. The Business Plan for clinical program growth and medical staff development is multi-faceted, and calls for the following strategic initiatives:

Community Ambulatory Care Initiatives

- **Developing new community based clinics.** The ILH has been developing new clinics throughout New Orleans. For example, the Landry West Bank Clinic is a patient centered Medical Home that began operating in January 2011. Monthly clinic visits have increased from 594 in January 2011 to 1,330 in June 2011. A second new offsite medical home, the OPW Clinic serves about 400 patients per month. A new "Access to Primary Care" clinic helps discharged patients access primary care clinics after discharge from the hospital. In its first year of operation, this clinic is seeing over 800 persons a month.
- **Relationships with existing primary care clinics and community providers.** LSU has been developing and strengthening relationships with Federally Qualified Health Centers and other primary care clinics. After Katrina, a number of primary care community clinics were funded through federal recovery funds and developed. In the past year, these funds ceased and CMS approved a Medicaid waiver to continue a primary care benefit for many of these recipients through a specified network of qualified providers. The waiver covers primary care services. The ILH serves as the system for diagnostic referrals, specialty clinic referrals and inpatient services. Community clinics serving the uninsured and the newly insured Medicaid waiver population are able to schedule directly

into some ILH specialty clinics, order diagnostic tests, and receive electronic results.

- **ILH Community Medicine Partnership Program.** A new inpatient service developed at ILH is staffed by physicians who have a mandate to share clinical information with community primary care providers and thereby facilitate follow up with these providers in a timely manner. These relationships have been formed with ILH through a formal community medicine partnership program with twelve primary care community clinics to improve communication and ease of access. The program has increased referrals to ILH for specialty care. The relationships are sustainable and will continue after Medicaid expansions and after UMC opens.
- **LSU Health Care Network Director of Community Health Clinics.** The LSU School of Medicine recently hired Mary Thoesen Coleman, MD, PhD to serve in the newly created position of Director of Community Health Clinics for the LSU Health Care Network. Dr. Coleman is the former Dean of Ross University School of Medicine. Her administrative role will entail developing a LSU network of primary care health clinics. This network of clinics will be developed as medical homes to serve a larger primary care patient base and to enhance the LSU educational programs and outcomes research.
- **New LSU-affiliated Clinic Sites.** LSU, in conjunction with the Bayou District Foundation, has a pending Federally Qualified Health Center application to start a new clinic, the Bayou District Health Center, on the campus of the foundation's new housing development. The site will provide primary care medical and dental care to a population of nearly 8,000 residents. While the award notices are pending, LSU began implementation in July, 2011 by providing services in this area through a mobile health unit.
- **Demonstrating to payers the benefits of medical homes and electronic health records.** LSU was the first provider in the state to achieve NCQA certified Medical Home designation for its outpatient clinics. Its current investment of nearly \$150 million in its implementation of a statewide electronic health record will provide LSU with the management tools necessary to improve its ability to deliver upon the payer expectations of efficient care with high quality outcomes for large patient groups.

Current Program Expansions

- **Telemedicine referrals.** ILH recently contracted with the LSU School of Medicine to develop a specialty telemedicine clinic designed to decrease clinic and emergency department visits by prisoners. The program has reduced prisoner visits to the hospital. LSU intends to expand the program to benefit non-prisoner community and rural patients across the state, contributing to increased referrals to UMC.

- **Expansion of Inpatient Psychiatry Services.** The current inpatient psychiatry program consists of 20 mental health emergency room extension (MHERE) beds and 38 acute inpatient beds. These units are staffed by LSU and Tulane Department of Psychiatry faculty and residents. The current 38 beds that ILH operates are nearly 100 percent occupied and the unit is frequently on “diversion” status. There is a widely acknowledged demand for more inpatient psychiatric beds in the city (and state). Consensus exists that the additional 22 psychiatric beds planned for UMC rapidly will be filled. Additional psychiatrists will be recruited to assist with the expanded services.
- **Radiology and Pathology Expansion.** The Business Plan calls for additional faculty members to be recruited to support overall UMC patient care needs, respond to growing demand for interventional radiology services, and accommodate growing reliance on the pathology lab for reference testing by LSU facilities across the state. These recruitments are planned to be accomplished through the LSU School of Medicine.
- **Expanded Emergency Department, Level 1 Trauma Center, and Urgent Care Services.** The new UMC facility is being developed to accommodate a substantially greater volume of emergency department visits than is possible at the ILH. The ILH ED currently is staffed by a private emergency medicine group. The group provides faculty supervision for the LSU Emergency Medicine Residency training program at the ILH. Prior to the opening of UMC, additional emergency medicine physicians also will be recruited and added to the medical staff.
- **Hospitalist recruitment.** The Business Plan calls for more than doubling the number of hospitalists that now provide inpatient services (including staff supervision) at the ILH. This model will help assure that trainees at UMC experience current and emerging care practices while also helping UMC achieve clinical efficiencies in an academic environment.

Destination Programs

- **Destination programs planned for UMC.** The Business Plan assumes that affiliation and services agreements between UMC and LSU will be negotiated successfully. With those agreements in hand, LSU would work diligently to repatriate and expand several existing services being performed by LSU faculty primarily at other hospitals in the region. LSU has identified 4 specific areas for development.

The Business Plan for UMC includes an increase of over 2,200 annual inpatient admissions of patients with health insurance (other than Medicaid) that will come from these existing LSU faculty programs that relocate to UMC. The firm hired by LSU to prepare a feasibility study/debt capacity analysis, Causey Demgen & Moore, has assessed this estimated volume, including interviewing faculty

members and analyzing discharge data, and has concluded that the incremental volume estimates associated with these program relocations are reasonable.

- **New and Expanded Destination Programs.** In addition to existing programs targeted for repatriation to UMC, a number of new or expanded programs have been identified for development. LSU's analysis indicates that upon maturity, these programs should yield an additional 1,150 annual admissions to UMC.
- **Other Planned Recruitments:** A number of other specific recruitments are planned by the LSU School of Medicine to support the programs described above and provide additional clinical volume.

Elimination/Reduction of Capacity Constraints

- **Elimination/Reduction of Capacity Constraints.** The Business Plan also indicates that volume and staffing projections for the UMC should anticipate the impacts of reducing clinic wait times, the ability to accept transfers from LSU facilities that could not be accommodated due to ILH capacity constraints, cancellation of elective admissions for the same reasons, and the effects of an expanded emergency department. For example,
 - Data indicate that over the last year, more than 100 cases were transferred from LSU-state hospitals to a New Orleans hospital other than ILH. In addition, ILH was not able to receive a number of non-psychiatric transfers from other emergency departments non-psychiatric related ED to ED transfers (which generally result in admission) because of hospital diversion status.
 - In 2010, the ILH had over 7,000 elective surgical cases scheduled. Of those, over five percent had to be cancelled due to capacity constraints.
 - The emergency department at ILH was on diversion 35 percent of the days in fiscal year 2011. The Business Plan for UMC provides for emergency department capacity of 126,300 and an additional 25,646 "urgent care clinic" visits (emergency department visits redirected to an urgent care clinic). In 2011 ILH had 62,203 emergency department visits. Of those, 12.8 percent were admitted.

The expanded emergency department should lead to an increase in admissions to UMC (e.g., 3,000 new admissions - if emergency department visits increase by 30,000 per year and 10 percent of these patients are admitted.)

Plan for Participation in CCN/Medicaid Managed Care

As a major provider of Medicaid services throughout the state, LSU and UMC intend to be active participants the state's Coordinated Care Networks (CCN) providing Medicaid

managed care. A large component of the clinical training is conducted in the context of providing services to Medicaid recipients, significant cost at the ILH for Graduate Medical Education funding is reimbursed through Medicaid, and Medicaid historically has been the hospital's largest third-party payer.

UMC's and LSU's participation is important to the Medicaid program as well. LSU physicians (particularly specialty physicians) are a dependable source of services for Medicaid recipients. Therefore, there is a mutual interest in LSU and UMC successfully participating in the Medicaid CCN program.

The CCN program presents some new challenges for LSU. Most were addressed by the state in the development of the CCN program.

- **GME reimbursement.** The state Medicaid program is allowed to reimburse teaching hospitals for GME in addition to the reimbursements for services paid by the CCN plans. The state explicitly excluded GME costs from the funds and rates available to the CCN plans, and intends to pay teaching hospitals directly for those eligible GME costs as a supplemental payment.
- **DSH payments.** The state Medicaid program is able to continue reimbursing hospitals for allowable uninsured costs through the DSH program. Allowable costs include Medicaid shortfalls.
- **Upper Payment Limit (UPL) funds.** Concerns were raised regarding the availability of UPL funds upon CCN model implementation. The state has indicated that the CCN – Shared Savings portion of the program would still be eligible for UPL and that a substantial proportion of enrollees would be in CCN – S (rather than CCN – P, or prepaid plans). The state has indicated that hospital UPL funds upon which the ILH depends would continue to be available.

The state Medicaid program advised LSU that overall, the ILH would continue to have its allowable costs covered through a combination of the DSH, UPL, and GME payments. ILH also would remain eligible for year-end cost settlements. With those assurances, LSU has been in active discussions with the various CCN award recipients to begin contract negotiations. Because ILH per diem rates will be set by DHH and will not include GME related costs, ILH will not be at a competitive cost disadvantage from the CCN perspective.

LSU and the ILH have been developing and enhancing its integrated network of care, chronic disease management programs, and electronic medical record systems. These programs and systems have been put into place so that UMC and its medical staff will be attractive to the CCN plans and will help meet the state's Medicaid managed care program goals.

Health Professions Education

The Business Plan recognizes that, as stated in the MOU, “97% of the parishes in Louisiana are currently designated as a Health Professionals Shortage Areas.” The challenges associated with a comparative undersupply of health professionals were highlighted in January 2011 when Louisiana was found to have one of the highest “access challenge index scores” in the nation. The index measures the readiness of each state for the anticipated greater demand for primary care services associated with upcoming Medicaid expansions.

Charity Hospital was known for the quality of its training programs. The Business Plan calls for building on these historical strengths while also developing a world class Academic Medical Center. Such an AMC is envisioned to yield many benefits associated with academic medicine.

The old Charity Hospital attracted medical residents, served as a training site for hundreds of nursing and allied health students, and provided safety net services for Medicaid and uninsured populations. It also housed the NIH funded General Clinical Research Center which supported Tulane and LSU clinical research.

With the loss of the Charity Hospital facility, there has been a dispersal of faculty, training, and care for the uninsured. In the process, many fewer residents are being trained in the state just as analysts are projecting a growing need for health professionals. Since 2005, LSU is down from 612 to 570 residents and fellows. Tulane also now has fewer .

The MOU specifies several requirements for UMC’s bylaws, including the following:

“The Corporation has, as a principal purpose, the support of programs, facilities and research and educational opportunities pursuant to La. R. S. 17:3390, and the Corporation will, at all times, adhere to the intent of the statute to support the education and research mission of LSU while also recognize the significance of the education and research mission of Tulane and other affiliated academic institutions. The AMC is a key component of the LSU Health System and as such will participate in mutually beneficial academic, clinical and business operations.”

The parties to the MOU share a vision that involves transforming the old Charity Hospital model into that of a modern Academic Medical Center that embraces its mission to serve the uninsured and underinsured and also provides specialized care for the benefit of the entire population. This will be done in the context of robust health professions education and research programs that serve the health needs of those receiving care at the AMC while training a health care workforce for Louisiana.

Current LSU Programs

Table 4 portrays the LSU training programs that currently are housed at the ILH and that will depend on UMC for their long term stability.

Table 4: Summary of LSU Programs Training at New Hospital

Total Trainees and/or Graduates 2010-11		
School of Nursing (Graduates 2011)		
Bachelor of Science in Nursing		196
Master of Nursing / Master of Science in Nursing		74
Doctor of Nursing Science		2
Total		272
School of Medicine		
MD Degree		166
Total Residents in Training (2011 graduates approximately 130)		450
Total Fellows in Training (2011 graduates approximately 35)		86
Total		702
School of Dentistry (Average number of graduates per year)		
Dentistry (DDS)		60
Dental Hygiene		42
Dental Laboratory Technology		10
Advanced Dental Education Programs		34
Total		146
School of Public Health (total graduates)		
Physicians		38
Residents		15
Medical students		8
Total		61
School of Allied Health		
Cardiopulmonary Science		13
Speech - Language Pathology		17
Audiology		7
Clinical Laboratory Science (Medical Technology)		26
Occupational Therapy		31
Physical Therapy		39
Rehabilitative Counseling		12
Total		145

Source: LSU.

UMC will be very important to the ongoing success of these clinical training programs.

- **School of Nursing.** Eighty percent of LSU School of Nursing trainees will rely on UMC as their primary training site.
- **School of Medicine.** All LSU students and residents will train at the new facility. The number relying on the new facility will be increased, limited only by the size of the hospital. This will be the primary training site for most of LSU's residencies and fellowships. Data show retention of graduates in Louisiana for training tracks very closely with student attitudes about their primary teaching site – currently the ILH.

The new hospital is anticipated to be a major factor in enhancing student retention, thus keeping those students in whom the state has invested. Furthermore, medical students who elect to complete their residency at UMC are far more likely to stay in Louisiana to practice.

- **School of Dentistry.** UMC will strongly enhance the education of dental students and residents and the quality of care provided to all UMC patients. The importance of quality oral health in the context of quality overall health is well recognized. Cross pollination between the various disciplines of the health care team will be facilitated greatly by this modern facility and its planned focus on Interprofessional Education (IPE). This model provides an opportunity for trainees to learn to work in teams, to develop mutual respect for and understanding of the roles and responsibilities of the various health care professions, and to treat the patient as a “whole patient.” The new facility will provide the opportunity for such experiences.
- **School of Public Health.** Although the School of Public Health trainees do not train directly at the hospital, they will have greatly enhanced opportunities to conduct clinical research and population-based research using data generated in the new facility.
- **School of Allied Health.** Allied Health has 430 students with 145 graduates this year. With the addition of the new Physician Assistance Program in 2013, enrollment will increase by 70 (35 students per year for 2 years). The new AMC will be their primary teaching site. All trainees will use the hospital for much of their training. The LSU School of Allied Health is responsible for training most of the Allied Health professionals that will work in the new hospital and in the state of Louisiana.

Training Programs for Tulane and Other Schools

In addition to the LSU training programs, a number of other schools will depend upon a vibrant UMC for their training. In the MOU, Tulane is provided the discretion to use 200 of Charity Hospital's 573.26 pre-Katrina residency slots. It is anticipated that the majority of those positions will be based at UMC. Schools that currently have affiliation agreements in place with the ILH are listed below. These programs also are looking forward eagerly to the availability of UMC.

- A&W LPN Program
- Charity/Delgado School of Nursing
- Delgado Community College
- Dillard University
- Emory University
- Loyola University
- Metropolitan State University (St. Paul, MN)
- Nunez Community College
- Our Lady of Lake School of Nursing
- Southeastern Louisiana University
- University of South Alabama
- William Carey University School of Nursing (New Orleans Branch)
- Cameron College
- Tulane School of Social Work, MSW Program
- Southern University at New Orleans
- Xavier University
- The U.S. Military
- Ochsner-Baptist Hospital
- ILH-Tulane Student Service Program
- Molloy University (New York, NY)

It is intended that additional academic affiliations will be developed.

Research

Research is a critical function of an AMC, translating important advancements in knowledge to health care services. LSU and Tulane, together with university partners, have a long history of conducting innovative research that has attracted research dollars

into the community. According to the Chronicle of Higher Education, both LSU and Tulane have ranked among the top 100 institutions in the United States in securing federal research dollars.

Prior to Hurricane Katrina and for over 15 years, Tulane, LSU and Charity Hospital operated a General Clinical Research Center (GCRC) at Charity Hospital funded by the National Institutes of Health (NIH). The GCRC had an annual operating budget of over \$3 million per year. This research unit provided the critical infrastructure for physician scientists from both schools to conduct their own innovative research projects supported in part by NIH grants. Investigators also were able to conduct clinical trials of new therapies supported by the pharmaceutical industry. All together these enterprises secured millions of research dollars as well as a multitude of jobs.

In the aftermath of Hurricane Katrina, clinical research suffered greatly by the loss of the NIH-supported clinical trials unit. During the past five years both LSU and Tulane have worked together to create a unified clinical research infrastructure and a network of clinical investigators. The shared vision is to transform the current clinical and translational research infrastructure and environment in order to increase the competitiveness of investigators in securing grant funding and to facilitate the performance of their studies. These studies in turn will lead to new ways to prevent, diagnose and treat disease. The Clinical Research Unit to be located in UMC is viewed as the “lynchpin” of the clinical research enterprise.

LSU and Tulane are planning to submit a research proposal to the NIH in September 2011 that will provide over \$20 million over five years to facilitate the transition to UMC. LSU and Tulane then will be well-positioned to apply for continued long-term funding from the NIH for this research unit.

The research unit will function like a magnet to attract the most talented faculty, the highest-funded researchers and the most gifted clinicians who seek to work in an exceptional environment. Without this facility and the researchers it will attract, researchers will not be competitive in the national arena and competing research programs (in Alabama and Texas) will continue to thrive. A very unique feature of the research unit will be its ability to conduct large clinical research trials throughout the LSU ten hospital system linked by an electronic medical record. Conducting clinical research in this patient population which largely has been composed of underserved minorities has been identified by the NIH as a strategically important target for future clinical investigations.

There are many reasons why the Business Plan calls for research to expand at UMC.

- Across the US, NIH supported research is an important source of income and employment. NIH investment in 2010 led to the creation of 487,900 quality jobs and produced over \$68 billion in new economic activity across the country. Sixteen states experience job growth of 10,000 jobs or more. Seventeen of the 30

fastest-growing occupations in the US are related to medical research or health care.

In 2010, Louisiana received \$133 million in NIH research awards; the awards are estimated to have created 4,500 jobs. In contrast, Texas received \$1 billion which created 31,000 jobs.

- The innovation and economic expansion that research dollars support extends beyond the healthcare industry. This wider effect of “medical research” ranges from pharmaceutical manufacturing to medical equipment manufacturing and beyond. Research is known to be an economic engine that helps to create employment opportunities in several economic sectors.

At the present time, the total combined NIH funding for the LSU and Tulane Schools of Medicine exceeds \$80 million per year. Both schools have increased their NIH funding significantly during the past few years by recruiting funded investigators from outside Louisiana with the vision of building a strong competitive research portfolio. The prospect of UMC in New Orleans has played a role in helping to recruit these investigators to the region. Areas of research strength include cancer, cardiovascular disease, diabetes, alcohol and drug abuse, infectious diseases, immunology, neuroscience, and environmental health.

The clinical trials unit in UMC will be part of an expanding biomedical corridor which includes two medical schools, a new cancer research building, a new VA hospital, several neighboring universities, and the BioInnovation Center.

Role of UMC in Disaster Recovery Efforts

Hurricane Katrina taught the entire nation lessons in emergency preparedness and response. The planning for the new UMC incorporates lessons learned into the physical design of the new building. In concert with that, the ILH leadership has assumed a more prominent role in local and regional disaster planning. As the LSU-affiliated academic medical center, the UMC will have a leading role in protecting the public through its planning and response to natural and man-made disasters.

The new facility will be built to standards for wind, flooding, and seismic activity. These features will allow the hospital to maintain operations for up to a week in the context of a hurricane that would bring damage beyond Katrina’s devastation. Key design features include the following:

- First floor constructed above the 100 year floodplain (established post Katrina)
- Vehicular access to I-10, above the 100 year floodplain, during a catastrophic event
- Mission critical functions are above the 500 year flood level

- 750,000 gallon potable water storage (a 7 day supply)
- Mission critical services, equipment and HVAC on emergency power
- Minimum of 7 day fuel supply for emergency generators
- Earthquake Seismic Category C structural design
- Building envelope designed to withstand winds up to 150 mph
- Black water (sewerage) storage tank
- Emergency Department has 5 Trauma Rooms plus 9 Rapid Response rooms
- Emergency Department has 6 bays for ambulance delivery/pickup plus parking for standby units
- Helipad capable of handling U. S. Marine 1 (President's), large enough to have one unit parked and one operational
- Emergency Department has a triple bay de-contamination shower for small hazardous material incidents
- Parking garage has a mass de-contamination shower for handling mass casualty events

From an operations standpoint, the staff at ILH has implemented a number of new emergency management procedures since Katrina, assuming a team-based approach to disaster planning that includes coordinated regional and statewide planning around a number of areas, including the following:

- Regional and State triage system to distribute patients based on medical needs and facility capabilities in a mass casualty event
- Protocol to receive trauma patients with the most severe cases directed to UMC and less severe injuries directed to other facilities
- Established an LSU System evacuation contract to evacuate patients if facility(s) cannot safely continue operation. This contract was successfully tested during Hurricane Gustav, moving patients from LSU hospitals in South Louisiana by ground and air transport to LSU hospitals in North Louisiana.
- Expanded 700 MHz radio, web based (At Risk Registry, EMSTAT and EM Systems), HAM, and satellite (BGAN) communications systems that are Regional, System and State wide

- Crisis Standard of Care procedure being refined to respond to pandemic type events. This includes detailed planning around intensive care capacity, blood and blood products, communications and public relations, and other matters.
- In addition, specific models of care have been developed that can be applied both on a point of care and population basis.

In summary, the new UMC facility will increase the physical capacity to respond to a major disaster; will be hardened to endure hurricane winds and flooding thereby allowing for the patients to receive uninterrupted care and the staff to shelter in place and be available to provide care to area survivors; and will be operated with a mission to provide leadership in the context of man-made or natural disasters.

Financial and Demand Analysis

Financial and volume projections were prepared to assess the financial implications of proceeding with the proposed Business Plan.

Demand Projections

The Business Plan builds on demand (volume) projections for UMC prepared by Kaufman Hall (“Proposed Business Plan Validation” for the UMCMC Board, dated June 2, 2011). That report included a volume (inpatient and outpatient utilization) projection that covers fiscal years ended June 30, 2010 through June 30, 2020. The projection indicated that by 2020, a range of annual UMC inpatient discharges of 15,206 to 18,160 was possible (and overall bed need ranging from 334 to 403 beds), depending on assumptions made. Assumptions governing that range of results were updated as follows:

- **Population growth.** The annual growth rate in population between 2010 and 2020 for Jefferson, Orleans, and St. Bernard parishes should be approximately 1.0 percent. Information supporting this assumption was provided by GCR & Associates and by the Greater New Orleans Community Data Center (GNOCDC).
- **Health reform effects on coverage.** As of 2014, the majority of the uninsured population in New Orleans and other areas of Louisiana would enroll in Medicaid or obtain commercial coverage through insurance exchanges. While about 15 percent of people in UMC’s three primary service area parishes in 2010 were uninsured, by 2020 only 4.4 percent would not have some form of health insurance benefits.

This outcome assumes that federal health reforms (as specified in the Affordable Care Act, or PPACA) include an individual mandate to purchase health insurance. Since PPACA was enacted, two federal judges have ruled that the individual mandate is unconstitutional. If the mandate is ruled unconstitutional by the US Supreme Court (and if other approaches to provide incentives for uninsured

individuals to purchase insurance are not implemented or are unsuccessful⁷), demand on UMC's safety net services may be greater than assumed.

- **Market shares for ILH and UMC.** Projected volume through 2013 also was based on the assumption that market shares reported for ILH would continue through that time. Beginning in 2014, UMC was assumed to retain a 75 percent share of the health services provided to its formerly uninsured (and now Medicaid or commercially insured) patients⁸. The assumption was made in part due to the view that as of 2014, previously uninsured patients who historically have traveled long distances to seek care at ILH would now have options available to them closer to home.
- **Obstetrics and NICU services.** The volume projection for UMC should assume that for the time being, the ILH and UMC no longer provide inpatient obstetrics and neonatal intensive care services. This reduces projected admissions by about 1,400 annually. The ILH stopped providing these services in July 2010. LSU decided that closure of these services was warranted due to low volumes (leading to high cost per delivery since services needed to be available on a 24-hour basis), a lack of adequate training opportunities for students in medical education programs, and the view that the OB-GYN Residency Review Committee might raise concerns.
- **Psychiatric bed capacity.** The facilities plan for UMC includes increasing the medical center's bed capacity from 38 beds to 60 beds. Consensus exists that the incremental 22 beds quickly will achieve full occupancy. At any given time, the ILH has as many as twenty patients waiting in the emergency room for admission to the psychiatric service. The volume projection includes another 800 psychiatric admissions each year.
- **Impact of Coordinated Care Networks.** The state plans for enrollment in Medicaid managed care programs (referred to as Coordinated Care Networks or "CCNs") in the New Orleans region to begin January 1, 2012. Two types of CCNs are scheduled to be in operation at that time: "CCN-P" providers will operate on a prepaid basis; "CCN-S" providers will share in savings that would be available if cost savings and other objectives for the CCN program are achieved. To set prepaid, capitation rates for the CCN-P providers, actuaries analyzed Medicaid claims data. Based on that analysis, the actuaries assumed that the CCN-P providers would achieve significant reductions in the use of inpatient services by Medicaid recipients. Across the various categories of Medicaid recipients who are to enroll in the program on a mandatory basis, the actuaries assumed a weighted average reduction in admissions of approximately 10 percent and a reduction in average lengths of stay of another 20 percent. Accordingly, the

⁷ See "After the Deluge: Health Reform Without An Individual Mandate," Frakt and Outtersen, Kaiser Health News: <http://www.kaiserhealthnews.org/Columnists/Frakt-Outtersen.aspx>

⁸ Scenarios ranged from 45 percent to 90 percent capture of formerly uninsured patient discharges.

volume projection assumes reductions in utilization (both admissions and lengths of stay) on the part of Medicaid patients in the New Orleans region.

- **Inpatient utilization rates.** By 2016, utilization rates (the number of admissions per 1,000 persons) for the Medicaid population will fall by 10 percent. Utilization rates for Medicare and commercially-insured persons would decline by a total of 2.0 percent by 2020, on the assumption that healthcare reforms would encourage shifting care from inpatient to outpatient settings.
- **Average lengths of stay.** By 2016, average lengths of stay for Medicaid patients at ILH/UMC also will fall by 10 percent. Lengths of stay would fall by 0.1 days for other payer categories between 2011 and 2013.
- **LSU Faculty repatriation volume.** LSU has estimated that UMC will experience an annual increase of over 2,200 inpatient admissions of individuals with health care insurance (other than Medicaid) that will come from existing LSU faculty programs now sited at non-ILH hospitals that will relocate when UMC opens. LSU has devoted significant effort to identifying the specific programs targeted for repatriation and quantifying the resultant inpatient volume available to UMC. This volume estimate has been included in the volume and financial projection; however, the amount has been discounted by 25 percent based on the possible impacts of competitor responses to these plans.
- **New Program Development at the UMC.** The Business Plan also assumes that new programs will be developed that after four years will yield about 1,150 incremental admissions per year.
- **Impact of Referrals from LSU-State Hospitals and clinic developments.** LSU has quantified the number of referrals that ILH has not been able to accommodate due to capacity constraints, has estimated the volume impacts associated with its community clinic strategies, and has assessed the implications of the planned emergency department expansion on inpatient admissions as well. A portion of these volumes also is included in the projections.

Table 5 provides projected discharges for UMC, incorporating the foregoing adjustments.

Table 5: Projected UMC Discharges

UMC Discharges	Year Ending June 30,					
	2015	2016	2017	2018	2019	2020
All Services	16,719	18,199	18,586	18,974	19,087	19,199

In fiscal year 2012, the ILH anticipates admitting 12,300 inpatients.

Financial Projections

Financial projections were prepared by building on assumptions included in the report submitted by Kaufman Hall to the UMCMC Board on June 2, 2011.⁹ That report estimated that to operate, UMC would require State General Fund (“SGF”) support of \$73.1 million for the year ending June 30, 2015, rising to \$96.1 million by 2020. Key assumptions behind those projections and the updated estimates in this report include the following:

- **Volume and case mix.** The projections incorporate revised volume projections, as described above. The impact of developing and expanding destination programs also is reflected in UMC’s projected case-mix index.
- **Update for ILH FY 2012 Budget Adjustments.** The financial projections incorporate the impact of various adjustments made in the fiscal year 2012 ILH budget. The largest of these recognizes that ILH no longer is paying about \$10 million in unallowable outpatient pharmacy costs (the majority of which were funded by state general funds).
- **Move-Related Costs.** UMC will incur approximately \$10 million in move-related costs in 2015 – an amount consistent with the experience of other comparable AMCs that have moved to new facilities.
- **Facilities Maintenance and Clinic Leases.** UMC is assumed to pay less for facilities maintenance costs (compared to the ILH) and for lease costs since with the Ambulatory Care Building UMC no longer will occupy certain outpatient clinics near the ILH.
- **Project Costs and Financing.** The projections also incorporate adjustments to total project costs and project financing:
 - Construction costs of \$99.6 million for the Ambulatory Care Building would be financed by an LSU affiliated entity, with financing costs at 7.5 percent.
 - Construction costs for parking garages (\$32.2 million) also would be financed by LSU or by developers.
 - Approximately \$25 million of medical equipment would be lease-purchased.
 - Total FEMA funds for the project are assumed to be \$630.7 million, or \$38.3 million higher than assumed in early June 2011.

⁹ University Medical Center – Proposed Business plan Validation, KaufmanHall, June 2, 2011

- **Medicaid Reimbursement Rates.** UMC will receive inpatient Medicaid reimbursement rates equal to 60 percent of allowable cost. Consistent with state requirements, Medicaid Coordinated Care Network vendors will provide reimbursement rates no lower than amounts paid under Medicaid fee-for-service.
- **Medicaid DSH Funds.** Regarding Medicaid Disproportionate Share Hospital (DSH) funds, UMC will receive in reimbursement the lower of 19 percent of state-wide funds or its allowable Medicaid and uncompensated care costs. On a state-wide basis and as specified by the Affordable Care Act, federal Medicaid DSH funds will be reduced beginning in fiscal year 2014. By 2018, Louisiana's federal DSH allotment may be reduced from its current \$750 million level to around \$400 million.
- **Medicaid UPL Funds.** Medicaid Upper Payment Limit funds also will be available to UMC; however the amount is capped at \$21.7 million – the amount the ILH anticipates receiving in 2012. In virtually all of the projection years, on a combined basis, Medicaid rates, DSH funds and UPL funds will cover the full allowable costs of Medicaid and uncompensated care services during the projection period.
- **Commercial Reimbursement Rates.** UMC's per-unit reimbursement by commercial payers will increase at a 3.0 percent annual rate – beginning with payment rates/levels received by the ILH prior to UMC's opening.
- **UMC Staffing Levels.** UMC's staffing levels will yield an overall ratio of Full-Time Equivalent Employees to Adjusted Occupied Beds of 6.0. On average, salaries per employee will increase by 4.0 percent annually from UMC's fiscal year 2013 through 2020.
- **Professional Fees Expense.** Professional fees paid by UMC for supervision of trainees, directorships, and for compensation of interns and residents will increase from \$87.6 million in 2012 to \$99.4 million in 2020. Growth in the resources needed to assure faculty supervision is assumed to moderate due to the changing payer mix of UMC (increased numbers of commercial and Medicare patients). The changing mix of patients by payer category at UMC also will be reflected in a changing payer mix for the faculty physician practices affiliated with the medical center. The UMCMC Board also will exercise its fiduciary responsibilities and would assure that the professional services costs borne by UMC would be carefully negotiated.

Based on these assumptions, the following annual SGF appropriations would be needed to assure that UMC's financial requirements are met.

Table 6: Actual and Projected State General Fund Appropriations

		State General	
		Year Ended June 30,	Funds (\$ Millions)
Actual ILH	2006	\$	37.5
	2007		36.4
	2008		48.7
	2009		50.6
	2010		26.1
	2011		57.4
Projected ILH	2012		32.5
	2013		33.2
	2014		33.8
Projected University Medical Center	2015		44.1
	2016		50.0
	2017		46.5
	2018		50.5
	2019		61.5
	2020		60.3

Source: UMC financial model developed by Kaufman Hall, incorporating assumptions as of September 2011.

During each of the six years ending June 30, 2020, state general fund needs are projected to average \$52.5 million.¹⁰ In addition to the amounts in Table 6 and assuming that UMC starts with a clean balance sheet, UMC may need access to \$120 to \$175 million in working capital in 2015. Options for working capital financing such as a line of credit are under consideration. Costs associated with such working capital financing have not been included in Table 6.

Context for the Projected State General Fund Needs

For comparison purposes, financial projections also were prepared to assess the implications of continuing to operate the ILH¹¹ beyond 2014. **State general funds needed to continue operating the ILH during the six years ending June 30, 2020 are projected to average \$54.8 million – an amount slightly greater than if the proposed project proceeds.** Remaining in the ILH means that awarded FEMA funds would be

¹⁰ The most significant drivers of variances from the estimates in the June 2, 2011 Kaufman Hall report include: updating the projections for changes in the ILH fiscal year 2012 budget (\$10 million), adjusting the projections for lower maintenance and clinic lease costs available upon UMC occupancy (\$8 million), and the benefits of increased FEMA funds and the alternative financing approach (\$14 million).

¹¹ The ILH was renovated using FEMA funds to be the Interim LSU Hospital to provide temporary health services for the region. Under FEMA regulations, these expenditures were allowed with ILH considered a “Category B” temporary facility. The ILH may not continue to be used as a hospital facility after the temporary need is met by permanent facilities. According to the Louisiana Division of Administration, if the ILH continues operating – funds awarded for the permanent replacement facility would be lost.

lost, that certain deferred maintenance costs would need to be addressed, that ILH inpatient admissions would be 25 to 30 percent less than at UMC, that LSU academic and clinical programs would remain dispersed across multiple sites, and that benefits of achieving the vision of the AMC would be lost.

During fiscal years 2015 through 2020, the state general fund amounts in Table 6 are projected to average \$52.5 million. That amount represents approximately 9 percent of UMC’s projected operating revenue. According to data assembled by NAPH, in 2009 “state and local payments” at 91 member safety net hospitals averaged about \$60 million, or 12 percent of net revenue. Some NAPH hospitals receive no such payments. For the 66 hospitals receiving state and/or local financial support, these payments averaged above \$80 million, or 19 percent of net revenue. See Table 7 below.

Table 7: Net Revenue for NAPH Member Hospitals, 2009

NAPH Member Data, 2009	All NAPH Members		NAPH Members With Subsidy	
	All (N= 91)	All (Excluding LSU HCSD)	All (N=66)	All (Excluding LSU HCSD)
Net Revenue (\$ Millions)				
Medicare	\$ 9,258	\$ 9,181	\$ 4,865	\$ 4,789
Medicaid	15,773	15,125	10,950	10,303
Commercial	11,272	11,226	5,429	5,383
Uninsured	1,876	1,869	1,192	1,184
Other	1,308	1,308	590	590
State/Local Payments	5,320	5,222	5,337	5,240
Total	44,807	43,931	28,364	27,488
Percent of Net Revenue				
Medicare	21%	21%	17%	17%
Medicaid	35%	34%	39%	37%
Commercial	25%	26%	19%	20%
Uninsured	4%	4%	4%	4%
Other	3%	3%	2%	2%
State/Local Payments	12%	12%	19%	19%
Total	100%	100%	100%	100%
Average Net Revenue	\$ 492.4	\$ 523.0	\$ 429.8	\$ 465.9
Average State/Local Payments	\$ 58.5	\$ 62.2	\$ 80.9	\$ 88.8

Source: NAPH, 2009.

Rationale and Anticipated Benefits

The Business Plan indicates that the proposed project will provide several benefits to Louisiana.

- The UMC project will help assure that Louisiana’s needs for well-trained health professionals are met and enhance the educational experiences for trainees who benefit from exposure to diverse patient populations and clinical services. The project thus will enhance the stature of the state’s medical schools, improving the ability of the schools to attract faculty, students, and research dollars.

UMC will be the primary teaching hospital of the LSUHSC in New Orleans, the largest producer of physicians and allied health professionals for the state, while also serving as an important teaching affiliate for Tulane, Xavier, and other educational institutions. A teaching hospital with modern facilities and the capacity to house the clinical activity of multiple disciplines will allow for the collegial atmosphere characteristic of high performing health sciences centers and for the professional interaction necessary to develop and support highly specialized services. UMC also will offer a more diverse clinical experience than the old Charity Hospital provided or the ILH can provide. This is essential to developing educational programs and attracting the best trainees to Louisiana. High quality training will translate into highly qualified health care providers for Louisiana’s citizens.

- Create immediate and longer-term economic benefits through construction activities, employment at UMC and associated enterprises, and the attraction of incremental research and grant funds.

BioDistrict New Orleans published an Economic Impact Study in October, 2010. That study discussed the impacts of the UMC project, the VA hospital, and other projected developments, and found that these projects “will create or save approximately 5,500 permanent jobs in the first five years of operations. These 5,500 direct jobs will lead to nearly 9,700 total jobs ... (annual) personal earnings of over \$350 million, infusing the state with over \$25 million and local government agencies with nearly \$22 million in annual tax collections.¹²” The study indicates that once these projects are fully operational, economic impacts will increase – in particular if the projects contribute to venture capital investment, research and development activity, and commercialization of new medical technologies.¹³

- Encourage and support development of high quality, specialty health services that will contribute to the health of Louisianans.

The new UMC will allow for the concentration of resources and disciplines necessary to develop highly specialized clinical (and academic) programs. The Business Plan calls for several “destination programs” to be repatriated to and developed at UMC. These programs will be available to all UMC patients – insured and uninsured alike.

- Yield a facility that will enhance public safety in the event of natural or man-made disasters.

¹² BioDistrict New Orleans Economic Impact Study, October 29, 2010.

¹³ *Ibid.*

UMC will be built to standards for wind, flooding, and seismic activity. These features will allow the hospital to maintain operations in the event of hurricanes or other natural disasters. The Business Plan calls for UMC to play a leadership role in local and regional disaster planning and response.

- Provide greater financial stability and a governance change for the state's largest safety-net hospital provider, placing oversight of UMC's success in the hands of a fiduciary board comprised of leading citizens.

The Business Plan will allow the UMC to diversify its revenue streams and to be managed under the oversight of a non-profit governing board. The benefits of governance changes of this nature have been demonstrated across the US.

Risk Factors to be Monitored

The following risk factors will require ongoing monitoring and management.

- The cost implications of any delays in constructing the facilities, and the implications of changes in the availability or cost of project financing.

Delaying the project will lead to price escalation. According to the Division of Administration, cost guarantees will expire unless construction begins in a few weeks. LSU has received assurances that financing will be available for the Ambulatory Care Building and for structured parking.

- Any inability to finance UMCMC's initial and ongoing working capital needs.

As a non-profit Corporation that also receives state general funds, UMC will need to be able to generate positive earnings and/or have other sources of capital to meet ongoing needs - including acquiring new technologies as they emerge. Historically (due in large part to the mechanics of the Medicaid DSH program), LSU-State hospitals have not been afforded ready access to capital. UMC will need access to working capital when it begins operating and on an ongoing basis. Options for working capital financing such as letters of credit are under consideration.

- The implications of any inability of UMCMC, LSU, Tulane, and other partners to reach agreement on the terms of affiliation agreements and how certain decisions will be made.

Implementing the Business Plan will require UMCMC, LSU, Tulane, and the state to negotiate several important agreements. The agreements will govern how UMC is reimbursed for the cost of services provided to the uninsured (and for prisoner care), how LSU and Tulane will provide services of medical school faculty members to UMC (and at what professional fees cost), and how other staff services will be arranged. The agreements also will specify how certain decisions will be made – for example, the role of UMCMC Board and executive management in decisions regarding academic programs at UMC – and the ability of UMCMC to influence clinical programs provided by LSU

faculty on and off the UMC campus. UMC only will be successful if agreements that are fair to the parties are reached.

- Possible competitive responses to plans to develop “destination programs” at the UMC by relocating and recruiting new LSU faculty.

Business planning for UMC has been conducted in public. Other organizations are well aware of the plans to develop destination programs at UMC, among other strategic initiatives. Competitive responses to developing these programs can be anticipated.

In any scenario, any future cuts to Medicare and Medicaid programs and to Medicaid Disproportionate Share Hospital and UPL funds will need to be monitored. Under health reform the US Secretary of Health and Human Services is to develop a methodology to distribute reductions to federal Medicaid DSH allotments to the states. Most likely, “high DSH” states like Louisiana would receive the largest reductions to their allotments of federal Medicaid DSH funds. Reductions to Louisiana’s federal Medicaid DSH allotment greater than the amounts assumed would affect the amount of Medicaid revenue available state-wide, including amounts available for UMC.

Next Steps

Upon approval of the Business Plan by the UMCMC Board, next steps include the following:

- Presentation of the Business Plan by the UMCMC Board to the Joint Legislative Committee on Budget, and if accepted, its authorization for the state Office of Facility Planning and Control to begin construction of the project.
- The UMCMC Board, LSU, Tulane, the state, and other parties negotiate affiliation agreements, services agreements, and funding agreements as contemplated by the MOU.
- An LSU-affiliated entity secures financing for the Ambulatory Care Building and for structured parking.
- The UMCMC Board and LSU work together on transition planning for UMC operations.