LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **HB 284** HLS 13RS 512
Bill Text Version: **ORIGINAL**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: April 30, 2013 7:16 PM
Author: ORTEGO
Dept./Agy.: DHH/LSU hospitals
Subject: Transfer of public hospitals to human service districts
Analyst: Jennifer Katzman

HEALTH SERVICES OR INCREASE GF EX See Note

Transfers governance and control of state hospitals from LSU to human services districts and authorities of the state and provides for delivery and financing of health services by such districts and authorities

Proposed law transfers the state public hospitals from LSU to the human services districts & authorities, or local governing entities (LGEs), within the Department of Health & Hospitals (DHH). To this purpose, the proposed law provides for various technical matters relative to the transfer and the expansion of the human services districts & authorities in order for them to assume hospital management as one of their functions. Included in these changes is the authority to levy and collect local ad valorem tax millages, collect shared savings revenues via participation in a Centers for Medicare & Medicaid Services (CMS) approved Accountable Care Organization (ACO), grants the right to incur debt, issue bonds, hold title to property, and participate in managed care systems.

Proposed law also separates the LSU medical school in Shreveport from the hospital and renames the hospital the University Hospital Shreveport.

EXPENDITURES	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**5 -YEAR TOTAL**
State Gen. Fd.	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Annual Total						

REVENUES	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Annual Total						

EXPENDITURE EXPLANATION

The net impact of the proposed legislation is indeterminable based on the increased need for SGF for administrative expenses, the amount of revenues collected from ad valorem taxes and the amount of SGF required to execute the public/private partnerships. This note assumes that the proposed LSU hospital public/private partnerships will continue under this legislation. An itemized review of expenditures is detailed below.

LSU Public/Private Partnerships: The proposed legislation grants the LGEs successor rights for current contracts held by LSU, including any current and future public/private partnership cooperative endeavor agreements (CEAs). There is $426.3 M in SGF budgeted for operations at all the hospitals in FY 13 before the Federal Medical Assistance Percentage (FMAP) reduction and after the closure of Earl K. Long hospital. Based on the level of current expenditures, there is no anticipated SGF need resulting from transference to the LGEs under the partnerships based on the maximum possible collection of millages ($326.8 M reflected below in Revenue Explanation) and the budgeted level of state match funded for the partnerships associated with Medicaid claims, Disproportionate Share Hospital (DSH) payments, and Supplemental Medicaid Upper Payment Limit (UPL) payments that exists in the budget for FY 14 ($222 M).
Note: Based on estimated payments to the private partners under the currently executed CEAs for EKL, UMC, and ILH, it is assumed that additional SGF above the $222 M will be required for public/private partnerships in all hospitals. To the extent the partnerships dissolve because of this measure, the LFO assumes the $222 M budgeted in FY 14 will remain available to mitigate hospital operational costs.
Expenditure Explanation Continued on Page 2

REVENUE EXPLANATION

Ad Valorem Taxation: Under the proposed legislation, the LGEs will be able to collect local revenue through ad valorem taxation, subject to majority vote by the local electorate for up to 10 mills for the support of their hospital operations. It is unclear when the elections will be held or whether a year's worth of revenue will be collected in time for the proposed legislation's implementation date of 7/1/2014. As such, it is assumed that the maximum possible collections cannot be achieved until FY 16 (beginning 7/1/15). Based on the LA Tax Commission's annual report of the total taxable assessed value of property within each parish, the maximum local revenue that can be collected and used as a state match source and the matching Federal Financial Participation (FFP) is detailed below. Allocations between Medicaid, DSH, and UPL payments are based on the FY 13 budget allocations at each hospital. The maximum possible collections will be enough to cover expenditures at 4 of the 10 hospitals at their FY 13 pre-FMAP reduction level; however, BMC, ILH, EKL/OLOL, UHS, EAC and HPL will be underfunded and require SGF support since millage collections cannot be pooled & shared amongst the separate LGEs.

	Max State Match	**Max Federal Match**	**Max Total Revenue**
Medicaid	$68,207,301	$115,937,680	$184,144,980
DSH	$223,099,367	$348,657,084	$571,756,452
UPL	$35,505,188	$60,351,152	$95,856,340
Max Revenue	**$326,811,857**	**$524,945,916**	**$851,757,772**

Note: These projections assume that LAK & BMC will each receive 50% of the FPHSA maximum millage collections.
Revenue Explanation Continued on Page 2

Senate Dual Referral Rules House

[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S&H} [ ] 6.8(F) >= $500,000 Annual Fiscal Cost {S}

[x] 13.5.2 >= $500,000 Annual Tax or Fee Change {S&H} [ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

John D. Carpenter
Legislative Fiscal Officer

LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **HB 284** HLS 13RS 512
Bill Text Version: **ORIGINAL**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: April 30, 2013 7:16 PM
Author: ORTEGO
Dept./Agy.: DHH/LSU hospitals
Subject: Transfer of public hospitals to human service districts
Analyst: Jennifer Katzman

CONTINUED EXPLANATION from page one:

Continued Expenditure Explanation:

Transfers will occur as follows:
Acadiana Area Human Services District (AAHSD) - University Medical Center - Lafayette (UMC)
Florida Parishes Human Services Authority (FPHSA) - Lallie Kemp Medical Center (LAK) & Bogalusa Medical Center (BMC)
Metropolitan Human Services District (MHSD) - Interim LA Hospital/University Medical Center - New Orleans (ILH/UMC-NO)
Imperial Calcasieu Human Services Authority (ICHSA) - W. O. Moss Regional Medical Center (WOM)
South Central LA Human Services Authority (SCLHSA) - Leonard J. Chabert Regional Medical Center (LJC)
Northeast Delta Human Services Authority (NEDHSA) - E. A. Conway Regional Medical Center (EAC)
Northwest LA Human Services District (NWLHSD) - University Hospital Shreveport (UHS)
Central LA Human Services District (CLHSD) - Huey P. Long Regional Medical Center (HPL)
Capital Area Human Services District (CAHSD) - Earl K. Long Hospital (EKL)/Our Lady of the Lake (OLOL) partnership

Administrative Costs: Under the proposed law, the 9 LGEs will continue to operate under their own governance boards, but with expanded administrative functions for business operations and oversight of the proposed public/private partnership CEAs for quality assurance, which LSU has centralized (approximately $19 M budgeted in FY 14). It is presumed that the private partners already have a majority of the business operations functions for hospital management in place, and costs at the LGEs will only minimally increase for this purpose. As such, costs are anticipated to increase by an indeterminable amount primarily due to duplication of contract review and oversight.
To the extent the partnerships dissolve as a result of this measure, administrative functions will be decentralized in the 6 separate LGEs in the south if the public/private partnerships do not continue under the LGEs. This is projected to increase costs by a significant amount to recruit hospital management personnel and incur various startup costs. Business operation costs may include areas such as disease management, administration, public relations, internal audit, compliance review, managed care review, program research & development, benchmarking & analytics, IT, accounting, human resources, purchasing, telemedicine, budget development, legal, and management of cost reimbursements/reporting. The increase in business operation costs will depend on what personnel and functions will need duplication in each LGE versus services that can be centralized via contract (such as billing). These costs are currently covered via SGF and revenues generated by the hospitals for allowable, reimbursable costs through Medicaid, Disproportionate Share Hospital (DSH) payments, and Medicare. It is assumed that the administrative costs resulting from the proposed legislation will continue to be covered by these sources of revenue from each hospital within the LGE. It is not anticipated that these costs will increase at UHS, EAC, or HPL as these functions were never centralized and will not need to be added or duplicated within the 3 separate LGEs in the north. It is also assumed that without the partnerships, LGE/hospital operational expenditures will increase by a significant amount due to the need for each LGE to contract with new specialist providers for patients that are currently referred to ILH, EKL/OLOL, and UHS for specialist care that is currently unavailable at their local hospital. Depending on available revenue from millages, these costs could be absorbed by some LGEs/hospitals.

Electronic Health Records: The proposed law also requires implementation of electronic health records (EHR) at each hospital. Currently, only UHS, EAC, HPL, and ILH have an EHR system in place through EpicCare (Epic) with LAK to be implemented on 5/12/2013 (EKL/OLOL has a different EHR system in place). Based on the costs of previously implementing Epic in the LSU hospitals, implementing EHR systems in the remaining 4 hospitals would cost an estimated $5,777,368 in one-time startup training/licensing expenditures and $767,874 in annual maintenance & support.

Bayou Health: Each LGE will have to negotiate new rates for reimbursement with the Bayou Health plans. It is unknown what impact this will have on future hospital expenditures and revenues. Payments from the plans are reflected as SGR.

Continued Revenue Explanation:

Accountable Care Organization (ACO): To the extent the hospitals participate in an ACO under the Shared Savings Program (42 U.S.C. 1395jjj), an indeterminable amount of additional Federal revenue may be collected by the LGEs if the ACO meets the requirements in statute and the quality performance standards set by the Secretary of the US Department of Health and Human Services (DHHS). Revenues will be based on savings the hospitals generate as a result of accountability and coordination of items and services for Medicare parts A and B patients via infrastructure investment and redesigned care processes, and will depend on specific benchmarks set by the Secretary of DHHS.

Provider Based Billing in LGE clinics: Under the proposed legislation, once the LGEs assume ownership and control of the public hospitals, the current behavioral health clinics operated by the LGEs will also be able to participate in provider based billing since they can be affiliated with the LGE's hospital as they are owned by the same entity. Provider based billing will allow the clinics to charge 2 separate bills to Medicaid and Medicare for physician services and facility expenses. Currently, the clinics can only make one charge for physician services (which are often contracted), and this does not cover the costs of the host facility such as overhead, IT, supplies, and nursing services provided by the clinic. With dual billing under provider based billing, the LGE's clinics will be able to generate revenue from Medicaid and Medicare to recoup some of its facility costs and the physician will continue to receive the same reimbursement. While this does increase the revenues of the LGEs, it also increases the need for SGF match in Medicaid by an indeterminable amount depending on the amount of additional reimbursement required. This need could potentially be met by collected millages where revenue is available.

Electronic Health Records Incentive Programs: The LGEs could also potentially receive an indeterminable amount of additional Federal revenue from the Medicare and Medicaid EHR Incentive Programs for implementation of EHR in the 5 remaining hospitals as discussed above. Potential revenue will depend on whether the LGE's hospital meets 18 of the 23 Federal "meaningful use" requirements set by the Centers for Medicare & Medicaid Services (CMS). The incentive base amount is $2 M, which is adjusted by the hospital's number of discharges and Medicaid/Medicare patient mix. However, if the hospitals do not implement EHR systems and attest to "meaningful use" by 7/1/2014, a 25% penalty on Federal inpatient physician service reimbursements to the hospital will be assessed in Federal FY 15, and the penalty will increase with each year that EHR is not implemented.

Senate	Dual Referral Rules	House
[x]	13.5.1 >= $100,000 Annual Fiscal Cost {S&H}	[ ] 6.8(F) >= $500,000 Annual Fiscal Cost {S}
[x]	13.5.2 >= $500,000 Annual Tax or Fee Change {S&H}	[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

John D. Carpenter
Legislative Fiscal Officer