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POST KATRINA HEALTH CARE IN THE NEW ORLEANS REGION: PROGRESS AND CONTINUING CONCERNS—PART II

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

AUGUST 1, 2007

Serial No. 110–62

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POST KATRINA HEALTH CARE IN THE NEW ORLEANS REGION: PROGRESS AND CONTINUING CONCERNS—PART II

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POST KATRINA HEALTH CARE IN THE NEW ORLEANS REGION: PROGRESS AND CONTINUING CONCERNS—PART II

WEDNESDAY, AUGUST 1, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:30 a.m., in room 2123 of the Rayburn House Office Building, Hon. Bart Stupak (chairman) presiding.

Members present: Representatives DeGette, Melancon, Green, Schakowsky, Whitfield, Walden, Burgess, and Blackburn.

Also present: Representative Jefferson, Delegate Christensen.

Staff present: Chris Knauer, Kristine Blackwood, Scott Schloegel, John Sopko, Angie Davis, Kyle Chapman, Alan Slobodin, Peter Spencer, and Garrett Golding.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This meeting will come to order. Today we have a hearing on Post Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns, Part II. This hearing, on the eve of the second anniversary of Hurricane Katrina landfall, is a follow-up to the subcommittee's March 13 hearing, which examined the immediate health care needs of citizens in the New Orleans region. Our hearing will touch on issues involving not just the immediate health care needs of the region but also some of the long-term plans that Federal and State officials have for rebuilding the large hospitals in New Orleans that were lost because of Hurricane Katrina. The Nation has much to learn from the people of New Orleans about the long and difficult road to full recovery after a major disaster. Katrina brought us the unprecedented experience of having a major American city health care system shatter overnight. Surviving the disaster and its immediate aftermath, while difficult enough, now appears less daunting than regaining a fully functioning and well-balanced health care infrastructure for the region. Fortunately, hospital workers no longer have to pump IVs and heart machines by hand to keep patients alive in a darkened hospital.

But the area's health care system remains vulnerable and overwhelmed and much work remains to be done. Since our hearing in March some progress has been made in the four Katrina affected

parishes known as region 1. Following our March hearing Health and Human Services Secretary Leavitt released $100 million in Deficit Reduction Act funds for public and not-for-profit clinics that provide primary care to low income and uninsured regions of region 1, uninsured residents of region 1. This targeted infusion of funds will help restore and expand access to outpatient primary care including medical and mental health services, substance abuse treatment, oral health care, and optomic health care. HHS also provided an additional $35 million to Louisiana for workforce development and retention and an additional $26 million direct funding to providers at acute hospitals, psychiatric hospitals, skilled nursing facilities, and community mental health facilities.

The subcommittee is still not clear as to exactly how these funds will be distributed, and we look forward to flushing that issue out in today's questions. While we have had some improvements since our March hearing there are still serious challenges facing local, State, and Federal public health officials. A similar degree of focus and effort needs to go towards stabilizing the graduate medical education GME programs in New Orleans. The whole State of Louisiana relies on GME assistance for developing of its future health care workforce. Louisiana State University historically trains 75 percent of all health care professionals in the State through its medical school in downtown New Orleans.

Tulane University's School of Medicine, also headquartered in downtown New Orleans, trains much of the balance of the health care workers for Louisiana. The Federal and State funds that support medical training are funneled through teaching hospitals like LSU's Big Charity and several other hospitals destroyed by Katrina. Without their principal teaching hospital to provide the necessary case concentration needed for accreditation, LSU and Tulane have had to close some of their medical specialty training programs.

At the same time, because of the cumbersome manner in which Medicare reimburses hospitals for hosting medical residents at their facility, the medical schools have had to enter into torturous and expensive negotiations with other hospitals so that residents may continue their training. Meanwhile, although host hospitals receive relief from Medicare's 3-year rolling average rule in the first year after the hurricane that relief of the 3-year rolling average expired in 2006 causing reimbursement shortages. Until LSU can build a new training hospital these other hospitals should be able to host medical residents without incurring a financial penalty.

I again urge the Secretary to engage academic and public health officials in the State to develop a fair way to insure that medical training can continue in the region at an adequate level. Likewise, I urge Secretary Leavitt to meet with the representatives from the local private hospitals who will testify today. Hospitals in the four Katrina-affected parishes report that they are incurring substantial increased costs of doing business that continue to disable the system and limit patient access to reliable health care. Hospital representatives will tell us of the financial pressures they face due to labor costs driven up by serious shortages of nursing and other personnel.

I am concerned that this labor shortage may have multiple weakening effects on an already fragile system. For instance, LSU has reported that it is difficult to open additional hospital beds at its rehabilitative university hospital facility due to lack of nurses. This in turn increases the burden on private hospitals and independent providers who are already treating unprecedented numbers of uninsured since Big Charity's closure. These challenges deserve the attention and leadership from our public health officials, and I hope the Secretary will lead efforts to address structural imbalance in the health care economy in the New Orleans region.

Finally, we have seen plans to build two of New Orleans' most important facilities, LSU's Academic Medical Center and the VA Hospital, mired in emotional and political debates. I believe the community in the New Orleans area needs as much clarity and transparency with respect to decisions being made regarding these two hospitals as soon as possible. It is difficult enough for low income and uninsured members of the community and veterans in the region to obtain convenient and consistent hospital care without these critical facilities up and running. Their wait should not be made harder by unnecessary delays and backroom politics.

In closing, I would like to thank the Republican members and the staff for their continued bipartisan approach to this investigation. I would also like to mention the leadership of my vice chairman of this subcommittee, Mr. Melancon, for his tireless effort to insure that rebuilding the health care system of New Orleans remains a priority for this Congress. You have my personal assurance that this subcommittee will continue to monitor the progress and push wherever necessary to see the region's health care needs are met. That concludes my opening statement. I next turn to my friend, the ranking member of the subcommittee, Mr. Whitfield, from Kentucky for an opening statement, please.

OPENING STATEMENT OF HON. ED WHITFIELD, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. WHITFIELD. Chairman Stupak, thanks very much. All of us are quite excited about this third hearing on health care needs and the situation in New Orleans and the surrounding area as a result of the devastation of Katrina. I remember last March when we had this hearing it was some 18 months after the storm, and hundreds of millions of dollars had been sent to the region and at that time there was still a lot of gridlock and stagnation. I remember I walked away from that hearing with the impression that there had been so much focus by different advocates on what reforms needed to take place in health care that the immediate needs were sort of placed on the back burner. I think we have 15 witnesses, and we genuinely appreciate all of you for being here because you are the ones involved in the trenches trying to address these problems. I know that people are always skeptical and scared when the Congress comes forth and says what can we do to help you, but that is really why we have these hearings for you all to give us some idea of how we can we be helpful and what can we do.

And I know after Chairman Stupak's March hearing, as he said, we were quite excited that Secretary Leavitt came forward and did

release about $160 million to help strengthen community health centers and primary care facilities as well as to support health provider recruitment and retention and to aid the hospital's financial situation. It is my understanding that we will hear this morning that there have been policy developments toward improved coordination of future care delivery, and most of the key State and regional players have developed a common vision for long-term rebuilding, which should help expedite the recovery and will encourage more health professionals to return to the region.

And by all accounts this is welcome news, positive news, and we are excited about that. But we also are quite concerned about these stories and about how the hospitals are facing dire financial needs and have continuing significant losses and then the stability and medical educational situation and the challenges faced by private practice physicians and the overall shortage of health care providers. So we want to be sure that the Federal Government, the Department of Health and Human Services, and the Congress is responsive. And as Chairman Stupak said, this is and has been a totally bipartisan effort because all of us want to do everything we can to help improve the health delivery system in New Orleans.

And once again, I want to thank all of you for being here. As I said, you are the ones in the trenches. You are the ones facing every day problems. Constituents come to you with their complaints, and we look forward to hearing your testimony and hopefully can help move us down the road to solving this problem and having a more effective health care delivery system. And I yield back the balance of my time.

Mr. STUPAK. I thank the gentleman. Mr. Melancon for opening statement, please.

OPENING STATEMENT OF HON. CHARLIE MELANCON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. MELANCON. Thank you, Mr. Chairman. We are now on the eve of the second anniversary of Hurricane Katrina. Nearly 2 years later we find ourselves in this room with much work still ahead. This committee made a commitment that it would continue to examine the collapse of the health care system in the greater New Orleans region, and this is the next installment towards that effort. As Chairman Stupak, Chairman Dingell, and previous chairman, Mr. Whitfield, said before: this body will work hard to show the people in the Katrina affected area by insuring that this government move things forward and see to it that the relevant Federal agencies continue to provide the necessary relief. This hearing is part of that process.

The testimony at our March 13 hearing on this topic revealed the landscape with citizens of the New Orleans region struggling to use a health care system comparable to what one might find in a developing country. Those without insurance were forced to wait in long lines at city sponsored health care fairs or volunteer clinics just to see a doctor and dentist. Health care workers told committee staff of families sleeping in cars outside the clinics to insure placement on a waiting list. Examples such as a diabetic being able to access even a few days worth of insulin were reported regularly. The com-

mittee was told how those with complicated chronic ailments, such as heart disease or a mental health condition, had almost no chance of locating a specialist if they lacked insurance.

Private hospitals were receiving large numbers of uninsured patients and were unsure how they would avail those costs or continue providing such services. Private physicians that were trying to rebuild their businesses were finding it almost impossible to do so because they were not being paid for the care they rendered. The major hospitals that took care of the poor and uninsured and the primary hospitals treating veterans remained closed. The University Hospital, the small Charity Hospital were so overwhelmed with patients it was often on deferral. In fact, when our staff visited that hospital in March much of the emergency room was dedicated as a holding area for individuals needing critical psychiatric care.

What we are doing today remains crucial to rebuilding the region. As recently reported by the New York Times just last week, restoring health care services may be the most important factor in restoring this region, and I would urge you to read this article for New Orleans reviving health care systems or said city's future. Today's hearing will attempt to highlight not only what has been accomplished but also what more we need to do in order to bring health care back to the region. I am pleased to report that some progress has been made since our last hearing on resolving key health care issues.

For example, HHS recently released nearly $135 million in DRA dollars to the greater New Orleans region with the objective of recruiting and retaining health care workers and provide some relief to the many primary care clinics which may play a key role in providing access to health care. From what we have been told, this should allow them to operate for about 3 more years. This is a very positive development and I thank the Department for making this money available. We look forward to hearing from HHS, Louisiana Public Health Institute, and Secretary Cerise regarding how this money will be spent and what they hope it will accomplish.

Nevertheless, while funding primary care claims is a particularly positive development, we are a long way from restoring adequate health care for the region. As you will hear today, many vexing health care challenges remain. These will require the attention of policymakers at the State and Federal level as well as this Congress.

Let me briefly summarize what appears to be among the most pressing. First, due to high labor costs and labor shortages the region's top five private hospitals report that they are collectively losing considerable sums of money and that these losses could ultimately result in a reduction of services. Collectively, Ochsner, East and West Jefferson, Tulane, and Touro report to our staff that they expect a combined loss of $125 million in 2007. We are told this loss is expected to go to over $400 million over the next several years.

As reported to staff, these losses are due to extraordinary high labor costs associated with staffing hospital beds and continued uncompensated care costs. The solution to this problem remains unclear. At a minimum, however, I believe that this concern must be

investigated to understand its potential impact on the region's health care services. I will ask representatives from both the State and Federal Governments what they know about this claim and how it should be evaluated or verified. I will also explore with key agencies what kind of relief might be made available to these hospitals should these claims hold merit. I will ask the U.S. Government Accountability Office, HHS, Office of Inspector General or some other objective third party entity to evaluate the concerns voiced by the five private hospitals that will testify today.

What they will describe is a potential new storm on the health care horizon for this area. It is a problem that deserves a thorough review and I look forward to hearing from my witnesses on how to best approach this. Second, the region's two primary teaching schools, Tulane and LSU, continue to struggle to keep their medical programs alive, and much of this relates to the current structure of the graduate medical education payments made by Medicare. Prior to Katrina both Tulane and LSU were both training residents at several regional hospitals. The one site where both of these schools had the largest concentration of residents, however, was the Medical Center of New Orleans, commonly referred to as "Charity."

According to both universities during this period of total and partial closure after Katrina, the medical schools remained responsible for the education of the residents and for paying the salaries and benefits of the residents despite being unable to receive reimbursement from the closed hospital. This ongoing arrangement has created a number of financial difficulties for both Tulane and LSU. Given that the bulk of all of Louisiana health care workers are trained in these two institutions, it is critical that we explore with HHS ways to remedy at least some of the burden placed on the universities by current GME rules. These rules are extremely complicated.

I will look forward to discussing with CMS what tools might be made available that may provide both flexibility and relief to these two institutions, at least until a new medical center is built. The third major problem we hope to examine is the continued debacle of rebuilding a major public hospital to replace Big Charity and determine the new location of the VA's proposed hospital, which may or may not be part of that deal. Unfortunately, both appear stymied by endless politics and debate. As we all know, Big Charity once served many of the regions working for it. Since its destruction many have had to pursue a patchwork of options when seeking medical care.

As plans were being made to rebuild Charity, the VA, who also lost its regional hospital in the flood, entered into an Memorandum of Understanding with LSU to explore the possibility that two hospitals would be rebuilt as a collaborative project. While it was understood by certain stakeholders that this project would soon be underway and that the VA would locate its facilities downtown and in close proximity with LSU's replacement facility, the plans for this project still remain unclear. Currently, the VA is considering both the downtown site, which is close to the existing health care facilities, and a site located in Jefferson Parrish. I believe it is time for the VA and the State to resolve this deal and to begin building

a hospital. Neither the citizens of Louisiana nor the veterans are being served by this continuing delay. I intend to explore with the VA and LSU the status of this proposal.

Moreover, because this project has been mired in continued confusion and controversy, I am asking that the VA formally brief this committee once a month as to the status of this project. For all parties involved, I believe that both LSU and VA's plans for building these two hospitals must be made clearer than they have been thus far. Not a shovel's worth of dirt has been lifted towards either hospital's construction and that I find totally unacceptable. I would like to conclude by first of all thanking my colleagues on this committee for the continuing work they and their staffs have done and provided to us helping torebuild this region.

This has been a continued effort and a continued bipartisan endeavor. I know that it will continue. I would also like to thank the many excellent witnesses providing testimony. Many of you remain in the trenches and are truly the heroes that are the most responsible for moving this effort forward. We are making progress, and as tired and frustrated as we are at times, I believe we will be successful. I do want to renew that commitment that we have made to you before. We will use this committee's resources to continue to examine this important area and assist you in what you are all trying to do in any way legally possible. That concludes my remarks, and I thank you, Mr. Chairman.

Mr. STUPAK. I thank the gentleman. Mr. Walden from Oregon, please.

Mr. WALDEN. Mr. Chairman, I am going to waive my opening statement. I know we have got a busy day on the floor and probably a few interruptions so it would be nice to hear from the witnesses. Thank you, sir.

Mr. STUPAK. OK. Thank you. Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman. I just want to welcome our witnesses today, particularly the mayor and others. Many of you who I have been working with for the last 2 years on the health care situation in Louisiana, as the chairman and the ranking member know, we went to New Orleans 6 months after the terrible tragedy, and we have been going back and we have been talking to people ever since. We are really committed to working with you to try to rectify the terrible health care situation that followed the hurricane. It really is an American tragedy what has happened, and we need to work together to make sure that this situation is rectified.

I have been frustrated, as my colleagues have, by the slow lack of progress and lack of communication between various governmental agencies, including Federal agencies, and remain committed with the other members of this committee to insuring that this problem is resolved and resolved quickly. Mr. Chairman, I want to apologize. I won't be able to stay for the whole hearing because I am the chief deputy whip in charge of the SCHIP bill which will

be up on the floor momentarily, so I too want to hear the testimony of the witnesses and yield back the balance of my time.

Mr. STUPAK. I thank the gentlelady for her statement. SCHIP, the Children's Health Initiative Program is on the floor today. All of us have worked on that legislation. It came through our Energy and Commerce Committee. The bill is on the floor, and I am sure members on both sides of the dais will be going down and making their comments, conclusions, whatever they would like, on the bill, but we appreciate everyone being here. So we will be moving in and out. No disrespect to our witnesses. Mr. Burgess, I am sure you want something to say on what I had to say or else at least an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I am going to forego saying something I wanted to say on what you had to say. I am actually going to forego an opening statement as well. We have important testimony to hear today. There is a lot going on on the floor, and I am anxious to hear from our witnesses. I am glad to see Dr. Peters and Mr. Muller back here from my first visit down to the area in October 2005 and understanding the problems that face them. Ms. DeGette called it an American tragedy. I would say it is a bureaucratic nightmare. And I still, frankly, do not understand where the logjam is. I don't know whether the logjam is here. I don't know whether the logjam is at the State. I don't know whether the logjam is at some point in the city. But clearly the work of this committee has to be to identify and unwind that logjam and get the dollars going to the people who need them.

At the end of the 106th Congress last year, we had put $100 billion towards this effort, and to find that we are still not receiving dollars on the ground to me is a source of enormous frustration. I go home and hear from angry constituents that you are spending too much money, and then I come to this committee and find that the money hasn't been spent at all. And that leaves me with an internal state of perplexion that really has to be resolved quickly for my continued good health. I want to work with this group today. I am anxious to hear your stories, and I will yield back, Mr. Chairman, and would hear from the witnesses.

Mr. STUPAK. Thank you, Mr. Burgess. Ms. Schakowsky from Illinois.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I am going to put my statement in the record. I just want to say I was able to go with this committee to have a similar hearing, in New Orleans months after the storm. I was shocked then, even more surprised now, that not enough is done. I feel responsibility that the Federal Government has missed the boat here and that we have to do better. I wanted to thank Mr. Melancon for all of his work for keeping this issue on the top of the agenda here in Congress, and now I am looking forward to some progress being made. And your testimony will be very important to help us do that. Thank you. I yield back.

Mr. STUPAK. Thank you. Mrs. Blackburn, opening statement?

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. I do have a brief opening statement I will submit for the record, but in the interest of time, I do want to say welcome to our witnesses. I want to say thank you to those that have worked since our very first hearing that we did in New Orleans to address this situation. One of the components of leadership is when you have a situation such as what happened with Katrina, one of the things you have to do is admit we did things wrong. And I think when you look at how the health care situation was addressed in Louisiana the plans that were not made, the things that were left undone as you looked at a readiness plan, when you looked at how you were going to secure your infrastructure, the admission of that as having been a mistake, and then the agreement and establish a health care network that is going to be beneficial for your citizens. I think that is an important step.

So as we move forward, I look forward to your continuing testimony, to your continuing work, and certainly to seeing all of yourebuild a health care system that will deliver accessible and affordable health care for the citizens of Louisiana. I do say welcome to the mayor. Some of us were here until about 3 o'clock this morning for the Rules Committee hearing for SCHIP, and I think we would be wishing that you had brought along some beignets and coffee with you to help us get through this as we take the SCHIP bill directly to the floor as we see that happen today.

But some of us were here a little bit later, and Mr. Pallone was also here through the evening, so we thank you and I yield back, Mr. Chairman.

Mr. STUPAK. Thank you. That concludes the opening statements by members of the subcommittee.

Any other statements for the record will be accepted at this time.

[The prepared statements follow:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Today, we will hear from public health leaders and representatives from the New Orleans area who are helping the brave citizens of that region rebuild their lives and their communities. We should pay close attention to the lessons they can teach us about the tenacity and creativity it takes for a health care system to recover from a national disaster.

At our last hearing on this topic, I promised that we would focus on stabilizing the health care crisis in the New Orleans area and that we would keep our focus on that issue until the system is stable. This is the second in a series of oversight hearings on these issues, and I assure you, it will not be the last.

Four and a half months ago, we heard testimony from doctors and clinic administrators about people lining up in their cars overnight, simply so they could get attention to basic health needs such as prescription eyeglasses and asthma medicine from health care professionals working in tents with flashlights. Their stories described a landscape we might see in third world countries, not one we could imagine here in our own country.

I am pleased that Secretary Leavitt took to heart the moving testimony we heard, and released $100 million in discretionary Deficit Reduction Act monies to target primary care in the greater New Orleans region. I thank the Secretary. These much-needed funds will soon flow to clinics in the greater New Orleans area that provide primary and preventive care—such as vaccinations, pre-natal checkups, and basic first aid—to poor and uninsured patients.

These funds will help fill in some—but certainly not all—of the holes in what is left of a shattered health care system in the New Orleans region. As we will hear today, that system is still precarious as we mark the 2-year anniversary of Hurricane Katrina. If the system were a patient, we might say it is still in the Intensive Care Unit. We will hear from today's witnesses that the area's economic recovery is stalled because the health care system remains fragmented and overwhelmed.

• There continue to be critical shortages of professional health care workers;
• Doctors are having difficulty sustaining their practices and are moving out of a city that desperately needs them;
• Graduate medical education programs are struggling to survive so they can continue to train the State's future healthcare workforce; and
• Private hospitals report they are hemorrhaging red ink in the post-Katrina economic environment.

Meanwhile, 2 years have passed since Veterans Affairs and the State lost their major hospitals in downtown New Orleans. However, not a shovel of dirt has been lifted to rebuild them. That is a simply outrageous situation for our country.

The people in the New Orleans region, and the wounded and maimed veterans returning to their homes, deserve to have these vital institutions rebuilt and rebuilt now. Likewise, the citizens of New Orleans need to have their public hospital rebuilt and rebuilt now. The uncertainty, particularly with respect to the VA's plans, is almost as damaging as the absence of the hospitals themselves.

I wish to thank our subcommittee chairman, Representative Bart Stupak, and our subcommittee vice chairman, Representative Charlie Melancon, for their leadership on these issues. Mr. Melancon has been heavily engaged in helping his own district, which is adjacent to the four New Orleans parishes, recover from these storms. I look forward to hearing from our witnesses today about the path ahead.

Statement of Rep. Jan Schakowsky
Subcommittee on Oversight and Investigations
August 1, 2007

Mr. Chairman, I just want to thank you and Mr. Melancon, who have both been pushing to keep the needs of New Orleans in the spotlight here on the Hill. I appreciate the opportunity to hear an update on the challenges that are still facing the area impacted by Katrina, and will try to keep my remarks short.

Progress has been made in the nearly two years since Katrina hit the Gulf Coast. A lot of hard work and collaboration have been put forth, and I commend all of our witnesses today – as well as those back in the Gulf Coast area – who have poured their heart and soul into these efforts.

Today, we are here to listen to you, to work with you, and to encourage all organizations, agencies, and individuals that have been involved in this process, as they fight to improve access to healthcare in the New Orleans area. I remember my first impression when I was down in New Orleans for our field hearing in January of 2006...there were so many competing needs. I'm sure we'll hear today what an uphill battle it has been, and how much work remains to be done, but I'm eager to begin what I hope will be a productive hearing and eager to build on the progress that has been made since our last hearing.

I understand that several pressing issues will be highlighted here today, among them, how we can make the Graduate Medical Education (GME) system fit the private hospital puzzle that has taken in the medical school residents who historically had been placed at the State's public hospitals.

A strategic fix to the GME payment system is critical to the future health and economic success of the entire area. Fifty-five percent of the physicians trained in Louisiana choose to stay and practice there once they are finished with their residency. Compare that with the national average of 30 percent, and it becomes clear how vital GME is to the future of New Orleans. Additionally, the health industry has been vital to the area's economy, supplying more dependable and higher paying jobs relative to the other leading employers. In fact, Tulane University now constitutes the largest employer in New Orleans.

Without relieving some of the financial pressure imposed by unfunded or only-partially reimbursed GME care, we only add to the significant financial burden of New Orleans' private hospitals. We would also be ignoring the urgent need for physicians – not to mention the even greater need for specialists – as fifty percent of those who worked in the region before Katrina, have left. As we move forward in this series of hearings, I hope we can work with CMS to ensure the stability of GME and in turn, bring improved stability to the healthcare workforce.

I also want to mention the importance of rebuilding Big Charity and bringing a public hospital back to the region. Additionally, I look forward to addressing the rebuilding of LSU's and the VA's Medical centers and how we can encourage progress there, as well as the importance of making certain that the $100 billion in discretionary DRA grants that has been released by HHS is used thoughtfully, and in a way that is conscientious of their limits.

Again Mr. Chairman, thank you for your work on this issue. I yield back.

Opening Statement of the Honorable Joe Barton
Ranking Member, Committee on Energy and Commerce
Subcommittee on Oversight and Investigations Hearing on
Post-Katrina Health Care in the New Orleans Region:
Progress and Continuing Concerns

August 1, 2007

Thank you Mr. Chairman. Let me echo Mr. Whitfield and express my appreciation for the bipartisan work of this subcommittee and its steady focus on the recovery of the health care system in the New Orleans region. I strongly support this work that our subcommittee is accomplishing because what we do can touch the lives of people who have suffered greatly.

To the extent we can assist where appropriate to speed recovery, we should do so. When the Oversight and Investigations Subcommittee focuses on problems in a bipartisan way, other people and agencies take the hint and focus as well. That can be a very good thing, because decisions get made, actions get taken, and problems get fixed.

I'm pleased to learn there has been progress since the March hearing. I'm pleased that Secretary Leavitt has committed to us that he will continue to monitor the situation and work with the state and local officials to help with the recovery effort. And I hope that the momentum we've helped build will continue.

Although many of the problems faced by New Orleans can only be solved by the people of Louisiana, we should look carefully at improving how the federal government responds when a natural disaster so devastates a region's infrastructure that its capacity to spring back is crippled. While Louisiana has its unique challenges, the problems in its health care delivery system and medical education system are those that would be experienced by any region that is trying to recover from a catastrophy like Katrina. Most of our districts are not particularly vulnerable to hurricanes, but we're all vulnerable to natural disasters that could damage our hometowns the way Katrina damaged New Orleans.

Only the Good Lord and good luck stand between some cities and a devastating earthquake or flood, for example, but what we do here can give the victims a chance to rebuild their lives.

Congress needs to take a close look at the situation and identify whether policies should be adjusted to ensure a more effective response both for this and for the next time such a catastrophe hits. We should keep that in mind as we discuss the New Orleans situation today.

I welcome the witnesses and look forward to your testimony. Thank you, Mr. Chairman. I yield back the remainder of my time.

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Mr. STUPAK. Let me call forward our first panel of witnesses. The Honorable Ray Nagin, mayor of New Orleans; Dr. Frederick Cerise, Louisiana Secretary of Health and Hospitals; Ms. Elizabeth Richter, Acting Director, Center for Medicare Management at CMS; Mr. Robert Neary with the Veterans Administration Office of Construction and Facilities, and he is accompanied by Ms. Julie Catellier; Mr. Clayton Williams, Louisiana Public Health Institute; and Ms. Kim Boyle, Louisiana Recovery Authority.

It is the policy of the subcommittee to take all testimony under oath. Please be advised that the witnesses have the right under the rules of the House to be advised by counsel during their testimony. Do any of you wish to be represented by counsel? Everyone seems to be shaking their head no.

[Witnesses sworn.]

Mr. STUPAK. Thank you. Let the record reflect that the witnesses replied in the affirmative. You are now under oath. We will begin with the opening statement of Mayor Nagin. If you would, please begin your opening statement. We have 5 minutes for opening statements. If it is longer, we will make it part of the record, but we have a large panel here and if we keep it to 5 minutes that would be great. Mayor, thank you and welcome.

STATEMENT OF RAY NAGIN, MAYOR, CITY OF NEW ORLEANS, NEW ORLEANS, LA

Mr. NAGIN. Thank you. Good morning to the Chair, Congressman Bart Stupak, Ranking Member Ed Whitfield, Vice Chair Charlie Melancon, distinguished members and guests of the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations. Thank you for calling this hearing today on the progress and continued challenges we face in providing basic and quality health care to meet our citizens' needs and provide what they deserve. We are grateful for your support of our continued efforts during the last 2 years. And we thank the American people and our friends throughout the world for their donations of resources, labor, prayers and positive thoughts as we continue to rebuild.

Most of all, I want to thank you for following up on the issues and the needs discussed in your March hearing on this topic. The attention you have brought to these issues has helped us to begin to repair critical aspects of our health care delivery system, which was decimated by Hurricane Katrina and the subsequent flooding. Ladies and gentlemen of this committee, this is my 28th lobbying trip and appearance before a committee since Katrina. I must admit I was a little reluctant to come up today because I am getting pretty weary about continuing trips up here and testifying and going over some of the same things over and over, but I think this is a very important day to be up here to make sure that everyone around the Nation, including this committee, continues to understand the challenges that we face.

But I must be frank with you. I keep hearing about this $100 billion that has been allocated to the city of New Orleans. I keep hearing about this $100 billion that has been allocated to the Gulf Coast for recovery, but I have seen very little of that money in the city of New Orleans. And in essence the city of New Orleans is suf-

fering in many different ways. We are in recovery, and our citizens are working in spite of the odds, but we are suffering, ladies and gentlemen, from financial malnutrition, and we need an acute infusion of resources into our environment to help us to overcome this incredible challenge that I don't think many people still understand.

Our city was totally devastated after Katrina, and after 2 years we are still trying to recover. It was unprecedented. But our citizens, as we sit here testifying and talking about this, they continue to suffer. We have increased mortality rates. We have increased stress levels throughout the city of New Orleans and the region, and we have many compounded mental health problems that are not being adequately addressed. A study by Dr. Kevin Stephens, the city's health director, documented a 47 percent increase in deaths in the city of New Orleans. I repeat that, 47 percent increase in deaths in the city of New Orleans. The State has a smaller number that they have presented but whether you believe it is 20 percent or 47 percent deaths are up in the city of New Orleans and it is growing at an alarming rate.

Our Orleans Parish coroner, Dr. Frank Minard, told the Associated Press he sees every death that happens in the city of New Orleans, that he has no doubt that Katrina, the after effects of Katrina, is killing our residents. These deaths have taken the form of pre-existing medical conditions that are made worse by the stress of living here in the city and in this area after the storm. It also is showing up in the elderly, many of them who are growing weary and tired and exhausted and too defeated and they are just giving up. Your committee has done some good work, and I must continue to applaud you. After your last meeting, which was recently, Secretary of Health and Human Services Michael Leavitt invoked his authority, you didn't have to do anything, under the Deficit Reduction Act of 2005 to make $100 million available to restore and expand access to primary health care for all those reasons.

But, guess what, that money has taken the normal route that it always takes. It may or may not leave the Federal Government. It may or may not hit the State government. And it definitely is having a long time getting to the city of New Orleans. And if there is anything that this committee can do, and if there is anything this Congress can do, you can put a speedway to getting funds directly to the devastated areas, and this would help this recovery tremendously. We have been 23, 24 months of going through this dance where money flows from the Federal Government to the State government and gets stuck and does not get to the people who need the money.

I am off script and I know that is very damaging sometimes for me. But this is my 28th trip to this Nation's Capitol, a mayor of a city that has been totally devastated, and I am getting really upset about this because we are getting ready to go to the second anniversary of the biggest natural and man-made disaster, and I still do not have adequate health care in my community. Our hospitals are still shuttered for the most part. The one that is open you have to wait hours and hours and hours to get emergency care. There is no substantial mental health care happening in the city

of New Orleans. There is very little substance abuse and many of our citizens are self-medicating, which is a nice term I am going to use, to take care of what they can't handle, the day-to-day struggle of our city.

Now we are 300,000 strong. Our citizens are doing incredible work in spite of not having the resources that they need but it shouldn't be this hard in the greatest country in the world. And I am pretty sick of it. The VA hospital, if we can get a decision on the VA hospital, that would stabilize the health care community in our city, but we keep going around this dance with RSVP and now the city of New Orleans is in a position where it is competing with the surrounding parish for this facility. We wouldn't be here if it wasn't for the failure of the Federal levee system that was supposed to protect New Orleans, and now I am sitting in the city of New Orleans competing with the surrounding parish to bring a facility back that should be downtown in the city of New Orleans, and I have to go through this ridiculous process.

That is what we deal with in the city of New Orleans and 47 percent more people are dying in the city of New Orleans because of this thing that we are going through. I implore, I ask, I beg this committee to really do something to help us. I am not sure where my city is going to be at the end of the day. It is coming back but I am losing people every day. Since I started talking, I probably lost a citizen in the city of New Orleans, and we need this committee, we need this Congress to help us. Thank you.

[The prepared statement of Mr. Nagin follows:]

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
"Post Katrina Health Care: Continuing and Immediate Needs in the New Orleans Region, Part II"

August 1, 2007

Testimony of C. Ray Nagin
Mayor, City of New Orleans

I am C. Ray Nagin, Mayor of New Orleans, one of America's most beloved and culturally distinctive cities, and a city which is facing the challenge of recovering and rebuilding smartly, soundly and strategically after the worst natural and man-made disaster to occur in the United States of America. As we rebuild, we want to ensure that our citizens will have even better access to services and opportunities than they did in the past. One of the most important of these is access to quality healthcare, to which every citizen is entitled.

To Chair and Congressman Bart Stupak, Ranking Member and Congressman Ed Whitfield, Vice Chair Charles Melancon, distinguished members and guests of the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations: Thank you for calling this hearing today on the progress and continuing challenges we face in providing basic and quality health care that our citizens need and deserve. We are grateful for your support of our recovery efforts during the last two years. And we thank the American people and our friends throughout the world for their donations of resources, labor, prayers and positive thoughts as we rebuild.

Most of all, I want to thank you for following up on the issues and needs discussed in your March hearing on this topic. The attention that you brought to these issues has helped us begin to repair critical aspects of our health care system, which was decimated by Hurricane Katrina and the subsequent flooding.

I. The Impact of Hurricane Katrina

I would like to take a few moments to talk about the great strides we have made in our recovery and to discuss the significant challenges that remain. Hurricane Katrina and the subsequent flooding caused unprecedented damage in New Orleans and the Gulf Coast region. Thousands of residents lost their lives. The uninsured property losses from Katrina are estimated to be in excess of $60 billion. Residential damage in New Orleans alone was $14 billion. Every level of our health care delivery system was affected. Every hospital and medical facility in Orleans Parish was shut down and since the storm only four of the eight hospitals have reopened, most at decreased capacity. The City of New Orleans Health Department, which employed more than 200 health professionals, lost more than 60 percent of its staff and closed eight of its 13 clinics.

The impact that Hurricane Katrina had on people's lives is also evident in the increased mortality and mental health problems that New Orleans is experiencing. Dr. Kevin Stephens, the City's Health Director, stated in his article in the American Medical Association journal "Disaster Medicine and Public Health Preparedness," that obituaries published for New Orleans residents – some of whom were still displaced – increased 47 percent during the first six months of 2006. Even state statistics showed a 20 percent increase in deaths in Orleans Parish for the same period, a still alarming death rate almost

twice the national one of 8.1 deaths per 1,000 residents. Federal, state and local health leaders must strive to identify the causes of this crisis and develop appropriate interventions to end it. A copy of the article is attached for your review.

II. What We Are Doing Now

Since your March hearing on this issue, Secretary of Health and Human Services Michael Leavitt invoked his authority under the Deficit Reduction Act (DRA) of 2005 to make $100 million available to restore and expand access to primary care in the Greater New Orleans area. We appreciate that $4 million of these funds were earmarked specifically for the City of New Orleans Health Department.

We will use this money to provide staffing for clinics set to open within the next few months. The first clinic will open in New Orleans East and will provide primary and obstetrical services. Since Hurricane Katrina, the only public clinical services in New Orleans East have been provided at a temporary site staffed by Operation Blessing, a faith based nonprofit.

The second clinic funded by this grant will be Mandeville-Deteige in the Gert Town neighborhood adjacent to Xavier University. This clinic experienced severe flooding after Hurricane Katrina, but will be repaired to partner with Xavier University and its renowned School of Pharmacy. The Mandeville-Deteige Clinic will reopen as a primary care clinic offering pharmacy services.

In addition to the clinic openings, the DRA funds will enable us to operate a mobile dental clinic and a mobile vision and hearing clinic. These health services are

critically needed by our citizens, many of whom were insured before Hurricane Katrina but have since lost their jobs, insurance and security.

Another concern, which your committee highlighted and which additional DRA funding is helping to address, is the need to attract and retain medical professionals to our region to fill critical shortages of doctors, nurses and other medical staff. Secretary Leavitt has made an additional $35 million available to tackle this problem. These funds, along with an earlier $15 million grant, are being administered by the Louisiana Department of Health and Hospitals and will provide incentives for retaining and recruiting health care professionals.

III. Ongoing Challenges and Immediate Needs

A particular problem is created by the shortage of specialty care physicians. With the closure of Charity and other area hospitals, many specialty care physicians such as oncologists, hematologists, orthopedists and cardiologists have left the region. This affects the speed with which people who have insurance can obtain services and makes it almost impossible for the uninsured and indigent to receive specialty care. Because of the reduction in access to primary care, many illnesses are much more severe by the time the patient seeks emergency help, making specialty care essential to reducing mortality and enhancing the quality of life.

We also remain concerned that no solution is imminent that would guarantee our poorest citizens access to key technologies and treatments. For example, with Charity

Hospital closed, uninsured patients with cancer or other illnesses requiring surgery or ongoing special treatment can receive emergency care, but will need to travel out of the area to another public hospital facility for chemotherapy, radiation or other life-saving interventions. If they have no money for transportation or lodging, they will not be able to get treatment. In order to address this issue, we must create a system in which the uninsured and underinsured have access to appropriate care regardless of their income.

This decreased access to primary care and mental health services is severely impacting hospital emergency departments throughout the region. Before Katrina, the state fulfilled its mandate to provide urgent medical and mental health care through Charity Hospital, the largest single point of entry in the state. With Charity and several other hospitals still closed, the emergency department inpatient bed capacity of the region comprised of Orleans, Jefferson, Plaquemines and St. Bernard Parishes is now just more than half of pre-Katrina capacity. For mental health beds, the capacity is about one-third.

This is far less than adequate for our population. According to the Greater New Orleans Community Data Center, the population of New Orleans alone is now approximately 66 percent of pre-Katrina levels, or about 300,000 people. If our residents continue to return at the current rate, we will be at 78 percent of our pre-Katrina population by the end of the year, which is consistent with projections I made just after the storm. This further demonstrates the need for significant increases in availability of services.

At the same time, the reality of the post-Katrina environment has led to a dramatic increase in the need for mental health services. The stress of survival and life in a

damaged region has increased the rate of Post Traumatic Stress Disorder and aggravated existing mental and physical health problems. Because few outpatient drug treatment centers and detox beds are available, people with addictive disorders who are in crisis also seek treatment in our already overtaxed emergency rooms, contributing to further delays and longer wait times for service.

Since the ancillary services that would form the continuum of care to appropriately move mental health patients out of the emergency departments are not in place, Emergency Medical Services (EMS) offload times are at an all-time high. In June, paramedics with the New Orleans EMS department spent more than 300 hours with patients waiting for their transfer to emergency department staff. This can have a negative impact on the patient's outcome and can cause the availability of fewer paramedics for responding to other medical and traumatic emergencies, an increase in overall response time, and additional costs. Because of increased offload times, the department has experienced additional personnel costs of nearly $107,000 and unbilled revenue of $855,000 since January.

In addition, police must contend with long delays when they are called to respond to situations involving mentally ill individuals in crisis. Police are responding to approximately 200 crisis mental health calls per month. Two officers must respond to each call, which in June averaged a 71-minute wait in emergency departments per mental health call. This time would be better spent fighting violent crime.

This situation must be fixed now. University Hospital recently opened 20 detox beds and the state has committed to implementing certain other critically needed services,

including 20 adult acute psychiatric beds and a crisis intervention unit for the New Orleans region. But these steps will still not address all of the immediate mental health needs of our region, and we are pushing for the urgent implementation necessary to produce reductions in the amount of time that emergency medical officials and police spend waiting in emergency departments.

IV. Importance of VA Hospital

I appreciate the opportunity this hearing gives me to highlight one of the most important Post-Katrina recovery projects in the region - the proposed construction of the Veterans Affairs Medical Center in downtown New Orleans. The VA Hospital has traditionally played an important role in providing quality health care for the hundreds of thousands of veterans living throughout the Gulf Coast, as well as the thousands who visit New Orleans as tourists and for special events and conventions. We look forward to its continuing to offer that level of services in downtown New Orleans, complementing the existing synergy of many components of the downtown medical district, and bringing major economic investment to the regional economy.

A. Location

In 2006, the Veterans Administration committed to creating a partnership with the Louisiana State University teaching hospital that would bring state-of-the-art medical

care to downtown New Orleans. They signed an agreement with LSU to work together on plans for new medical facilities for both institutions.

The proposed new downtown location, which we support, is only blocks from the site of the VA Hospital that was in service prior to Hurricane Katrina. It is centrally located in the metropolitan region, which is home to veterans living within commuting distance to the facility. In addition, it is on major public transportation routes for those who do not have vehicles, and is easily accessible for the many homeless veterans who are in critical need of its care. For those veterans and their families who travel to receive its services, the location is close to hotels, restaurants of all kinds, and cultural attractions.

The area where the new hospital would be located is within a legislatively created medical district, encompassing more than 30 public, private, and not-for-profit organizations, including facilities of several colleges and universities (LSU, Tulane, Xavier, Delgado), several hospitals, two medical schools, nursing schools, medically related offices and businesses, and associated biotech companies. The physical proximity of institutions allows for sharing of expensive and ever-changing technologies and diagnostic equipment. It also encourages human interaction and intellectual exchanges that can lead to more accurate diagnoses, varied treatment approaches and important scholarly and medical research and discovery.

B. Bioscience Research

Pre and post Katrina, the area's bioscience institutions have been conducting cutting-edge research in areas such as gene therapy, cancer biology, peptide pharmaceutical design, and infectious diseases. Federal and private grant funding in New Orleans exceeded $180 million in 2003 and was growing substantially as New Orleans based institutions capitalized on their core strengths. In fiscal year 2005, the New Orleans area accounted for $129.8 million in awards from the National Institutes of Health, representing 74 percent of the total amount awarded within the entire state of Louisiana.

One of the recent signs that our recovery has turned the corner and that the medical district pays a major role in our recovery is the beginning of construction of the Louisiana Cancer Research Center. This project was slowed down by Katrina, but is back on track with a safer and smarter building design. The $94 million Center is being built in the downtown medical district by a consortium of Louisiana State, Tulane and Xavier Universities. It will be a center for treatment, teaching and research, and is a prime example of the economic engine our downtown medical district has become.

The cutting-edge research taking place at these institutions will allow us to provide the highest level of care to our veterans.

C. Regional Support

This downtown medical district location for the VA Hospital has the support of a coalition of regional partners, including the New Orleans Regional Planning

Commission, the New Orleans City Council, and the Downtown Development District, each of which unanimously approved resolutions to keep the hospital downtown. In addition, the Louisiana chapter of the American Legion, with more than 1,000 delegates in attendance at its recent annual meeting, also unanimously supported the downtown New Orleans location. We ask for your support in ensuring that this facility is built in downtown New Orleans and that it is constructed as soon as possible.

This critical hospital facility, which we hope will be co-located with the new LSU teaching hospital, will take several years to construct even on the quickest timetable. In the meantime, all avenues must be explored for providing mental and physical health services to address the urgent immediate needs of our veterans and all of our citizens. Quick action is necessary, first and foremost for our veterans' healthcare, and for the benefit of our entire region.

V. Conclusion

My administration will continue to work toward and advocate for solutions to immediate critical health care concerns while supporting the long-term projects and vision of a premier medical delivery system that will serve all citizens regardless of income. In spite of unprecedented challenges presented in the aftermath of the largest natural and manmade disaster in our country's history, we have made great strides in re-establishing the health care systems that the citizens of the Gulf Coast deserve. With your continued support, we will not only return to pre-Katrina capacity, we will become a 21st Century model of health care for the nation.

Thank you for this opportunity to come before you today. The recovery of New Orleans is underway. We look forward to continuing our partnership with you as we work to fully restore one of America's greatest cities.

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RESEARCH

Excess Mortality in the Aftermath of Hurricane Katrina: A Preliminary Report

Kevin U. Stephens Sr, MD, JD, David Grew, MSPH, Karen Chin, MSPH, Paul Kadetz, MSN, MPH, P. Gregg Greenough, MD, MPH, and Frederick M. Burkle Jr, MD, MPH, DTM

ABSTRACT

Background: Reports that death notices in the Times-Picayune, the New Orleans daily newspaper, increased dramatically in 2005 prompted local health officials to examine whether death notices could serve as a valid alternative means to confirm suspicions of excess mortality requiring surveillance, preventive actions and interventions.

Methods: Monthly totals of death notices from the Times-Picayune were used to assess frequency and proportion of deaths from January to June 2005. To validate this methodology the authors compared 2005 to 2004 monthly death frequency and proportions between death notices and top 10 causes of death from state vital statistics.

Results: A significant increase in the proportion of deaths was seen compared to the mean baseline proportion.

Discussion: Death notices from local daily newspaper sources may serve as an alternative source of mortality information. Problems with delayed reporting, bias, analysis, and interoperability between state and local health departments may be solved by the implementation of electronic death registration. [Disaster Med Public Health Preparedness 2007; 1: 1–7]

Key Words: excess mortality, natural disasters, Hurricane Katrina, public health system, death notice surveillance, mortality data, health statistics

Editors' Note: *After not experiencing a major public health emergency in almost 100 years, the US is relearning the stark realities that occur when a public health system is compromised and the pulse of a community is temporarily lost. In the chaotic aftermath of Hurricane Katrina the impact on health, through its influence on infrastructure and the determinants of health, subtly began to rear its ugly head. When the daily capacity to evaluate and monitor health indices fails, as it has in New Orleans, morbidity and mortality remain unnoticed and uncounted. Predictably, vulnerable populations suffer the most.*

Stephens and his colleagues, alerted by the concerns of the citizenry, again took the pulse of the community and found that the rate of death notices, as just 1 "imperfect" measure of excess mortality, was suspiciously elevated. Is this an ideal population-based study? No, but both the question and the strength of this preliminary report are something that disaster medicine specialists have been struggling with for decades. What do we need to know to prevent needless mortality and morbidity while the public health system is recovering? How do we derive the essential information to guide health relief efforts and measure the interaction between the human host and the compromised environment to prevent further harm when the traditional system of assessing mortality is debilitated? The entire postdisaster surveillance system may have only 1 person doing essentially all of the tasks. What does this lone person do when resources are limited?

Our disaster medicine colleagues who respond to catastrophic public health emergencies worldwide have educated us on the nuances of the prolonged effect that such disasters have on the community. Following the prototypical wars that destroyed their countries' public health infrastructure, the decay factors that cause preventable deaths continued for many years after the shooting had stopped. Years later, retrospective studies recorded many more deaths from indirect causes, and those that suffer the most typically are women, children, old people, and people with disabilities. Ninety percent of excess deaths were preventable.

The US is not a developing country, but the uncomfortable reality of the public health impact and management of Katrina is painfully similar. The authors' study has exposed that glaring deficiency—that an attentive and proactive surveillance and response mechanism is justifiably obligated from state and federal agencies.

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How can dependable mortality data be accessed when the usual means of data collection have been profoundly disrupted? Mortality data and health statistics reports provide public health officials with critical insight into the health status of a population. These data provides key information for public health research, facilitate long-term surveillance, and are commonly the basis for health interventions.[1]

The National Association for Public Health Statistics and Information Systems is partnering with the National Center for Health Statistics in a cooperative agreement to upgrade all 50 states from paper-based to electronic death registration systems (EDRS).[2] A nationwide EDRS will facilitate rapid reporting and interoperability between local, state, and national health agencies, and will streamline the vital records request process (G. Land, personal communication, July 7, 2006). This system is not currently in place to address the immediate public health issues from future disasters in Louisiana.[3]

AQ: 1

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Under normal circumstances, mortality rates are derived from death certificates registered at each state's office of vital records. Before Hurricane Katrina, the Louisiana Department of Health and Hospitals issued an annual health report card, which included statistical reports across various health indices, serving as an overall evaluation of Louisiana's health. The most recently released health report card was submitted to the state legislature in March 2006 for the 2005 report; however, all of the mortality data presented in the state's report date from 2003.[4]

"The significant increase in proportion of deaths in the first 6 months of 2006 supports the civilian population's suspicions about the enduring health consequences of the hurricane."

The Louisiana Department of Health and Hospitals Office of Vital Statistics is responsible for processing requests for vital record certificates, including birth, death, and marriage certificates, as well as generating statistical reports.[5] The department's ability to function at full capacity was interrupted by Hurricane Katrina. Only 80% of vital record certificates were moved from the flooded basement of the New Orleans State Office Building to a floor higher in the building before the flooding. The majority of these certificates were birth records. The Office of Vital Statistics is operating at nearly half the pre-Katrina capacity, with a reduction from 87 employees to a current staff of 51 employees. Furthermore, a majority of this workforce is temporary and/or new employees. Although the staff has been significantly reduced, the requests for documents have markedly increased from 300,000 requests in 2004 to 534,936 requests within the last year.[6] Operations for the Office of Vital Statistics have been relocated from New Orleans since the storm and are now divided between Baton Rouge[6] and Metairie.[7] Consequently, the ability of the Louisiana Department of Health and Hospitals Office of Vital Statistics to generate accurate and timely statistical reports, in light of these myriad factors, is compromised.

The floodwaters caused by Hurricane Katrina have had a lasting impact on the health system of New Orleans and its surrounding parishes. Only 15 of 22 area hospitals have reopened, with less than half the number of prestorm beds.[8] A significant portion of the population is still living in substandard conditions, contributing to the reported pervasive, unmitigated stress among residents.[9,10] As such, health officials fear there will be increases in morbidity and mortality.[8] Given the compromised mechanism for registering local deaths, there is a demonstrated need for alternative means of generating mortality information and indices. Death notices in the *Times-Picayune*, the greater New Orleans daily newspaper, increased dramatically in 2006.[10] In the absence of an EDRS and current, verified vital statistics from the state, the present study attempts to use extrapolated daily newspaper death notices as a valid alternative to the conventional but deficient registration system, and in so doing, determine a workable mortality rate for greater New Orleans in the aftermath of Hurricane Katrina.

METHODS

The source for 2006 mortality data was the *Times-Picayune*, which maintains a Web site that contains a 6-month backlog of death notices.[11] The *Times-Picayune* receives death notices via a passive data collection mechanism: funeral directors and families of deceased not using funeral homes may submit death notices via e-mail or fax. Death notices for the years 2002 to 2003 were obtained from the NewsBank, Inc, online database through the New Orleans Public Library[12] to establish a baseline mortality rate. Death notices from the *Times-Picayune* were counted per month for the years 2002 to 2003 and for the months of January to June 2006.

For a standard of comparison, the number of deaths were obtained from the Louisiana Office of Public Health, State Center for Health Statistics for the greater New Orleans area that includes Orleans, Jefferson, Plaquemines, Saint Bernard, Saint Charles, Saint James, Saint John the Baptist, Saint Tammany, Tangipahoa, and Washington parishes. Monthly mortality data representing the top 10 causes of death for the greater New Orleans area was obtained for the years 2002 to 2003 from the Louisiana Department of Health and Hospitals Health Statistics Center. These datasets were extrapolated from data available on the department's Web site.[13] Top 10 causes of death is used in place of total mortality because data on total mortality were not available at the parish level.

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In a stable, open population, an estimate of the mid-year population serves as the denominator of a mortality rate. Therefore, mid-year population estimates were used for denominator data for the 2 baseline years, 2002 and 2003.[14] At the time the present study was carried out, the only population estimate available for greater New Orleans was from January 2006.[9] Therefore, this population was used to represent the denominator for the mortality calculations from January to June 2006.

To limit the effects of potential confounders on the results, the authors excluded death notices that reported an out-of-state death, an out-of-greater New Orleans (but still within Louisiana) death, a death that occurred during Hurricane Katrina but was reported after January 1, 2006, or a duplicate entry death. Because removing all of these entries would require reading each death notice in detail, the authors sampled 1 week of death notices in the middle of each month, totaled the number of death notices that satisfied exclusion criteria, and averaged the number over the 6-month period.

To determine whether the newspaper death notice and official state datasets were correlated, the authors compared mortality rates during the period of 2002 to 2003 for each dataset. To detect any significant change in mortality across 2002 to 2003, mortality rates from 2002 were compared to 2003 for each data source. These analyses were performed separately. Death notices were compared with death notices and state data were compared with state data across the 2-year period to test the integrity of the data source. Mortality rates derived from the *Times-Picayune* death notices in the first 6 months of 2006 were compared with those from 2002 to 2003 (pre-Katrina). Data entry and tests of statistical significance and correlation were done using Microsoft Excel 2002 (Microsoft, Inc, Redmond, WA).

"death notice monitoring provided real time mortality information well ahead of official state health information mortality data."

RESULTS

Total death notices from January to June 2006 and death notices meeting exclusion criteria during the same period are
T1 described in Table 1. The resulting number for mortality rate
T2 calculation is included in Table 2.

Average monthly mortality rates for 2002 to 2003, calculated from Louisiana state data and *Times-Picayune* death notices using the greater New Orleans pre-Katrina population esti-
F1 mates from those years, are compared in Figure 1. The r value for correlation between the mortality rates derived from the 2 datasets is .6563, representing a significant (large positive) correlation.

The strong correlation gave validity to the death notices as a reasonable alternative to determine post-Katrina mortality and make comparisons with pre-Katrina mortality. A baseline average of deaths per month from January to June and the mortality rates based on pre-Katrina greater New Orleans population estimates are compared with mortality rates during the same months in 2006 on the post-Katrina greater New Orleans population estimate. Confidence intervals for mean mortality rates were calculated for both periods (Table 2). The unpaired Student *t* test was used to test significance between the sample means. The *t* value was calculated to 3.94, statistically significant at $P < .005$.

The post-Katrina mortality rate for the first 6 months of 2006 was approximately 91.37 deaths per 100,000 population; compared to the pre-Katrina population mortality rate of 62.17 deaths per 100,000 population, this represents an average 47% increase from the baseline mortality, suggesting a marked increase in indirect (excess) deaths postdisaster (Figure 2). Although the confidence interval around the 2006 F2
mean is wide, there is little overlap with the 2002 to 2003 confidence interval, suggesting a significant difference in the mortality distributions between the 2 populations.

DISCUSSION

The significant increase in proportion of deaths in the first 6 months of 2006 supports the civilian population's suspicions about the enduring health consequences of the hurricane. This major natural disaster resulted in a severe compromise of the public health infrastructure, the loss of health care facilities and the ability to deliver care, and a chaotic shift in a major metropolitan population. Furthermore, it disabled the ability of the state to perform optimal evaluation and monitoring studies. Such sequelae characteristically prolong public health emergencies and allow for conditions that are ripe for indirect effects leading to increased mortality and morbidity, data that are often unnoticed and uncounted.

Excess death studies, especially those performed during large-

TABLE 1

Frequency of Death Notices by Inclusion and Exclusion Criteria, 2006

	January	February	March	April	May	June
Total death notices	1589	1301	1418	1214	1194	1185
Excluding Katrina deaths	1558	1270	1387	1183	1163	1154
Excluding out-of-LA deaths	1427	1139	1256	1052	1032	1023
Excluding duplicate entries	1205	918	1035	831	811	802
Excluding out-of-10 parish deaths	1108	820	937	733	713	704

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TABLE 2

Frequency of Death per Population and Mortality Rates, Pre- and Post-Katrina, *Times-Picayune* Death Notices

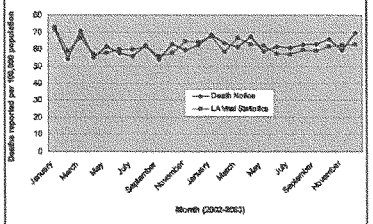
	2002–2003				2005			
	Av No. of Deaths	Total NO Metropolitan Population	%	Mortality Rate (deaths/100,000)	No. of Deaths	Total NO Metropolitan Population	%	Mortality Rate (deaths/100,000)
Jan	1037.5	1,481,393	0.070	70.04	1108	914,745	0.121	121.13
Feb	864.5	1,481,393	0.058	58.36	820	914,745	0.090	89.64
Mar	986.5	1,481,393	0.067	66.59	937	914,745	0.102	102.43
Apr	887	1,481,393	0.060	59.88	733	914,745	0.080	80.13
May	885	1,481,393	0.060	59.74	713	914,745	0.078	77.95
Jun	865	1,481,393	0.058	58.39	704	914,745	0.077	76.96
Mean with 95% CI				62.17 (95% CI 52.31–72.02)				91.37 (95% CI 56.44–126.30)

Abbreviations: NO, New Orleans; CI, confidence interval.

scale public health emergencies, risk inherent loss of the stringent evaluation and monitoring standards that are expected during less chaotic times. Whereas death rate reports may prove alarming, they must first alert decision makers to rally resources to intervene where prevention of further deaths are most likely and to develop robust evaluation and monitoring programs to identify and verify the exact nature of possible excess mortality and the most vulnerable of subpopulations experiencing mortality and morbidity. There is an urgent need to understand the etiology of the problem so that local, state, and federal health agencies can better prepare for and anticipate future public health emergencies. The present study raises this concern in the post-Katrina greater New Orleans population and suggests an urgent need for further study to investigate the causes and age distribution of these excess deaths. It is a call to action to federal and Louisiana state health authorities to direct the necessary resources to determine and monitor these causes.

FIGURE 1

Comparison of average monthly mortality rates for 2002–2003, Louisiana state data vs *Times-Picayune* death notices



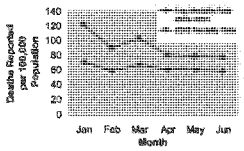
Immediately following disasters, public health officials need reliable sources of mortality information to determine direct and indirect consequences, particularly when traditional health information systems are debilitated. In this study, an alternative source of mortality information—death notices published in the daily metropolitan newspaper, the *Times-Picayune*—was found to correlate highly with mortality data from the conventional state health information system in the pre-Katrina population. The authors believe that this study validates this alternative source in this population. Furthermore, death notice monitoring provided real-time mortality information well ahead of official state health information mortality data, giving impetus to the Louisiana health departments to adopt an interoperable statewide EDRS to rapidly assess and monitor mortality.

Strengths

The exclusion criteria of this study eliminated 2006 death notices that did not occur in the specified geographic area of the study or within the specified time frame of the study (Table 1). This was done to eliminate death notices that may artificially inflate the 2006 mortality rate calculation. Elim-

FIGURE 2

Comparison of average mortality rates between January–June 2006 and January–June 2002–2003, *Times-Picayune* death notices



inating death notices by using strict exclusion criteria would likely result in a conservative estimation of true mortality rates in the first 6 months of 2006. It should be noted that before Katrina, the *Times-Picayune* offered both paid and free death notices, whereas after the storm they only offered paid death notices. This difference would also likely result in an artificially reduced number of death notices and minimize the likelihood of an inflated mortality rate in the first 6 months of 2006.

Limitations

The data source for current mortality, the *Times-Picayune*, uses a passive data collection system. This would likely result in underreporting of the true mortality because there are deaths that occur in the area that are not published as death notices in the *Times-Picayune*. Underreporting of mortality would result in an underestimation of current mortality rates, making the results of this study even more alarming.

The study source for the population of greater New Orleans provides only an estimate for January 2006, and the authors necessarily used this population estimate in the denominator data for mortality rate calculations for each month of 2006. However, according to recent data, the population of greater New Orleans has been exceptionally dynamic and growing steadily (demonstrated in data collected through May 2006).[9,15] If the population of greater New Orleans did increase in the first 6 months of 2006, the calculations of mortality rates will overestimate the true mortality rate over the first 6 months of 2006 by virtue of underestimating the true population.

There may be demographic differences, particularly in age distribution, between the pre-Katrina and post-Katrina populations of greater New Orleans. The 2006 population of greater New Orleans may have a disproportionate number of older adults and therefore a higher death rate. The authors did not adjust for age in their mortality calculations. The degree to which changing demographics affected the results of this study cannot be known until further studies investigating the current demographics of greater New Orleans are carried out.

CONCLUSIONS

A significant increase in the mortality rate for the first 6 months of 2006 substantiates the deleterious effects of enduring health consequences resulting from a major disaster. This must be understood as an urgent call for further studies and subsequent interventions. The authors believe that the underlying causes of the increased mortality rates within the greater New Orleans' population are complex, multifactorial, and persistent. This disaster severely compromised the public health infrastructure. It is suggested that a destroyed or poorly recovered public health infrastructure, which normally would be able to identify health problems and protect the health of a population, has in fact contributed to excess mortality.

Finally, the necessity to set standards that will open the lines of communication across public health agencies in the event of a disaster is clearly indicated.[16] Interagency communication can deteriorate rapidly in the midst of a disaster; each office is often solely focused on meeting its own needs and thereby unavailable to provide information across jurisdictions. Offices were flooded, paper records had to be rerouted, and only a fraction of office staff returned to work. This confluence of events reveals the urgent need for states to adopt electronic reporting systems.

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Mr. STUPAK. Thank you, Mr. Mayor. Mr. Cerise, opening statement, please, 5 minutes.

TESTIMONY OF FREDERICK P. CERISE, M.D., M.P.H., SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Dr. CERISE. Mr. Chairman and members of the committee, thank you for the opportunity to testify on the status of Louisiana's health care system. I am Fred Cerise, Secretary of the Louisiana Department of Health and Hospitals. Today my comments will center around three areas, new Federal and State commitment, continuing needs, and sustaining some of the momentum that has begun with State and Federal relief. In the 2 years since Katrina hit, New Orleans has accomplished much through local, Federal, and State investments. Recent Federal actions include the allocation of the remaining DRA funds. Louisiana received $161 billion which is targeted at workforce recruitment and retention, stabilization to hospitals, and primary care stabilization and expansion.

I will note that the workforce recruitment and retention effort is ongoing. Out of the $50 million that has been allocated for that $11 billion in recruitment offers have been made. Over 100 people have been recruited back to the area as a result of that work. There was an award of $2.5 million in HRSA grants to increase access to health care services in the area and the extension of social services block grant funding to September 2009. Those are things we asked of this committee and HHS, and you responded and we appreciate the attention to those requests that we have made.

I think it is also important to note that Louisiana has stepped forward with significant State investments in health care. Over a billion dollars in new State and matched funds were dedicated to programs including several proposals put forth by the redesign collaborative such as expanded insurance coverage to children, and individuals with disabilities, Medicaid rate increases to retain access to services, health information technology investments building on Federal grants, the establishment of a quality forum, and funds for a medical home systems pilot program.

In addition, there is new funding to replace expiring Federal relief to expand and restructure mental health care delivery and to replace an academic medical center in conjunction with the VA in downtown New Orleans. The VA's return to the city, as the mayor mentioned, is a critical piece to the city's recovery. Extensive planning among LSU, Tulane, and the VA has occurred over the past 18 months. In addition to providing high quality care to veterans, this joint venture will save American taxpayers an estimated $400 million in long-term operational costs while serving as a centerpiece of a vibrant, academic teaching center and a bio-sciences research cell.

We need an expedient decision to rebuild on the land currently being assembled in New Orleans so that both the LSU and the VA can focus more directly on returning vital services to the region. For the next few minutes, I will outline a few of our continuing and new issues, those surrounding graduate medical education, hospitals, and care for the uninsured. In response to the previous hearing, I convened a graduate medical education stakeholder

group which the group identified as its major ongoing concern an extension of the 3-year rolling average exemption for the medical schools and hospitals which step forth to assist the residency program post Katrina. HHS advised that Federal legislation would be required to address this issue.

Estimates from the hospital place the cost of $10 million to $15 million over the next 4 years. This is a complex area, as many of you know, in which we will need a commitment of solution oriented, active engagement by CMS in crafting a satisfactory resolution. In terms of the hospitals it, was made clear in the March hearing that the hospitals in the New Orleans area were struggling with uncompensated care. In response to that issue, the State revised its existing $120 million community hospital uncompensated care pool to allow more funds to flow to the New Orleans area hospitals and has continued to support in this fiscal year through this pool and through Medicaid rate increases.

However, the State has been notified by the hospitals that they continue to have a significant need for additional funding beyond UCC and beyond the previously estimated Medicare wage index projections. The State has not conducted a detailed analysis of the individual hospital's profits and losses. I agree with Representative Melancon's recommendation that an independent third party, such as GAO or some other party, conduct this detailed analysis to identify documented needs and identify ways to insure viability of these important community resources. And then finally as the State continues to recover, please note that we are doing so with an eye towards long-term systems redesign.

Louisiana recently received notice, this was on July 23, so the State is not sitting on these funds, we recently received notice of the $100 million primary care stabilization grant. We believe this large investment in primary care should be leveraged to result in approved delivery system. If these funds are properly deployed, we should expect to see significant relief on emergency departments in the region and improved preventive services for residents. The State, with its local partner, who you will hear from, hopes that as we work through details with HHS the opportunity to place explicit requirements for access, care coordination and quality, and IT will be made available.

Above all, the State wants to insure that this Federal investment is sustainable and coordinated with State programming. We know that this increase in primary care, for instance, and the capacity will generate more demand for specialty services for which there is no ready funding available. We once again request the ability to use Federal funds to support these physician services. The State has been informed by CMS that flexibility in the use of the DSH funds will be considered only in the scope of a larger waiver request that ultimately shifts DSH funds to the purchase of insurance for uninsured individuals. Although coverage is a desirable goal of the State, we have done extensive analysis of this proposal and concluded that we have insufficient funds in the DSH program today to adequately cover the target population.

Currently, the State is criticized for supporting a centralized institutional base system of care. However, Federal rules dictate this approach. The rule, which is waivable, paradoxically results in

more patients relying on emergency rooms for non-emergent care. DSH funds require a State match and have a Federal cap. This simple waiver would require no additional Federal funds that is not already available to the State today, and I urge you to prevail upon the administration to allow the State to use DSH funds, up to but not in excess of our cap, as a way to provide critically necessary physician services today. Along with traditional Medicaid, this will allow us to sustain the care once the primary care grant expires.

So I will end here. Thank you for the opportunity to testify and for your ongoing commitment to the recovery of the region, and Ilook forward to the discussion.

[The prepared statement of Dr. Cerise follows:]

Frederick P. Cerise, M.D., M.P.H.
Secretary, Louisiana Department of Health and Hospitals

Testimony for:
"Post-Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns"
August 1, 2007

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives

Introduction: Mr. Chairman and members of the Committee, thank you once again for the opportunity to testify on the current status of Louisiana's health care system. I am Dr. Fred Cerise, Secretary of the Louisiana Department of Health and Hospitals (DHH). Today, I will share with you our progress to date highlighting the continued federal assistance and the commitments that the state has made towards short term recovery and long term health systems redesign. I will close my testimony by describing the continuing and most pressing needs in the New Orleans region health care system.

In the 2 years since Hurricane Katrina hit New Orleans, much has been accomplished through local, state and federal commitments towards remediation of the devastation to the health care system. Still, there are remaining issues which only steady work and support, building on the momentum already in place, can resolve. Recent federal action is helping to ameliorate the situation. This includes

- The allocation of the remaining Deficit Reduction Act (DRA) funds. These funds include $35 million for workforce recruitment and retention; $26 million for direct funding for provider stabilization to acute hospitals, psychiatric hospitals, skilled nursing facilities, and community mental health clinics; and $100 million for primary care.
- The award of $2.5 million in HRSA grants to increase access to health care services in New Orleans and Franklin Louisiana. The funding provided for these community health centers will expand services to over 13,600 additional patients.

- The extension of Social Services Block Grant funding to September 2009, allowing Louisiana to continue the recovery of primary and behavioral health services.

Louisiana is greatly appreciative of the federal assistance. In particular, I thank this committee for its role in securing the above assistance and for its continued interest in the recovery of the Orleans health care system.

Bridging Short-Term Needs with Long-Term Redesign: The combination of continued federal support with new state commitments in health care is improving the devastated health care system in the New Orleans region. The state's approach to short-term recovery has always included an eye towards long-term redesign. One example of this is the use of SSBG to create much stronger community-based programs for behavioral health across the state consistent with the Governor's long term vision expressed in her Executive Order in 2005. These funds have allowed us to better serve patients and to relieve the strain on inpatient facilities and emergency departments. The new and innovative programs established by the SSBG will be sustained with state funds. In essence, the state is trying to meet short-term needs while laying the groundwork for systemic changes that will improve the quality of health care. The goal of this approach is to ensure that our vision for health care in Louisiana is realized.

Louisiana's vision for health care in our state is that it will be patient-centered, quality-driven, accessible to all citizens, and sustainable. Creation of this system involves workforce development, much greater coordination among providers, greater

accountability for outcomes, and more rational reimbursement rules. It is with this vision in mind that we look to best deploy the assistance provided us by the federal government and to invest new state funds. In my remarks I will discuss progress towards this vision as well as ongoing challenges.

Primary Care Stabilization and Access Grant (PCASG)

On May 23, 2007, Louisiana received a letter from HHS regarding the availability of $100 million Deficit Reduction Act (DRA) funds directed towards needs highlighted at the previous Subcommittee on Oversight and Investigations hearing on March 13, 2007. Louisiana's grant submission was submitted in early July and the grant award notice was made on July 23, 2007.

This grant will be used towards the overall administration of a clinic stabilization initiative with the bulk of the funding ($90.5 million) for direct allocation to eligible provider entities for the provision of primary care over a three year period. Four million of the $100 million is to be provided directly to the City of New Orleans Health Department.

These grant funds will assist in the restoration and expansion of access to outpatient primary care, including medical and mental health services, substance abuse treatment, dental care and eye care. With the receipt of grant funds, it is expected that clinics will facilitate the delivery of health services by increasing their staffing, expanding existing service delivery sites, extending hours of operation and/or developing satellite service delivery sites. By enhancing access to primary health care services, it is anticipated that

there will be a decrease in the dependence of the uninsured on hospital emergency departments for such care.

The current grant guidance does not allow explicit standards of accountability for systems performance for clinics to be eligible, nor the ability to use these dollars for health information technology (HIT). This large investment in primary care should be leveraged to create an improved delivery system through accountability for systems' performances as envisioned by the Redesign Collaborative model. The state, with its local partner, hopes that as we work through the details with HHS, the opportunity to place explicit requirements on system standards for access (e.g. evening and weekend hours for primary care as alternatives to EDs), care coordination and quality, and HIT will be permitted.

LSU–VA Joint Venture

A recent letter from Governor Blanco to Secretary Nicholson urging the Department of Veterans Affairs' (VA) continued collaboration with the Louisiana State University (LSU) to rebuild the VA facility in downtown New Orleans was cosigned by Louisiana's legislative leadership; the presidents of LSU and Tulane Universities and the chancellors of their medical schools; the mayor of new Orleans; the director of the downtown development district; and individuals representing veterans organizations. A copy of this letter is attached.

This new state of the art facility, in close proximity to the LSU and Tulane health sciences centers, will ensure that the veterans of the region are provided with the highest quality of care in an academic teaching and research environment. The state and the VA have similar visions for health care – to provide patient-centered, coordinated care that utilizes health information technology and improves health outcomes in the most efficient manner possible. The existing partnerships among the VA, Tulane, and LSU will only be strengthened through this proposed new model.

In the more than 18 months since the memorandum of understanding (MOU) was signed between LSU and the VA, an LSU/VA Collaborative Opportunities Study Group and a Collaborative Opportunities Planning Group have set up the basic framework for construction and operation of the hospital complex outlined in the MOU. In addition to providing high quality care of veterans, this joint venture will save the American taxpayers an estimated $400 million in operational costs while serving as the centerpiece of a vibrant academic teaching center and a biosciences research zone. The VA's return to the city is a critical piece of the city's recovery.

The commitment from the VA to rebuild in the region, the commitment from the state and city to provide the necessary land, the partnership with LSU and Tulane to ensure ready access to high quality care for veterans, and the cooperative business plan that demonstrates hundreds of millions in savings over the life of the project as a direct benefit of the shared downtown model, show that Louisiana is ready to move forward on this project. I recommend an expedient decision to rebuild on the land currently being

acquired in New Orleans so both the VA and LSU can focus more directly on returning vital services to the region.

The State's Commitment to Health Care Recovery and Systems Redesign

The recent session of the state legislature continued the dual focus of responding to immediate needs while making investments to the long term redesign of Louisiana's health care. Governor Blanco, along with the legislature, pushed forward a health care agenda that ranges from addressing hospitals' uncompensated care to expanding health insurance coverage to the state's most vulnerable citizens. This includes the following:

- Expanding behavioral health care funding for mental health and addictive disorders, including the continuation of funding for SSBG programs - $116 million;
- Continuing funding for the uncompensated care pool and increased Medicaid rates for hospitals - $120 million;
- Ensuring ongoing access to care for patients in the Medicaid program by increasing physician rates to 90% Medicare levels - $64 million;
- State funding for land acquisition, planning, and building of a new university teaching and research hospital in New Orleans as part of a joint partnership with the Veterans Administration - $300 million;
- Investments in HIT including rural HIT and care networks - $53 million;
- Pilot medical home system - $25 million;
- Expanding federally qualified health center infrastructure - $41 million; and

- Expansion of health insurance to uninsured children through LACHIP - $30.9 million.

The state is actively moving forward in implementing initiatives to ensure better access to higher quality services for our citizens. Two fundamental building blocks for a higher performing system in Louisiana include the Louisiana Health Care Quality Forum (LHCQF) and investments in HIT.

Louisiana Health Care Quality Forum

In the 2007 regular legislative session, the Louisiana Health Care Redesign Collaborative's recommendation to establish a *Louisiana Health Care Quality Forum* was realized through an appropriation of $1.07 million and the passage of House and Senate concurrent resolutions. The resolutions direct DHH to work with private stakeholders to create a private non-profit organization whose purpose is to plan, promote and conduct quality improvement activities. The newly incorporated LHCQF is a private non-profit organization governed by a 12 member Board of Directors and is dedicated to improving the quality of health and health care throughout Louisiana.

The LHCQF will collect and analyze population health measures across providers and insurers, promote national HIT standards in Louisiana, promote EMR adoption, facilitate health information exchange, and actively engage health care organizations to implement quality initiatives, to achieve better outcomes. Louisiana now joins other progressive states across the nation whose commitment to quality will lead to better health outcomes.

The LHCQF was recently recognized by Secretary Leavitt as a Community Leader for Value-driven Health Care.

Health Information Technology

The majority of Louisiana's 1.2 million citizens who were displaced due to Hurricane Katrina lost access to their physicians as well as their medical records. Recognizing the enormous challenge this presented, shortly after the storm, the DHHS Office of the National Coordinator (ONC) committed $3.7 million to Louisiana to develop an electronic health information exchange (HIE) to recover and recreate electronic medical records.

Through this contract between ONC and DHH, a prototype of a statewide HIE was developed. This prototype demonstrated the ability to collect critical medical information for Louisiana citizens into a database that could be accessed in the event of another disaster. In addition, it demonstrated the utility of having the ability to share electronic information in the day to day care of patients. Governor Blanco and the legislature subsequently committed $53 million dollars to strengthen its aggressive health information technology agenda.

These funds will build upon the federal funding from the ONC as well as a $350,000 contract from DHHS/ONC and the Agency for Healthcare Quality and Research for work on Louisiana's Health Information Security and Privacy Collaborative to further develop the Louisiana HIT agenda. This agenda is focused on creating an interoperable health

information system that allows for seamless sharing of electronic information to improve patient safety, improve health care outcomes and increase efficiency in the provision of health care. Specific plans include:

- Developing regional health information organizations (RHIO) in 3 major regions of the state, including the New Orleans area - $3 million;
- Supporting the adoption of electronic medical records in physicians' offices - $7 million; and
- Promoting the use of electronic medical records systems in rural hospitals - $13 million.

In addition, the Louisiana Legislature appropriated $30 million for the Louisiana State University System Electronic Medical Records adoption. These funds will support the overall state's commitment to health information technology.

The state is moving forward with the recovery of the New Orleans health care system as well as redesign. To ensure continued progress and long-term success, the short-term health care system needs must be addressed.

Continuing Health Care System Needs: While much has been accomplished, as we approach the second anniversary of Katrina, much remains to be done. Subsequent to my last testimony before your committee, I put forth a response to HHS outlining many of our needs as we work towards reestablishing an improved system of care. The response from HHS was the allocation of the remaining DRA funds. The following is a list of the unresolved issues as well as new needs that have evolved as recovery continues.

Graduate Medical Education

In response to the previous hearing, I convened a Graduate Medical Education stakeholder group to formalize the issues regarding the placement and funding of resident slots. The concerns brought forth at this meeting represent two issues:

1) Financial relief is needed and could be achieved through an extended exemption from the "three year rolling average" for the medical schools and hospitals which stepped forth to assist residency programs post Katrina. HHS advised the state that federal legislation would be required to address the three year rolling average. Estimates from the hospitals place the cost of this at approximately $10 - $15 million over the next 4 years.
2) The GME programs do not have the ability to readily reassign residents in disaster programs. Creating stewardship would allow for greater flexibility and coordination of placements and payments in the event of a disaster. HHS advised the state that it may address this issue locally though that would not impact future emergency situations in other states. The state is currently exploring options on how to address this issue.

Workforce Shortages

Through two DRA grant opportunities, fifty million has been allocated to Louisiana to restore health care workforce capacity. The administration of this funding is being handled by the departmentally created Greater New Orleans Health Service Corps (GNOHSC). As of July 2007, the GNOHSC has obligated $11 million for a total of 127

awards. The awards have gone to providers of primary care (62), mental health care (42), dental care (16), pharmacists (5), specialty care (2), as well as medical faculty. The GNOHSC is also working on placement opportunities for the providers awarded funding to practice in impacted areas of need. In total, 370 applications from physicians, dentists, mid-level providers, behavioral health providers, and pharmacists have been submitted since the program began accepting applications on April 5, 2007.

The GNOHSC began taking applications for nurse recruitment and retention in July 2007 and is aggressively targeting the recruitment of 150 nurses and the retention of 150 nurses. The GNOHSC is also targeting the recruitment of 98 allied health professionals and the retention of 98 allied health professionals. Most of these professionals will work in either hospitals or nursing homes. These targeted activities will assist in mitigating a percentage of the understaffing in these critical facilities.

Despite this infusion of funds, the state still expects that workforce shortages will persist, particularly in the nursing and allied health sectors.

Behavioral Health

In Louisiana, the pre-hurricane mental health infrastructure was overcommitted and inadequate to meet the needs of all those with serious mental illness. To date, the inpatient and outpatient mental health system is still significantly compromised, requiring major structural repairs as well as strategies for the recruitment and retention of professional and para-professional mental health care providers.

The damage to the mental health infrastructure in the New Orleans area following hurricane Katrina left the region with a net loss of 342 acute inpatient psychiatric beds – from a pre-hurricane level of 578 beds to the current number of 236 beds. The state has been working with all potential providers to reestablish inpatient capacity and there are an additional 80 beds that are expected to come on line within the next 3 to 6 months. In prior appeals, we requested a waiver of the federal Medicaid IMD exclusion to allow a stand-alone inpatient psychiatric facility to receive federal match for Medicaid services. This would allow the state to more quickly expand beds for psychiatric services in the New Orleans region. Last week, DHH was directed by the CMS to submit a brief concept paper for their consideration regarding this.

Inpatient capacity is just one aspect of the difficulty Louisiana has faced in reconstituting behavioral health services. SSBG funds have allowed us to implement greatly needed community-based services. The state recognized the benefit of the programs that had been initiated through the grant and dedicated significant new dollars to continue these services beyond the current funding.

In behavioral health, however, the challenges go beyond funding. The New Orleans region has been plagued by the inability to hire sufficient workers to implement services. While DRA workforce funds are being used to recruit and retain mental health professionals, the immediate need for behavioral health services far exceeds the supply of willing providers. To this end, Louisiana is exploring opportunities to work with the

United States Public Health Service Commissioned Corps (USPHS) to address some of its critical mental health workforce shortage issues.

In April 2007 we sent a follow up request to HHS in response to our March testimony outlining our current need. In that request we proposed to expand Medicaid eligibility to individuals with serious mental illness and we proposed a five year redevelopment and mitigation/prevention plan for behavioral health services. We did not receive a favorable response to these requests.

Community Hospitals

It was made clear during the March 2007 hearing that the hospitals in the New Orleans region were struggling with higher than their usual levels of uncompensated care (UCC). In response to this issue, the state revised its existing $120 million community hospital UCC pool to allow the New Orleans hospitals to receive 85 percent of total UCC costs in FY 06-07 (UCC is defined as gross uninsured costs as a percent of total costs). The state has also committed to an $80 million private hospital UCC pool for fiscal years 2007-2008 and $40 million to increase Medicaid rates for hospitals. This shift in UCC funds to private hospitals puts their UCC percentages well below national averages.

However, the state was recently notified by the hospitals that they have a significant need for additional funding that goes beyond traditional UCC and prior Medicare wage index adjustment requests. The hospitals are reporting that their labor and insurance costs are outpacing what Medicare reimburses and causing extreme strain on their financial

sustainability. The state has not conducted a detailed analysis of individual hospitals profits and losses. I request that an independent third party entity, such as the U.S. Government Accountability Office, conduct a detailed analysis of hospital financial reports to identify documented needs and the best way to ensure viability of these important community resources.

Sustaining Systems of Care

The state is trying to ensure that the federal funds, in particular the PCASG funds, coming into Louisiana for health care system recovery are used to both provide immediate access to care and to help create systemic improvements in access, quality and efficiency. Above all, the state wants to ensure that its actions are sustainable. Flexibility in the usage of Disproportionate Hospital Share (DSH) funds is necessary if the state is to provide greater emphasis on non-hospital based services.

The state continues to seek approval for a budget neutral solution to help support a primary care expansion and sustain the services being put in place with one time recovery funds. In order to support the delivery of appropriate services, the state again requests that section 1902(a)(13)(A) be waived to permit the use of DSH for payments for non-hospital and physician services provided to the uninsured. This is particularly relevant to provision of specialty physician services. The PCASG will enhance access and is expected to create more demand for specialty services not covered by this grant. The state seeks approval to use DSH funds to reimburse for these essential physician services.

The state has been informed by CMS that flexibility in the use of DSH funds will only be considered in the scope of a larger waiver request that ultimately shifts DSH funds to the purchase of insurance for uninsured individuals. Although coverage is a desirable goal, the state has done extensive analysis of this proposal and has concluded that there are insufficient funds in the DSH program to adequately cover the target population. The Center for Budget Policy and Priorities concurs, stating that "... the experience of Louisiana shows that even in states with higher DSH allocations, the Administration's approach would leave many state residents uninsured, would provide inadequate coverage to many who do obtain insurance, and would leave safety-net health care providers without the necessary support to provide care to people who remain uninsured or are underinsured." The Urban Institute also concluded that $2.3 billion would be needed to insure the existing low-income uninsured population in Louisiana, which is well below the roughly $1 billion in the state's DSH program.

Using the funds in a more flexible manner is a budget neutral solution that would allow the state to support physician and non-hospital (e.g., clinics) services and support the ultimate redesign of the health care system. Currently, the state is criticized for supporting a centralized, institutional-based system of care. However, federal DSH rules dictate this. The rule, which is waivable, results in more patients relying on emergency rooms for nonemergent care. DSH funds require a state match and have a cap on federal funds. This change in rule interpretation would allow us to provide greater access to care outside of institutional settings with no additional federal funding that is not already available to the state today.

Medicaid State Plan Amendments

The state legislature passed the Health Care Reform Act of 2007, which requires the DHH to implement a medical home system of care that is rooted in quality and utilizes HIT. The state will pilot this system of care in the two hurricane affected regions of the state – New Orleans and Lake Charles. Amendments to the state's current Medicaid plan will be necessary to implement the legislation. In accordance with this legislation, DHH intends to present the concept for necessary Medicaid state plan amendments (SPAs) to the appropriate state legislative committees in the next 30-60 days.

These amendments will include a request for a Medicaid expansion for parents in the hurricane impacted regions. It is likely that, given the structure of the recent HHS primary care grant award, the state may request an unconventional benchmark plan that actually excludes a primary care benefit in Medicaid for the next three years since this is now being funded with the DRA grant in the New Orleans area. We do not want to duplicate funding for any services. We will be looking for favorable action on these SPAs as they are critical to the state implementing the redesign recommendations of the Louisiana Health Care Redesign Collaborative.

Conclusion: I want to thank this committee for its attention to our needs and the federal response over the past few months. I hope you can appreciate the level of commitment to immediate relief and long term recovery that has been made with new investments of state dollars. Still, we have ongoing needs, some of which will require additional funds

and some that can be substantially addressed with flexibility of existing federal rules. I greatly appreciate the opportunity to testify today as well as your ongoing commitment to our region's recovery.

KATHLEEN BABINEAUX BLANCO
GOVERNOR

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July 27, 2007

The Honorable R. James Nicholson
Secretary of Veterans Affairs
United States Department of Veterans Affairs

RE: LSU-VA Joint Hospital Project

Dear Secretary Nicholson:

We write today to offer our strong support for the construction of a new Veterans Affairs Medical Center in downtown New Orleans. This new state of the art facility will ensure that the veterans of our region are provided with the highest quality care in a vibrant academic teaching and research environment.

In the more than 18 months since the MOU was signed, an LSU/VA Collaborative Opportunities Study Group (COSG) and a Collaborative Opportunities Planning Group (COPG) have set up the basic framework for construction and operation of the hospital complex outlined by the MOU. We believe this joint venture will save American taxpayers hundreds of millions of dollars in operational costs while serving as the centerpiece of a vibrant academic teaching center and bioscience research zone.

Since Katrina, nearly 90% of our region's veterans have returned to the greater New Orleans region. With your support, significant progress has been made during the last year in meeting the health needs of our veterans but they must still travel long distances to Alexandria, Mississippi and Houston for much of the care they require. It is time for the State and the VA to move forward as quickly as possible to establish permanent facilities to care for our rapidly expanding veterans population.

As the elected and appointed leadership of Louisiana and members of the New Orleans business community, we strongly believe that clustering our city's critical health care assets in downtown New Orleans will yield the highest quality care, education and research for all of the citizens of our region.

Clustering of health care assets has resulted in joint Tulane-LSU collaborations, such as development of a 60,000 square foot bio-innovation center and an $86 million dollar Louisiana Cancer Research Consortium (LCRC) facility. The LCRC is expected to develop coordinated cancer research and education programs to optimize discovery and

development of new cancer therapies and innovative clinical treatments for early detection, treatment and prevention of cancer. The VA is a cornerstone of these efforts and veterans will benefit as a result of the synergies created by such a dynamic research and teaching environment. Proximity to both the LSU and Tulane medical schools will maximize the involvement of highly trained faculty specialists providing value-added clinical expertise to an already excellent level of care provided by the VA system.

Likewise Xavier University, which is nationally known for training minority pharmacy students, needs a new hospital to help educate future pharmacists.

The following steps have been taken to accelerate land acquisition, design, and construction of these facilities, including:

- Utilization of state funds to replace $300 million in federal hurricane relief funds to eliminate any possible delay in obtaining approval for Community Development Block Grant (CDBG) funds. Among those state funds is $74.5 million being specifically allocated to the purchase of 37 acres of land in downtown New Orleans for the joint LSU/VA facility and design work for the LSU component of the project.
- The City of New Orleans and the State Division of Administration have executed a Cooperate Endeavor Agreement (CEA) to purchase an additional 29 acres of adjacent property for the exclusive use of the VA.
- The State Office of Facility Planning and Control has hired legal teams to identify and expedite resolution of property acquisition, environmental assessment, and relocation matters.
- Architects have been selected to design the new public academic medical center.
- Timelines for land acquisition and design have been established and work is underway. Photographs of the site, preliminary ownership information, and title abstracts have been completed for nearly half of the project site.
- Base evaluations are being determined in establishing the value of property to be acquired.
- A relocation assistance consultant will be hired by the end of August.
- The business plan for the complex takes into account health care delivery models and the future of medical education. The Louisiana Health Care Redesign Collaborative put forth the recommendation for a redesigned system of care centered on the "medical home" model. This model is very similar to the operational structure of the VA system today. We expect the demonstration project to be approved by the first quarter of 2008 with implementation to follow immediately.

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In addition. local and state leaders from seven southeastern Louisiana parishes have unanimously passed a resolution expressing their collective support and their strong wish that the VA remain downtown. The American Legion passed a resolution in early June at its state convention unanimously supporting the re-building of the Veterans Affairs Medical Center in downtown New Orleans. As well. the Louisiana Recovery Authority has called the hospital project and the return of high quality health care to New Orleans "one of the top priorities in Louisiana's recovery" and the Louisiana Legislature has endorsed the business plan for the LSU hospital.

Thank you for your commitment to our country and our veterans. We appreciate your attention to this matter and will make ourselves available at any time for further discussions or to assist in overcoming any remaining obstacles.

Sincerely.

Kathleen Babineaux Blanco
Governor. State of Louisiana

Sydney Mae Durand
Representative Sydney Mae Durand
Chair. House Committee on Health and Welfare

Don Hines
Senator Donald E. Hines
President. Louisiana Senate

Dr. William L. Jenkins
President. Louisiana State University System

Joe Salter
Representative Joe Salter
Speaker. Louisiana House of Representatives

Scott Cowen
Dr. Scott Cowen
President. Tulane University

Mayor C. Ray Nagin
City of New Orleans

Arnie Fielkow
Arnie Fielkow
President. New Orleans City Council

Joe McPherson
Senator Joe McPherson
Chairman. Senate Committee on Health and Welfare

Rod West
Rod West. Esq.
Chairman. LSU Board of Supervisors

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Dr. Larry Hollier
Chancellor, LSU Health Sciences Center

Dr. Alan M. Miller
Interim Senior Vice President for Health Sciences
Tulane University

Dr. Norman Francis
President, Xavier University &
Chairman, Louisiana Recovery Authority

Dr. Michael Butler
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William Detweiler, Esq.
Past National Commander of the American Legion

Sandra M. Gunner
CEO & President,
New Orleans Chamber of Commerce

Hunt Downer
Major General, LA National Guard &
Secretary, Louisiana Department of Veterans Affairs

Walter R. Brooks
Executive Director, New Orleans Regional Planning Commission

Dr. Byron Harrell
Chairman, New Orleans Downtown Development District

cc: The Honorable Bob Filner
Chair, House Committee on Veteran's Affairs
U.S. House of Representatives

The Honorable Steve Buyer
Ranking Member, House Committee on Veteran's Affairs
U.S. House of Representatives

cc: The Honorable Bart Stupak
Chair, Energy & Commerce Subcommittee on Oversight and Investigation
U.S. House of Representatives

The Honorable Edward Whitfield
Ranking Member, Energy & Commerce Subcommittee on Oversight and Investigation
U.S. House of Representatives

Honorable Mary L. Landrieu
United States Senator

Honorable William J. Jefferson
United States Representative

Honorable Jim McCrery
United States Representative

Honorable Rodney M. Alexander
United States Representative

Honorable Richard H. Baker
United States Representative

Honorable Bobby Jindal
United States Representative

Honorable David Vitter
United States Senator

Honorable Charles Boustany
United States Representative

Honorable Charles Melancon
United States Representative

Mr. STUPAK. Thank you. Ms. Richter, 5 minutes, please, opening statement.

TESTIMONY OF ELIZABETH RICHTER, ACTING DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. RICHTER. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss post-Katrina health care and the actions the Centers for Medicare and Medicaid Services have taken to help rebuild the Louisiana healthcare system. I am Elizabeth Richter, the acting director of the Center for Medicare Management at CMS and I am pleased to be joined today by Rear Admiral Kenneth P. Moritsugu, the Acting Surgeon General, to help answer any questions you might have about broader Health and Human Services actions.

I will focus on two issues the subcommittee asked CMS to address, which are graduate medical education payment, and the Medicare area wage index. Since the first days after Hurricane Katrina, CMS has worked diligently to address issues related to medical residents displaced by the disaster. In particular, CMS has moved quickly to provide flexible funding through all available means of Medicare GME payment in three ways. First, the New Orleans hospitals asked CMS for a way in which host hospitals taking on displaced residents could receive payment for the training they were providing. In response, CMS immediately issued a provision in the existing regulations which allows hospitals that have closed programs to temporarily transfer their allotment of full-time equivalent residents paid for under the Medicare Program to the hospitals hosting the displaced residents.

As a result, host hospitals that were already training residents at or above their cap could receive payment for training additional residents displaced by the hurricane. Our second initiative in order to provide relief where the programs have not or are no longer closed was to use the rule making process to publish a new regulation to allow closed hospitals an adjustment to their FTE count. The new rule allows the host hospitals to receive financial relief for the additional medical residents they have taken on in the wake of the disaster. The new regulations establish a new kind of emergency affiliation agreement to facilitate the sharing of residents between hospital situations where special waiver has been implemented in an emergency area during an emergency period.

As a result, Katrina-affected hospitals were able to temporarily transfer residents anywhere in the country. Host hospitals were then able to receive payment without regard to the otherwise existing rules that affiliations be limited by geography and we also relaxed the shared rotational arrangement requirement. Under usual GME payment rules, a hospital is paid in the current year based on a 3-year rolling average count of residents. Therefore, the third action we took was to allow displaced residents from August 29, 2005 to June 30, 2006, to be excluded from the rolling average calculation.

As a result, payment will be made in full in 1-year for the period when host hospitals would have expected the closed program provision to apply. CMS has been advised by our Office of General

Counsel that the 3-year rolling average cannot otherwise be waived without a change in the law, thus exhausting CMS authority within the GME rules. CMS has authority to conduct demonstrations in cases where certain payment rules warrant the study to help achieve more efficient and effective administration of the Medicare Program. For example, there is currently an ongoing demonstration examining the effect of managing resident slots at the State level. Towards that end, CMS welcomes the opportunity to share information about the demonstration process.

In the meantime, CMS remains committed to providing technical solutions within its authority to any concerns related to GME. I have reviewed the paper submitted by LSU and Tulane, and would be happy to comment in response to any questions you may have about their particular GME concerns. CMS has also been responsive to concerns about providers' requests for an increase in the area wage index to be reflective of reported increases in wage rates for health care facility staff. The wage index is a relative value based on wage data reported from hospitals across the country. There is a uniform national process for updating the wage index that will not be based on post-storm data until fiscal year 2010.

Given the data collection, auditing, and budget neutrality requirements under the current wage index structure provides certain limitations, HHS recognized the rapid rise in wages in this affected area, and thus directed approximately $98 million of the $160 million in DRA provider stabilization grants be made available to compensate Louisiana providers for higher wage cost before the wage index is based on post-storm wage data. CMS would very much like to understand the impact of the grant funds, and if they are having their intended impact of offsetting the cost of persistent higher wages in Louisiana, including how wage issues are impacting other payers, namely, Medicaid and private pay patients.

Due to the complex nature of the data issues across payers and programs, CMS also recommends an outside entity lead a thorough assessment of the issues the hospitals have raised across all HHS programs along private payers.

In conclusion, since the March 13, 2007, hearing before this subcommittee, HHS has made $195 million in supplemental grant funding for health care rebuilding and provider stabilization efforts in the Gulf Coast region. Secretary Leavitt has made a personal investment and focus of energy on rebuilding of the Louisiana health care system, supported by continuous technical expertise offered by CMS and senior officials throughout HHS.

CMS will continue to make relevant expertise available to the State as the two work together toward the goal of a high-functioning, sustainable health care infrastructure. Thank you, and Dr. Moritsugu and I would be happy to answer any questions you may have.

[The prepared statement of Ms. Richter follows:]

Testimony of
Elizabeth Richter, Acting Director, Center for Medicare Management
Centers for Medicare & Medicaid Services
Before the
House Energy & Commerce Subcommittee on Oversight and Investigations
Hearing on
"Post Katrina Health Care in the New Orleans Region:
Progress and Continuing Concerns – Part 2"
August 1, 2007

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss post-Katrina healthcare and the actions the Centers for Medicare & Medicaid Services (CMS) have taken to help rebuild the Louisiana healthcare system. As then-Acting Administrator Norwalk testified before this Subcommittee on March 13 of this year, the public health and medical situation in greater New Orleans and throughout the Gulf Coast following Hurricanes Katrina and Rita required an immediate deployment of substantial Federal resources to prevent even further loss of life. I do not intend today to re-state all of the actions that HHS and CMS have taken to encourage and facilitate rebuilding of the healthcare infrastructure along the Gulf Coast since the hurricanes hit, but I refer you to the March 13, 2007 CMS statement before this Subcommittee, which sets forth our actions as of that date in detail. Rather, I want to focus on the two issues the subcommittee asked CMS to address, which are Graduate Medical Education (GME) payment and the Medicare area wage index.

Medicare Graduate Medical Education

Since the first days after Hurricane Katrina, CMS has worked diligently to address issues related to medical residents displaced by the disaster. In particular CMS has moved quickly to provide flexible funding as appropriate in Medicare GME payment.

Since the inception of the Medicare program, the federal government has paid its proportionate share of the direct costs associated with GME. The Medicare program makes payments to teaching hospitals for a portion of the added costs associated with medical residency training programs. Under the inpatient hospital prospective payment system, teaching hospitals also receive an add-on payment for each discharge to reflect the indirect costs of medical education. The added direct costs incurred by teaching hospitals in providing GME include both the stipends and fringe benefits of residents, the salaries and fringe benefits of faculty who supervise the residents, and other direct costs of operating the teaching program. The amounts Medicare pays are specific to the hospital in question, reflecting the costs of its program. Medicare's payment is based on the number of residents the hospital is training, the hospitals historical per resident training costs and the hospital's percent of Medicare inpatient utilization. Medicare also provides support to teaching hospitals for the indirect costs of graduate medical education (IME). The IME adjustment is made to each Medicare discharge under the inpatient prospective payment system (IPPS) to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals. Under both direct GME and IME, the Medicare statute established a cap on the number of residents the hospital can count based on the number of residents the hospital was training in a base year, usually 1996. Residents often train at more than one hospital and in any given year may spend more time at one hospital than another depending on the year of training. To account for these annual variations in a hospital's FTE count, Medicare allows for hospitals that cross train residents that meet specific requirements to affiliate and "share" an aggregate cap. Under usual GME payment rules, the Medicare statute requires that a hospital is paid in the current year based on a three-year "rolling average" count of residents; that is, the average of the number of residents in the current year and two prior years. This is a statutory

requirement intended to distribute the impact of increasing or decreasing the number of residents at a hospital over a three-year period. Thus, if a hospital increases or decreases the number of FTE residents in a given year, the hospital counts only one third of the change in FTEs in that year, two-thirds in the second, and all of the change only in the third year.

The New Orleans hospitals asked CMS for a way in which host hospitals taking on displaced residents could receive payment for the training they were providing. In response, CMS immediately issued a document discussing a provision in the existing regulations which allows hospitals that have closed programs to temporarily transfer their allotment of full time equivalent (FTE) residents paid for under the Medicare program (referred to as the hospitals' FTE cap) to the hospitals hosting the displaced residents so that host hospitals that were already training residents at or above their cap could receive payment for training additional residents displaced by the hurricane.

Further communication with teaching hospitals in New Orleans clarified that in most cases the hospital training programs did not close entirely. In addition, hospitals in the hurricane-affected areas are in the process of reopening their residency training programs incrementally. The existing closed program regulation did not address these hospitals' issue. In order to provide relief where the programs have not or are no longer closed, the Department of Health and Human Services used the rulemaking process to publish a new regulation to allow host hospitals an adjustment to their FTE caps. The new rule allows for the host hospitals to receive financial relief for the additional medical residents they have taken on in the wake of the disaster.

Emergency Medicare GME Affiliation

CMS has revised existing regulations to address new affiliations between hospitals and nationwide affiliations in situations where a special waiver has been implemented to ensure medical care for Medicare, Medicaid or SCHIP populations in an emergency area during an emergency period. This regulation change allows Katrina-affected hospitals, as well as hospitals dealing with future national disasters or states of emergency, the flexibility to temporarily transfer residents while permitting payment for all affected hospitals. On April 12, 2006, CMS issued an interim final rule that allows hospitals to:

- Establish "emergency affiliation agreements" to allow for long distance affiliations. Under existing rules, affiliations are limited by geographical requirements or to hospitals under common ownership.
- Maintain emergency affiliations to no more than three years. During the effective period, the shared rotational arrangement requirement would also be relaxed so that residents will not be required to train in both hospitals that are members of the affiliated group.

For example, many residents of hospitals in New Orleans were moved to hospitals in Texas to continue their training and the Texas host hospitals were able to count those residents and receive increased Medicare GME payments through this emergency affiliation agreement provision.

Host Hospital Payment

Many host hospitals took in displaced residents in the belief they would be paid in full for those residents because of a special provision in the rules dealing with training residents from closed programs. Under usual GME payment rules, a hospital is paid in the current year based on a

three-year "rolling average" count of residents. However, under the new affiliation option in the interim final rule, displaced residents from August 29, 2005 to June 30, 2006 (the end of the academic year) will be excluded from the rolling average calculation and payment will be made in full in one year rather than spread over three years.

The response and revised process in the interim final rule provides hospitals with greater flexibility to transfer residents within an emergency affiliated group while ensuring payment for all the hospitals involved. It is also important to note that in the first year not only will host hospitals receive payment in full for training displaced residents, but home hospitals also receive 2/3 payment under the three-year rolling average mechanism, providing some much needed relief to the Katrina-affected hospitals.

When CMS reviewed the public comments on the April 12, 2006 interim final regulation regarding emergency affiliations, we quickly addressed a highly time-sensitive issue in the comments regarding the deadline for submission of the emergency Medicare graduate medical education (GME) affiliation agreements. The deadlines to submit the emergency Medicare GME affiliation agreements for the 2005 through 2006 and 2006 through 2007 academic years were changed in response to the comments from on or before June 30, 2006 and July 1, 2006, respectively, to on or before October 9, 2006. As a result, hospitals that accepted displaced residents but that did not complete affiliation agreements before the original deadline were able to complete their agreements and receive Medicare payments for training those residents.

CMS has been actively addressing stakeholder requests to extend the exemption of the three-year rolling average in order to provide a financial incentive for hospitals to keep training displaced residents. CMS has been advised by the Office of General Counsel that the three-year rolling average is mandated by statute, thus exhausting CMS authority within the GME rules.

CMS has authority to conduct demonstrations in cases where certain payment rules warrant study to help achieve more efficient and effective administration of Medicare. There is currently an ongoing demonstration in Utah examining the effect of managing resident slots at the State level. Under the demonstration, hospitals participating in the demonstration are allowed to form a statewide affiliated group in order to pool direct GME caps which may be redistributed at discretion of a statewide Medical Education Council. This demonstration also uses fiscal intermediaries (FIs) to calculate interim payments for direct GME due to the hospitals under the existing Medicare GME regulations; however, instead of making the payments to the hospitals, the FIs redirect the direct GME funds from each of the teaching hospitals and pay those amounts to the Council, which is an agency of the State government and reports to the governor, while the discharge-based indirect medical education payments are made to the hospitals as customary.

Area Wage Index

CMS has also been responsive to concerns about providers' requests for an increase in the area wage index to be reflective of reported increases in wage rates for health care facility staff. Under the payment system for hospitals, the base payment rate is comprised of a standardized amount that is divided into a labor-related share and a non labor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. The

wage index is a relative value based on wage data reported from hospitals across the country. There is a uniform national process for updating the wage index that will not be based on post-storm data until FY 2010. Given the data collection, auditing, and budget neutrality requirements under the current wage index structure provides certain limitations, HHS recognized the rapid rise in wages in this affected area and thus directed approximately $98 million of the $160 million DRA appropriated grant toward hurricane relief efforts to compensate for higher wage costs. The funds are intended to provide an adjustment to eligible provider types that reflects higher wage costs until the wage index is based on post-storm wage data. CMS would very much like to understand the impact of the grant funds and if they are having their intended impact of mitigating the costs of higher wage index issues in Louisiana. In addition, we would like to understand how the wage issues are impacting other payers, namely Medicaid and private pay patients. Due to the nature of the data systems reported through multiple competing hospitals and the multiple payers, CMS recommends an outside entity conduct a thorough audit and evaluation on the wage issue.

Funding for Healthcare Assistance and Workforce Rebuilding

In addition to the CMS actions to provide flexible assistance through Medicare GME and wage index relief, HHS made available more than $2.8 billion in Katrina-related funding in Fiscal Year 2006 to help respond to the health-related needs of people affected by the disaster. This included $2 billion for federal payments to States for healthcare assistance; $70 million in funding for healthcare related costs provided to CMS through a FEMA Interagency Agreement; a $550 million Social Services Block Grant; a $90 million Head Start hurricane-related Head

Start appropriation; and $104 million in emergency Temporary Assistance for Needy Families (TANF) funding for states affected by the Hurricane.

Of the $2.8 billion, the Deficit Reduction Act of 2005 (DRA) appropriated $2 billion for payments to eligible States for healthcare needs of individuals affected by Hurricane Katrina. To date, payments have been made to 32 states for a range of health-care related services and administrative costs for persons made eligible under the waivers, for uncompensated care costs, and for the State share of ongoing Medicaid and SCHIP costs for the affected areas in Louisiana, Mississippi, and Alabama.

The $2 billion DRA appropriation also enabled the Secretary to make $160 million available in February 2007 to Louisiana, Mississippi and Alabama for payments to hospitals and skilled nursing facilities facing financial pressure because of changing wage rates not reflected in Medicare payment methodologies. Of the wage index related grants, 45 percent, or roughly $71 million, went to Louisiana.

On March 1st, 2007, HHS provided another $15 million DRA grant to Louisiana for professional healthcare workforce sustainability in the greater New Orleans area. These funds are for use in the four parishes that comprise Region 1, as defined by the Louisiana State Department of Health and Hospitals; namely, Orleans, Jefferson, St. Bernard, and Plaquemines parishes. The four parishes have been designated by the Secretary of HHS as Health Professional Shortage Areas.

On April 5, 2007, the Secretary visited Louisiana to determine the condition of health-care delivery in the region. Upon his arrival, it became clear that health care providers in Alabama, Louisiana and Mississippi were still experiencing difficulties. In the Greater New Orleans area, the Secretary and senior HHS officials conducted a "needs assessment" field visit with several local primary care clinics throughout the city. Almost immediately, it was determined that there was a severe shortage of access to primary care where the storms and resulting floods impacted the uninsured and those with low incomes first-hand. With these concerns in mind, the Secretary authorized an additional $195 million in DRA grants for the Gulf Coast region with $161 million being specifically allocated to the State of Louisiana.

This $195 million allowed HHS to grant a supplemental award of $35 million to the State of Louisiana's prior workforce recruitment grant. The grant will further help recruit and retain health-care professionals in the Greater New Orleans Region. This amount, when combined with Louisiana's original $15 million allotment, has provided the region a total of $50 million in workforce supply grant funds. Health care professionals that would be eligible recipients of workforce supply funds include physicians, dentists, registered nurses, nurse practitioners and physician assistants, other licensed professional health care staff. Clinical faculty for medical schools, dental schools and other health training programs are also included and targeted in these efforts.

Additionally, this included a supplemental award of $60 million in provider stabilization grant funding was also awarded since the March hearing to Alabama, Louisiana and Mississippi, to help health-care providers meet changing wage rates not yet reflected by Medicare's payment

policies. Roughly $26 million, or 44 percent of the total, was allocated to providers in Louisiana, bringing the State's total provider stabilization grant funding to $98 million.

Finally, as a result of concerns identified by the Secretary during his April, 5, 2007 visit to the Lower Ninth Ward, Covenant House and St. Cecelia clinics and based on input from local providers, State health care officials and others, HHS announced the availability of a new $100 million Primary Care Grant to help increase access to primary care in the Greater New Orleans area. This grant that was awarded on July 23 will help the state assist New Orleans to expand primary care services in the region. Because of the unique impact on the low-income and uninsured populations of Greater New Orleans caused by the storm and its resulting floods, the state will work with a locally based partner, the Louisiana Public Health Institute, to make payments available to certain non-profit and public health care clinics to finance outpatient primary care services including medical and mental health services, substance abuse treatment, oral health care and optometric care. Of this $100 million available, $4 million will be made available for the exclusive use of the City of New Orleans to restore capability to its Parish Health Department for providing primary care in city neighborhoods that are not adequately served. Following the primary care, workforce recruitment, provider stabilization grant announcements, CMS and other HHS agencies (SAMSHA, HRSA) have conducted multiple technical assistance calls with the State.

We have outlined the funding breakdown in the chart below.

Agency	Program	Emergency Funds for Hurricane Relief FY2006 in Millions
Administration for Children and Families (ACF)		
	Head Start	$ 90.0
	Social Services Block Grant	$ 550.0
	Temporary Assistance for Needy Families -- Emergency Loan	$ 68.8
	Temporary Assistance for Needy Families -- Contingency Fund	$ 48.4
ACF Total		$ 757.2
Centers for Medicare & Medicaid Services (CMS)		
	Additional Federal payments for medical and child health assistance for Hurricane Katrina Relief	$ 2,000.0
	Funding for Katrina & Rita victim aid, provided through FEMA IAA to CMS (for emergency hospital & State uncompensated care costs)	$ 70.0
CMS Total		$ 2,070.0
Centers for Disease Control and Prevention (CDC)		
	Mosquito and other pest abatement activities	$ 8.0
CDC Total		$ 8.0
Health Resources and Services Agency (HRSA)		
	Health Centers - Emergency Communications Network	$ 4.0
HRSA Total		$ 4.0
	HHS TOTAL	$ 2,839.2

Conclusion

Since the March 13, 2007 hearing before this Subcommittee, HHS has made $195 million in supplemental grant funding available for healthcare rebuilding and provider stabilization efforts in the Gulf Coast Region. Secretary Leavitt has made a personal investment of focus and energy in rebuilding the Louisiana healthcare systems, supported by continuous technical expertise offered by CMS and senior officials throughout HHS. The department will continue to make that expertise available to the State, as we work together toward the goal of a highly functioning, sustainable healthcare infrastructure for Greater New Orleans, which is capable of providing quality care, in the right setting, when needed.

Thank you, and I would be happy to answer any questions you might have.

Mr. STUPAK. Thank you. Mr. Neary, please, for an opening statement.

TESTIMONY OF ROBERT L. NEARY, EXECUTIVE-IN-CHARGE, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. NEARY. Good morning, Mr. Chairman, and members of the committee, thank you. I am pleased to appear before the committee today to discuss plans for the design and construction of a new VA medical center in New Orleans. In broad terms, the VA intends to construct a state of the art hospital in the New Orleans metropolitan area requiring approximately 1 million square feet to include 140 hospital beds, outpatient clinic capacity to receive 410,000 visits per year, a 60-bed nursing home, appropriate parking, and mitigation features to protect the medical center against natural and man-made threats. The VA presently has been appropriated $625 million of which $300 million has been authorized by the Congress, and we have requested the full authorization be enacted during this session.

In February 2006 the VA and LSU entered into a Memorandum of Understanding to establish a mutually beneficial relationship to foster discussions regarding the future of VA and LSU medical care. The MOU led first to the establishment of a Collaborative Opportunity Study Group in March 2006 and then a planning group in September 2006. Work of the study group completed in June concluded that there were potential cost savings associated with a joint medical complex. The planning group then began to further develop the degree to which VA and LSU should collaborate. The planning group's report is due in September 2007.

Subsequent to receiving that report, VA and the State will be positioned to make decisions on the extent of collaboration going forward in both programmatic and physical terms. We will then know specifically what will be built and by whom. In March the Department determined that a review of alternative sites would be undertaken. That search identified two viable sites meeting all of the requirements. Ochsner Health Systems proposed a site of about 50 acres approximately 4 miles from downtown New Orleans. Later it was determined that only 28 acres were available, however. The New Orleans Regional Planning Commission in conjunction with the city, State of Louisiana, and several parishes proposed acquiring approximately 34 acres downtown adjacent to the site of the proposed LSU medical campus.

My full statement contains a map outlining the site search and maps of the two sites. These two sites are currently under evaluation. Each site is rated according to established criteria, which includes such factors as proximity to affiliated medical schools, proximity to veteran population, access to highways and major streets, site characteristics including wetland and flood plain status and the existence of any environmental issues. In addition, VA has contracted to study the site from the perspective of suitability for construction and any characteristics which would impact the cost at each location. We are particularly interested in the potential for future flooding and what steps could be taken to mitigate against a repeat of the flooding of 2005.

The VA is also required under the National Environmental Policy Act to assess the environmental implications of locating the new facilities at each location. A consultant will complete the appropriate environmental studies in accordance with NEPA and the Comprehensive Environmental Response, Compensation and Liability Act. The construction of these facilities is a high priority for VA. This is a large and complicated project, however, that will take time to design and construct. Our plan would enable construction to begin in February 2009 with completion in July 2012. A graphic of a more detailed schedule is included in my full statement.

That concludes my oral statement. I would like to add that Congressman Melancon, in his opening remarks, asked that the VA commit to brief the committee on a monthly basis so I would say that we would be pleased to do that as long as that served the committee's purposes. Thank you very much.

[The prepared statement of Mr. Neary follows:]

STATEMENT OF
ROBERT L. NEARY, JR., DIRECTOR
SERVICE DELIVERY OFFICE
OFFICE OF CONSTRUCTION & FACILITIES MANAGEMENT
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE

AUGUST 1, 2007
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Mr. Chairman and Members of the Committee

I am pleased to appear before the Committee today to discuss plans for the design and construction of a new VA Medical Center in New Orleans, LA.

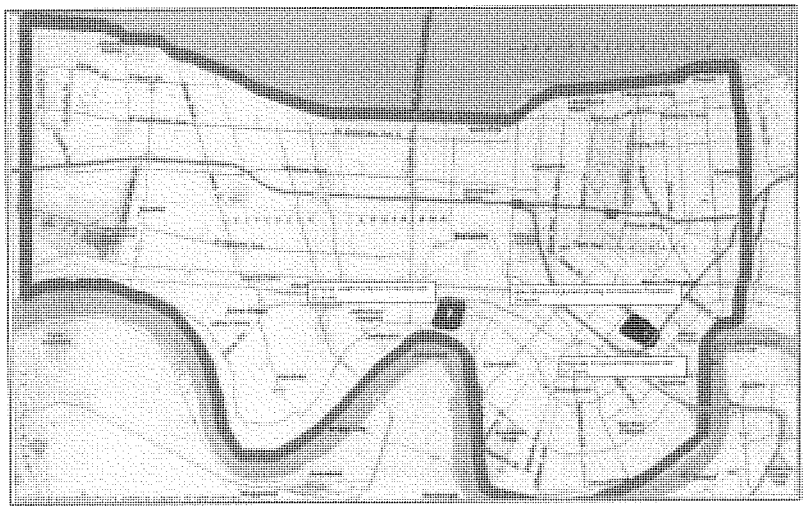
In broad terms, the VA intends to construct a hospital in the New Orleans metropolitan area which we estimate will require approximately 1 million gross square feet to include 140 hospital beds, outpatient clinic capacity to receive 410,000 visits per year, a 60 bed nursing home and a mix of structured and surface parking will be constructed to meet the needs of patients, employees and visitors to the new medical center. This state of the art facility will incorporate mitigation features to protect the medical center against natural and man-made threats.

The Department presently has appropriated funds totaling $625 million of which $300 million has been authorized by the Congress. VA has requested full authorization be enacted this session of Congress.

In February 2006, VA and LSU entered into a Memorandum of Understanding (MOU) to establish a mutually beneficial relationship to foster discussions regarding the future of VA and LSU medical care delivery in the New Orleans, Louisiana area. The MOU led to the establishment of first a Collaborative Opportunities Study Group (COSG) in March 2006, and then a Collaborative Opportunities Planning Group (COPG) in September 2006. The purpose of the COSG was to jointly explore the advantages of collaboration. The work of the COSG was completed in June 2006 and concluded there were potential cost savings associated with a joint medical complex between VA and LSU. The COPG then began its work to further develop the degree to which VA and LSU should collaborate. The report of the COPG is due to be received by September 30, 2007. Subsequent to receiving that report, VA and the State will be positioned to make decisions on the extent of collaboration going forward in both programmatic and physical terms. We will then know what specifically will be built and by whom.

In March 2007, out of a concern that the originally planned location of VA and State facilities might not be workable, the Department determined that a review of alternative sites would be undertaken. An advertisement was placed in the major local newspaper from April 1 through April 8, 2007, and we alerted real estate firms of our interest. The advertisement indicated that VA was looking to

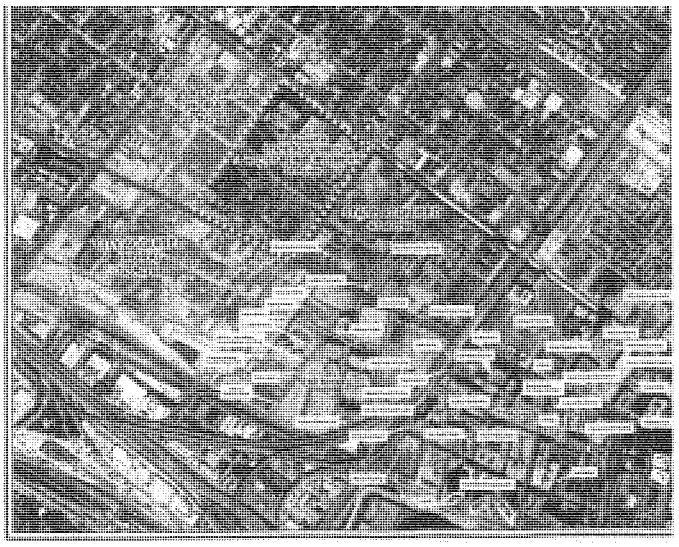
identify a suitable parcel of between 25 and 75 acres. Below is a map of the City which depicts the geographic boundaries of the area of our interest.



Those interested in proposing sites were asked to notify VA by April 30, 2007. The site search brought forth two viable sites which met all of the advertised requirements. Ochsner Health Systems proposed a site of about 50 acres across Jefferson Highway from the Main Campus of the Ochsner Hospital, about four miles from downtown New Orleans. Later, based on further discussions, it was determined that only 28 acres were available.

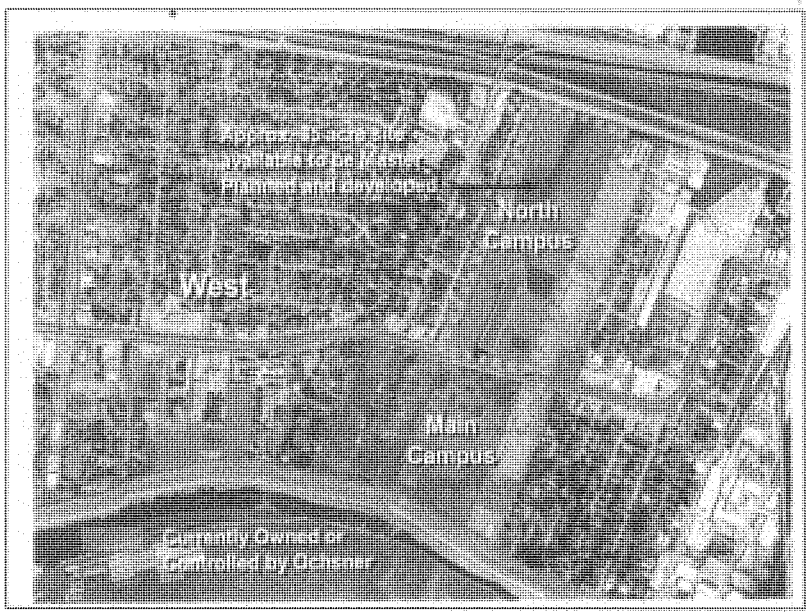
The New Orleans Regional Planning Commission in conjunction with the City, State of Louisiana and several Parishes proposed acquiring about 34 acres

downtown, adjacent to the site of the proposed Louisiana State University medical campus and near both LSU and Tulane University medical schools. The maps below locate these sites for the Committee.



Regional Planning Commission Site

The Regional Planning Commission Site is bounded by Canal Street, South Rocheblave Street, Tulane Avenue and Galvez Street. It is currently occupied by commercial and residential properties. The City and State have entered into an agreement that the State will acquire the properties and provide clear title to the Department if this site is chosen.



Ochsner Health System Site

The Ochsner site is owned by Ochsner and currently contains warehouse type facilities.

These two sites are currently under evaluation. As part of this evaluation, each site is rated according to pre-established source selection criteria. These criteria include:

- proximity to an affiliated medical school;
- types of surrounding land use;

- zoning compatible with medical facility uses;
- proximity to the veteran population;
- access to highways and major streets;
- access to public transportation;
- access to eating and shopping opportunities;
- multiple, safe access points from surrounding roads;
- the shape and topography of the site;
- availability of utilities;
- site characteristics, including wetland and flood plain status; and
- existence of known environmental issues.

In addition, VA has contracted with an architecture/engineering firm to study the sites from the perspectives of suitability for construction of these medical facilities and any characteristics which would impact the cost at each location. In this regard, we are particularly interested in the potential for future flooding and what steps could be taken to mitigate against a repeat of the flooding of 2005.

The Department is also required under the National Environmental Policy Act (NEPA) to assess the environmental implications of locating the new facilities at each location. A consultant will complete the appropriate environmental studies in accordance with NEPA and the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA).

The construction of these medical facilities is a high priority for VA and we are committed to this effort to enable VA to fully and effectively meet the health care needs of veterans into the future. This is a large and complicated project however, that will take time to design and construct. Below is a graphical depiction of our anticipated schedule. As indicated, with the completion of the COPG report in September, we will finalize the space and functional requirements in accordance with the decisions made by VA and the State and expect to be fully into the design process in January. This plan would enable construction to begin in February 2009 with completion in July 2012.

VA New Orleans, LA
Replacement Hospital

Task	Start	End	2007	2008	2009	2010	2011	2012
Environmental Analysis	7/18/07	12/1/07	7/18 12/1					
Site Selection	12/1/07	12/15/07	12/15					
Schematic Design	12/15/07	5/15/08	12/15 5/15					
Design Development	5/16/08	11/15/08		5/16 11/15				
Construction Documents	11/16/08	5/1/09		11/16 5/1				
Construction Procurement	5/1/09	7/31/09			5/1 7/31			
Construction	2/1/09	7/31/12			2/1			7/31

Thank you for the opportunity to appear today and I would be pleased to answer any questions the Committee may have.

- The state needs flexibility to use DSH payments for non-hospital and physician services to the uninsured, to ensure the sustainability of recovering primary care networks.

Mr. STUPAK. Thank you. Ms. Catellier, are you going to do an opening statement?

TESTIMONY OF JULIE CATELLIER, DIRECTOR, SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM

Ms. CATELLIER. Mr. Chairman, thank you for the opportunity to be here. We have made significant progress in the past 23 months in meeting veterans' health care needs. Three new clinics opened in Slidell, Hammond, and St. John Parish, for a total of six permanent outpatient facilities. Eighty percent of our patients drive 30 minutes or less to receive their primary and general mental health care, which are offered at every location. Patients requiring complex care are referred to other VAs or cares obtained within the community. Plans are progressing to lease space for specialty care and ambulatory surgery. The ability to perform in-house procedures and surgeries will significantly reduce our costs. This year we will spend nearly $25 million for purchased care compared to $2.4 million pre-Katrina, a 10-fold increase.

Laboratory services have been enhanced and currently are centralized in Baton Rouge. Pharmacy services exist at all our clinics and a $3.5 million project for a new pharmacy in New Orleans will be completed early next year. A diagnostic imaging center will open in New Orleans this fall providing the full range of radiology services. Dental care has been expanded to two locations, and currently there are no patients on the waiting list. In order to deliver patient focus, family-friendly care, we tripled staff in our community and home care program. This includes a unique hospital-at-home program where clinician teams visit patients in their home to both shorten hospital stays or to avoid the need for hospitalization altogether.

The home-based primary care program has grown from an average of 95 patients enrolled on any given day to 125, a 32 percent increase. This is one example of how VA is reinventing care to meet the specialized needs of veterans post-Katrina. We recently implemented a new program through an agreement with our affiliate which allows VA physicians to admit and manage the inpatient hospitalization of veterans at the Tulane University Hospital. Veterans responded favorably to this initiative because it allows them to remain near their families in their communities while being treated by their personal VA team. In the past month, 45 patients were admitted to this program. To the best of our knowledge, this hasn't been done elsewhere in the country.

Over half of our patients are diagnosed with a mental health disorder. Specialized mental health programs, including PTSD and substance abuse treatment are currently provided, and we are still acquiring additional space to expand those services. Psychiatric beds in metropolitan New Orleans are critically limited. Therefore, VA patients requiring inpatient care are most often transported by ambulance to VAs in Alexandria and Shreveport. This year we expect to admit 225 patients for acute psychiatric hospitalization. A significant challenge for our mental health programs is the loss of nine psychiatrists or 41 percent of our pre-Katrina strength as a result of relocation. Patients are grateful for the Government's response and are seeking care with us in record numbers.

We served over 30,000 veterans through June of this year. Of those, over 4,000 were new. On average, 1,000 outpatients are seen daily in our system. We project that by year end 35,000 will be treated. That is 90 percent of our pre-Katrina level. There are currently 76 physician residents compared to 120 pre-Katrina. To maintain the stability of our residency training programs and meet our obligation to educate America's physicians, we are working with our academic affiliates to place medical staff and residents at facilities throughout VISN 16 until our full clinical program's return. I would be remiss if I didn't address the issue of recruitment and retention of professional staff.

As a direct result of Hurricane Katrina, 57 physicians and 70 nurses left our employment. These losses and the subsequent challenges and recruiting positions have resulted in delays in some of our specialty clinics. Losses include 90 percent of our orthopedists, over 60 percent of our otolaryngologists, half of our ophthalmologists, neurosurgeons, and rheumatologists. Lucrative recruitment packages have been drafted in an attempt to attract qualified professionals. A recent offer for a physician to move to New Orleans required a salary at the top of the pay scale, 3 consecutive years of annual $30,000 recruitment incentives, and full moving expenses. The applicant declined.

Louisiana veterans have every right to receive high quality health care they deserve and have come to expect, and it is my job to deliver it. Thank you for allowing me this opportunity, and I look forward to answering your questions.

[The prepared statement of Ms. Catellier follows:]

STATEMENT OF
JULIE A. CATELLIER, DIRECTOR
SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE

AUGUST 1, 2007

Mr. Chairman, Committee Members, and Members of the Louisiana delegation, thank you for the continued support Congress has given the Department of Veterans Affairs (VA) in our rebuilding and recovery efforts in southeastern Louisiana. Today, I will report accomplishments and describe remaining challenges.

The Southeast Louisiana Veterans Health Care System (SLVHCS) has made significant progress in the past 23 months in meeting veterans' health care needs in the greater New Orleans area. With the support of Congress, VA accelerated the activation of Community Based Outpatient Clinics (CBOCs) in locations proposed under the Capital Asset Realignment for Enhanced Services (CARES) program. Three new CBOCs are now open in Slidell, Hammond, and St. John Parish, Louisiana, for a total of six permanent CBOCs. Primary care and general mental health services are offered at each of these locations. Eighty percent of our patients drive thirty minutes or less to receive their primary and general mental health care.

Plans are progressing to lease additional space for specialty care and ambulatory surgery and procedures. Patients requiring complex care are currently referred to other VISN 16 facilities or care is obtained within the community. The ability to perform in-house procedures and surgeries will significantly reduce current purchased care expenditures. This year SLVHCS will spend up to $25 million for purchased care outside the VA. This compares to $2.4 million pre-Katrina, a ten-fold increase.

Pathology and laboratory services were enhanced in the past year and are currently centralized in Baton Rouge. Pharmacy services exist at all our CBOCs and a $3.5M project to establish a new and enhanced pharmacy in New Orleans will be

completed in early 2008. A newly constructed Diagnostic Imaging Center will open on the New Orleans campus in Fall 2007, providing the full range of general radiology, CT and MRI capability. Dental services are provided at the Baton Rouge clinic and were expanded in April 2006 by leasing space in Mandeville, Louisiana. Currently no patients are waiting for dental care.

In keeping with national initiatives to provide patient care in the least restrictive environment, SLVHCS has tripled the number of staff in community and home-based care programs. This includes Home Based Primary Care (HBPC), telemedicine, contract community nursing homes and a unique "Hospital at Home" program whereby teams of clinicians visit patients at home to shorten hospital stays or, if possible, avoid the need for hospitalization. The HBPC program has grown from an average of 95 patients enrolled on any given day to 125 - a 32 percent increase. This is one example of how VA is reinventing care to meet the specialized needs of veterans post-Katrina.

In June 2007, VA implemented a new program through an agreement with its affiliate, Tulane University Hospital and Clinic to allow VA physicians to admit and manage care of veteran patients at Tulane hospital. Veterans responded favorably to this "virtual VA inpatient" program because it allows them to remain near their families and support systems while being treated by their own familiar team of VA physicians and social workers. In the past month, 45 patients were admitted. To the best of our knowledge, this has not been done elsewhere in the country.

Over half of SLVHCS patients are diagnosed with a mental health disorder. Specialized mental health programs (including PTSD and substance abuse treatment) are currently provided and we are acquiring additional space to significantly expand these services. Psychiatric beds in metropolitan New Orleans are critically limited; therefore, VA patients requiring inpatient mental health care are most often transported by ambulance to VA medical centers in Alexandria and Shreveport, Louisiana. This year we expect to admit 225 patients for acute psychiatric hospitalization. A significant challenge impacting our mental health programs is the loss of 9 psychiatrists, due to relocation, (41 percent of pre-Katrina levels) as a result of the storm.

VA is using adaptability and flexibility to meet the needs of veterans during the recovery period. Patients are grateful for the government's response and are seeking care within the SLVHCS in record numbers. SLVHCS has served over 30,000 veterans through June 2007. Of those served over 4,000 were new patients. On average, 1,000 outpatients are seen daily in the CBOCs. It is projected that by year end, 35,000 veterans will have been treated. This is 90 percent of the pre-Katrina level.

There are currently 76 physician residents compared to 120 before Hurricane Katrina. In order to maintain the stability of residency training programs and meet our obligation to educate America's physicians, VISN 16 is working with academic affiliates, Tulane University School of Medicine and Louisiana State University School of Medicine, to place VA faculty, medical staff and residents, and student trainees at VAMCs throughout VISN 16 until full and robust clinical programs return to the SLVHCS.

I would be remiss if I did not address the issue of recruitment and retention of professional staff. As a direct result of Hurricane Katrina, 57 physicians and 70 nurses left our employment. These losses and the subsequent challenges in recruiting physicians have resulted in delays in some of our specialty clinics. Losses include 90 percent of our orthopedists, over 60 percent of our otolaryngologists (ENT), half of our ophthalmologists, neurosurgeons, and rheumatologists. Lucrative recruitment packages have been drafted in an attempt to attract qualified professionals. A recent offer for a physician to move to New Orleans required a recruitment package that included the salary at the top of the pay scale and moving expenses. The applicant declined. This is an example of both the challenges in recruiting qualified health care providers and that money is not necessarily the biggest hurdle.

Conclusion

Mr. Chairman, the Committee and the Louisiana delegation are partners with VA in seeing that southeast Louisiana veterans continue to receive the high quality health care they deserve and have come to expect.

Your continued interest and support in our recovery efforts as we reestablish critical services is and will continue to be an important part of our commitment to uncompromised excellence in health care services for veterans in southeast Louisiana.

Thank you for the opportunity to be here today. I will be pleased to answer any questions you may have.

Mr. STUPAK. Mr. Williams, for your opening statement, please, sir.

TESTIMONY OF CLAYTON WILLIAMS, DIRECTOR, URBAN HEALTH INITIATIVES, LOUISIANA PUBLIC HEALTH INSTITUTE

Mr. WILLIAMS. Mr. Chairman and members of the subcommittee, thank you for this opportunity to provide an update on the stabilization and expansion of a coordinated system of primary care clinics in the greater New Orleans region, and thank you for all you have done thus far to support our rebuilding efforts. The Louisiana Public Health Institute or LPHI is a private, not-for-profit organization with a mission to promote and improve the health and quality of life in Louisiana through public-private partnering. As it relates to the recovery of the health care delivery system, our focus has been on working with health care providers with a mission or mandate to provide access to everyone regardless of their ability to pay primarily through its support of the partnership for access to health care or PATH, which I have directed for the past 6 years.

If all the components of the health care system were rebuilt as they were prior to Hurricane Katrina the people of greater New Orleans will likely be doomed to the same poor health outcomes that we have historically experienced, nearly the worst in the country. There is evidence that suggests we are even worse off than before the storm in some areas which makes the situation even more urgent. Therefore, now is the time to get it right and perhaps in so doing glean some lessons that will be of value for the rest of the country. Working closely with its partners, LPHI is striving to achieve a new health care system with a foundation of a network of public and private primary care clinics to facilitate access to the right care delivered in the right place at the right time to advance quality and reduce the cost of care.

We don't need to start from scratch towards this vision. In the four-parish region there are currently 27 fixed site primary care clinics of varying size and scope delivering discounted services to everyone regardless of their ability to pay. The heroic group of leaders that have managed to establish these critical community resources in Katrina's wake should be commended. Since January, 2006, these clinics provided for more than 120,000 patient visits. While they have accomplished a great deal after Katrina, they are still in need of much support as they expand to meet the growing needs. We estimate that 35 additional primary care physicians will be required to meet the needs of the uninsured in the four-parish region. Since the March 13 hearing, the Federal Government has done a remarkable job of addressing the need for primary care.

The announcement of the $100 million primary care access and stabilization grant on May 23 is evidence of the extraordinary work done by the subcommittee, HHS, including officials from CMS, HRSA, and SAMHSA to address this concern. We offer our sincere thanks to all in the Federal Government who made this happen. After responding to a public announcement, LPHI was chosen as the State's local partner in administering the grant, and I serve as the director of this program for LPHI. Since the announcement of the grant, LPHI, DHH, and HHS have worked steadily and tirelessly to put the pieces in place.

As a result, we anticipate that the first payments to stabilize these clinics will be awarded by September of this year. The principal goal is to demonstrate increased access to primary care, behavioral health care, and related services. This grant represents an opportunity to do much more than simply distribute funds to primary care clinics assuming we can work together to address the many other areas of need. As the State's local partner administering the grant, LPHI is committed to establishing robust administrative systems to insure Federal funds are spent appropriately, working to advance the goals of the grant in an inclusive and transparent way with all major stakeholders, maximizing opportunities to insure the grant program is designed as a bridge to a well-organized and sustainable system of care and providing technical assistance and incentives to advance quality and efficiency.

LPHI takes very seriously its role as steward of taxpayer dollars, and therefore we will request an opportunity to share our proposed fiscal controls for up front review by the HHS Inspector General. And we and our partners have several areas of need that will have to be addressedto insure our success in alleviating the health care issues that persist in the region. LPHI will require assistance in either gaining approval for use of grant dollars to establish necessary health information systems or in securing additional funding for this purpose. Robust, standardized, fully implemented and network information systems need to be in place in the participating primary care clinics if we are to be successful in achieving, measuring, and reporting results as required in the terms and conditions of the grant.

Despite this reality, health information systems are not allowable expenses under the grant terms and conditions. There are other opportunities to build mechanisms into the grant to help drive the development of a high quality, organized, and sustainable system of care. LPHI, DHH, and our partners will require continued flexibility from HHS as these program components are developed, so we can maximize the opportunities to build in incentives and performance requirements. Accessible and high quality primary care is an important part of a health system but good primary care must include linkages to timely diagnostic, specialty, and inpatient services, and there are several looming concerns in the health care system beyond primary care that I would like to express.

We strongly emphasize the importance of continued and enhanced attention to helping alleviate critical health care workforce shortages; No. 2. flexibility in establishing payment mechanisms for necessary specialty care providers; No. 3, insuring the viability of our community hospitals; and, No. 4, providing support for the development of a new academic medical center to serve the region. In conclusion, it has been an honor and a privilege for LPHI to participate in today's hearing. Thank you for your outstanding leadership and responsiveness, and for your continued support of our efforts to rebuild a healthier, greater New Orleans. I welcome your questions.

[The prepared statement of Mr. Williams follows:]

TESTIMONY OF CLAYTON WILLIAMS

Mr. Chairman and members of the subcommittee, thank you for this opportunity to provide an update on the stabilization and expansion of a coordinated system of primary care clinics in Greater New Orleans, and thank you for all you and the Congress have done thus far to support our rebuilding efforts.

I. LOUISIANA PUBLIC HEALTH INSTITUTE (LPHI) BACKGROUND

The Louisiana Public Health Institute was established in 1997 and is one of 25 Public Health Institutes nationally. LPHI is private not-for-profit organization with a mission to promote and improve the health and quality of life in Louisiana through public-private partnering at the community, parish and state levels.

LPHI maintains a population-level focus on health improvement, and recognizes the relative importance of addressing all determinants of health through its programming—from social, to environmental, to the influences that can be realized through the healthcare delivery system. LPHI places an emphasis on promoting equity and reducing racial and economic disparities in health outcomes.

As it relates to the recovery of the healthcare delivery system in Greater New Orleans, our focus has been on working with healthcare providers with a mission or mandate to provide access to everyone regardless of their ability to pay. For the past six years, LPHI has advanced its work in this area primarily through its support of the Partnership for Access to Healthcare (PATH), which includes most of the public and private healthcare providers in the region that have historically provided healthcare to people falling below 200 percent of the Federal Poverty Level.

Since the day after Katrina and the breaches in the levy system that caused catastrophic flooding throughout the region, LPHI has been very active in recovery. In partnership with governmental, non-profit and private sector stakeholders at all levels, LPHI has:

- Convened the Greater New Orleans Health Planning Group which created the first comprehensive framework for rebuilding the health system of the region (Framework for Rebuilding a Healthier Greater New Orleans);
- Created StayHealthyLA.org in partnership with the Louisiana Department of Health and Hospitals;
- Conducted operations for the Louisiana Health and Population Survey on behalf of the LA Department of Health and Hospitals and the LA Recovery Authority, the first household population survey of parishes most affected by hurricanes Katrina and Rita (with technical assistance from the U.S. Census Bureau and the US Centers for Disease Control and Prevention); and
- Following the immediate aftermath, supported the recovery of community-based healthcare services (PATH and the Health Services Recovery Council), school-based health centers (School Health Connection) and behavioral health services (Behavioral Health Action Network).

II. PRIMARY CARE RECOVERY AND EXPANSION IN THE GREATER NEW ORLEANS AREA

If all components of the health system were rebuilt as they were prior to Hurricane Katrina, the people of Greater New Orleans will likely be doomed to the same poor health outcomes that we have historically experienced—nearly the worst in the country. Therefore, we agree with all previous major consensus planning efforts that NOW is the time to get it right, and perhaps in so doing glean some lessons that will be of value to the rest of the country. It is not too late to achieve this if we stay aligned at the local, state and Federal levels in our pursuit of healthcare equity, quality and efficiency for the people of Greater New Orleans.

LPHI holds a fundamental belief in a healthcare system with a foundation of a public/private network of neighborhood-based primary care clinics to facilitate access to the right care, delivered in the right place at the right time to advance quality and reduce the cost of care at all levels. These neighborhood clinics should be portals to diagnostic, specialty, and acute care, and be linked to other supportive services through a coordinated system, and be under-girded by robust information systems. Advancing this vision is central to our approach to rebuilding.

The Greater New Orleans region does not need to start from scratch to advance towards this vision. In the four-parish region, there are currently 27 fixed-site primary care clinics, of varying size and scope, delivering discounted services to everyone, regardless of their ability to pay. Most have been participants in the collaborative efforts of PATH's Regional Ambulatory Planning Committee which is staffed and supported by LPHI. These clinics include federally Qualified Health Centers, school-based health centers, hospital-based clinics of the Medical Center of Louisi-

ana, university sponsored primary care clinics, private not-for-profit health centers, and faith-based organizations.

The heroic group of leaders that have managed to establish these critical community resources in Katrina's wake should be commended. Since January 2006, these clinics provided for more than 120,000 patient visits.—In addition to primary healthcare, they provide preventive health services, obstetrics and gynecology, behavioral health, and some specialty care. While they have accomplished a great deal since Katrina, they are still in need of much support as they expand to meet the growing needs of the people of the region. We estimate that 35 additional primary care physicians will be required to meet the needs of the uninsured in the four-parish Greater New Orleans area.

III. LPHI'S ADMINISTRATION OF THE PRIMARY CARE ACCESS AND STABILIZATION GRANT

The March 13, 2007 testimony to this Subcommittee from stakeholders at all levels emphasized the need for resources to support primary care for the people of Greater New Orleans, with an emphasis on the low-income un- and under-insured. Since those hearings, the Federal Government has done a remarkable job of addressing short-term stabilization needs and continuing efforts to expand existing primary care clinics. On May 24, the Secretary of the Louisiana Department of Health and Hospitals (DHH), Dr. Cerise, received a letter from the Acting Administrator of the US Center for Medicare and Medicaid Services (CMS), the Honorable Leslie Norwalk, announcing the availability of $100 million to stabilize and expand primary care clinics and behavioral health services. The announcement of the Primary Care Access and Stabilization Grant availability is evidence of the extraordinary work done by the Congress, this Subcommittee, and the Department of Health and Human Services, including officials from CMS, Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration to address this concern of the people of Greater New Orleans. We in Greater New Orleans would like to offer our sincere thanks to all in the Federal Government who made this happen.

By responding to a public announcement, the Louisiana Public Health Institute was chosen as the State's local partner in administering the grant, and I serve as the director of this program for LPHI. Since the announcement, LPHI, DHH and HHS have worked steadily to put the pieces in place, and we have reached the following critical milestones:

- LPHI was chosen as the state's local partner in administering the grant.
- An application to CMS was completed and submitted by DHH with assistance from LPHI.
- The Cooperative Endeavor Agreement between LPHI and DHH has been fully executed.
- HHS issued the official Notice of Award on July 23, 2007.
- The eligibility screening process and methodology for determining initial base payments to clinics has been finalized.
- LPHI released the Request for Applications to participate in the grant on July 27th, and a public meeting to address questions about the grant program and application process is scheduled for August 3, 2007.

In the midst of the State's Legislative Session, the DHH staff worked tirelessly with LPHI to put critical elements in place to ensure timely distribution of funds to stabilize the primary care providers of the region. It is anticipated that the initial base payments to clinics will be announced by September of this year.

The principal goals of the Primary Care Access and Stabilization Grant are to demonstrate increased access to primary care, behavioral health care, and other related services; and to ensure greater numbers of low income un- and under-insured individuals are being served in Orleans, Jefferson, St. Bernard and Plaquemines parishes.

In its role as the State's local partner in administering the Primary Care Access and Stabilization Grant, LPHI has committed to: Establish robust administrative systems and controls to ensure the Federal funds are spent appropriately by all subrecipients to achieve the goals of the grant;

- Work to advance the goals of the grant in an inclusive and transparent way with all major stakeholders;
- Pursue complementary resources to maximize the impact of Federal grant funds towards improving the health of the people of Greater New Orleans as they return;

• Maximize opportunities to ensure the grant program is designed as a bridge to a well-organized and sustainable system of care for the people of Greater New Orleans;

• Provide technical assistance and incentives to advance quality and efficiency among participating sub-awardees; and

• Regularly convene forums among sub-recipients for region-wide health planning and coordination.

This grant represents an opportunity to do much more than simply distribute funds to primary care clinics. Working closely with the healthcare providers in the region and DHH, we are committed to building in mechanisms that will help create an organized system of care that continue to serve the people of the region well beyond the three year grant period (granted, many other areas of concern for the healthcare system must be successfully addressed concurrently if we are to be successful).

With this in mind, LPHI intends to use a portion of its administrative budget and other complementary resources to establish a Scientific Advisory Committee made up of local and national experts to anchor this program in best practices as the program is designed and implemented. In addition, we will continue to convene a stakeholder group to provide a mechanism for input on critical program decision-making, allow for regular communication among sub-grantees, and provide a forum for data-driven planning as sub-grantees grow primary care capacity in the region.

LPHI takes very seriously its role as steward of taxpayer dollars. Therefore, we will request an opportunity to share our proposed fiscal controls and program integrity plans for up-front review by the Department of Health and Human Service's Inspector General. As a responsible public health agency, we believe a pinch of prevention is worth a pound of cure in administration as well as healthcare delivery.

IV. Moving Forward

We have several areas of need that will need to be addressed to ensure our region's success in alleviating the healthcare issues that persist in the region:

We will require assistance in either gaining approval for use of grant dollars to establish necessary health information systems, and/or in securing additional funding for this purpose. Robust, standardized, fully implemented and networked information systems need to be in place in the participating primary care clinics if we are to be successful in achieving, measuring and reporting results as required in the terms and conditions of the grant. Despite this reality, health information systems are not an allowable expense under the grant terms and conditions.

There are at least two more opportunities to build mechanisms into the Primary Care Access and Stabilization Ggrant to help drive the development of a high quality, organized, and sustainable system of care for the uninsured in the region. One is the development of the sub-contracts between LPHI and the participating clinic sub-awardees, and the other is the design of the methodology for making supplemental payments to them. LPHI and DHH will require flexibility from HHS as these program components are developed so we can maximize the opportunities to build in incentives and performance requirements that will help us improve access to sustainable high quality and comprehensive primary care.

Accessible and high quality primary care is an important part of a high performing health system, but good primary care must include linkages to timely diagnostic, specialty and inpatient services. There are several looming concerns in the healthcare system beyond primary care that I would like to express. We strongly emphasize the importance of: 1) continued and enhanced attention to helping Greater New Orleans alleviate critical healthcare workforce shortages; 2) flexibility in establishing payment mechanisms for necessary specialty care providers; 3) ensuring the viability of our community hospitals; and 4) providing support for the development of a new academic medical center to serve the region.

It has been an honor and privilege for LPHI to participate in today's hearing. Thank you for your outstanding leadership and responsiveness in the months since the March hearings, and for your continued support of our efforts to rebuild a healthier Greater New Orleans. I welcome your questions.

Mr. Stupak. Thank you. Ms. Boyle, your opening statement, please.

TESTIMONY OF KIM M. BOYLE, CHAIRMAN, HEALTH CARE COMMITTEE, LOUISIANA RECOVERY AUTHORITY

Ms. BOYLE. Chairman Stupak, Ranking Member Whitfield, members of the subcommittee, at this critical time in the rebuilding of the great city of New Orleans, it is an honor and privilege for me to testify this morning as a volunteer member of the Board of Directors of the Louisiana Recovery Authority as Chair of the LRA's health care committee, but also as a life-long resident of New Orleans. Thank you for the opportunity to bring to your attention the most pressing issues to address as we all work with your critical assistance to rebuild a sustainable health care system in the New Orleans region. Consistent with Congressman Melancon's inquiries, I cannot stress enough the monumental importance of the planned joint Medical Center of Louisiana in New Orleans and the Veterans Affairs medical center in downtown New Orleans to the sustainability of our health care system to the delivery of quality health care services to our citizens, and to the overall recovery, and more importantly rebuilding of our community.

Second, we continue to need your help to address the immediate barriers that continue to plague the comprehensive restoration of health care services in the New Orleans region. As all of you are aware, Katrina was by far the single most devastating disaster in American history and Rita ranks third on the all time list, 1,500 lives lost, 1.3 million American citizens displaced, 200,000 homes destroyed, and 64,000 people who remain in FEMA trailers. The storms and the failure of the Federal levee system caused an estimated $100 billion in damages to homes, property, businesses, and infrastructure in Louisiana alone. Federal investments in Louisiana's recovery have been generous and crucial, and I would like to personally thank all of you and the members of the subcommittee for your persistent and consistent support of Louisiana's recovery.

However, considerable needs remain unfunded. Federal commitments total $110 billion for recovery and rebuilding in five of the Gulf Coast States that were impacted by Katrina, Rita, and Wilma. Out of this $110 billion a little over $60 billion was committed to Louisiana but half of that was used to fund immediate disaster relief services and insurance payments to policy holders under the National Flood Insurance Program. $26.4 billion is available to Louisiana for rebuilding critical services and infrastructure. Unfortunately, that is far short of our needs in such an unprecedented catastrophe. Therefore, I am here today to address what we can and should do to get the New Orleans region's health care system on its feet. I do not believe that anyone can dispute that the health care system's speedy, comprehensive, and sustainable recovery is of paramount importance to the future of the city and to south Louisiana itself. Uncertainty and blunt concerns about health care access has slowed our recovery, as well as rebuilding an undermined public confidence about the ability to return home.

Business owners will not bring investments and employees to a city without available health care services. The citizens will not bring their children, elderly parents and family back absent available health services. As all of you are aware, the LRA's mandate from the beginning is building a stronger, safer, and better Louisiana, and the plans for a joint MCLNO as well as be a medical cen-

ter in downtown New Orleans is a recovery project without peer and is without question the best option for the people of our city and the surrounding region. Congresswoman Blackburn referred to an agreement to move forward. The joint medical centers are integral to three critical elements of community recovery and the benefits of their co-location are innumerable.

First, to address Congressman Melancon, the joint facilities will serve as critical providers of high quality, primary and specialty health care, and the MCLNO will also offer the region's only level 1 trauma center, and will be home to inpatient psychiatric care that is accessible by veterans. As a member of the LRA and as a resident of New Orleans where I grew up and I continue to live today, I am very concerned that not relocating the VA to downtown New Orleans will negatively impact the citizens of our region including our veterans, who do not have the means to travel to other areas for treatment.

I am also concerned that relocating the VA could be destructive to the quality of care and diversity of treatments available at each institution by eliminating the sharing of LSU, Tulane, and VA physicians that were so prevalent before Katrina. The Louisiana American Legion specifically recognized veterans who have been the beneficiaries of the close proximity and the walking distance between the MCLNO and the VA downtown, as well as beneficiaries of their joint medical research and teaching. The facility, second, will anchor the region's medical education including the LSU and Tulane medical schools, graduate medical education, which many of you have addressed, and research programs dependent on shared clinical space in MCLNO and the VA.

Relocation of the VA would have a devastating impact on medical education and research as well as the economy of the city of New Orleans. Third, consistent with our philosophy of rebuilding better and stronger the long-term economic revival and diversity of the New Orleans region is dependent upon the MCLNO and VA facilities serving as the clinical cornerstone of the emerging downtown biomedical district. This will stabilize this area. The plans include the development of a 60,000 square foot biomedical research incubator and an $86 million Louisiana cancer research center, which is a collaboration between LSU, Tulane, and Xavier, which will be located adjacent to the new joint hospitals.

Now let me paint a different picture. The failure of the VA to return as a partner in the downtown biomedical district could condemn a viable economic engine to an embarrassing urban blight of abandoned empty buildings and have a devastating impact on our economy. Losing the VA medical center as a cornerstone of the biomedical district downtown will leave central New Orleans with a dark future. For all the reasons I have listed, what matters is that the pertinent leadership, a broad range of stakeholders, and the citizenry at large agree on what is best. Governor Blanco and the legislature have made good on their commitment to this project and a diverse set of community leaders have joined these State officials in strong vocal support for this project which include the American Legion, the Secretary of the Louisiana Department of Veterans Affairs, the New Orleans Regional Planning Commission,

as well as the mayor, the Council, the Chamber, and many, many other groups.

The citizens of New Orleans have also independently identified the joint medical centers as critical to recovery and have prioritized this initiative in the UNOP Plan, Unified New Orleans Plan, the Louisiana Speaks Regional Plan. Finally, I cannot emphasize enough what damage would be inflicted on the progress of community recovery and the public psyche and confidence if this partnership falls through. Our citizens are focused on rebuilding, not building back what was there before these devastating hurricanes, but rebuilding stronger, safer, and better to benefit the community. It is clear that rebuilding the VA medical center downtown would have the best and most positive impact on community recovery and public confidence in the future of this great city and state. Mr. Chairman and members of this committee, thank you for your time and attention today. I look forward to working with you as we advance the resurrection and rebirth of one of America's treasured regions. Thank you.

[The prepared statement of Ms. Boyle follows:]

WRITTEN TESTIMONY OF KIM M. BOYLE,

CHAIR

OF THE

LOUISIANA RECOVERY AUTHORITY

HEALTH CARE COMMITTEE

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

AUGUST 1, 2007

Chairman Stupak, Ranking Member Whitfield, Members of the Subcommittee, thank you for inviting me to testify today. My name is Kim Boyle and it has been my honor and privilege to serve as a volunteer member of the Board of Directors of the Louisiana Recovery Authority (LRA) and as chair of the LRA Health Care Committee.

Since its creation by Governor Kathleen Blanco in October 2005, the LRA has focused on developing policies and strategies for recovery, securing public and private resources, leading long-term regional and community planning initiatives, and providing transparency and oversight on the expenditure of recovery dollars, including federal Community Development Block Grant and Social Services Block Grant funds. We do not run any programs at the LRA; our job is to recommend expenditure allocations to the Governor and the Louisiana Legislature and to set broad policy guidelines for the programs they approve.

I am speaking to you today as a life-long resident of New Orleans and as a representative of the LRA. I thank you for the opportunity to bring your attention to the most pressing issues to address as we all work to build a sustainable health care system in the New Orleans region:

- First, I want to make clear the monumental importance of the planned joint Medical Center of Louisiana (MCLNO) and Veterans Affairs (VA) medical center in downtown New Orleans to the sustainability of our health care system, and to community recovery overall;
- Second, we need your help to address the immediate barriers that continue to plague the comprehensive restoration of health care services in the New Orleans region.

Before I begin, I want to express our sincere gratitude to Congress and the American people for their extreme generosity after the storms of 2005. I would like to personally thank you and the members of your subcommittee for your persistent support of Louisiana's recovery, especially the members and staff of the subcommittee who have traveled to Louisiana to witness the scale and magnitude of this catastrophe first hand.

Hurricane Katrina was by far the single most devastating and expensive disaster in American history. The storm that hit Louisiana three weeks later—Hurricane Rita—ranks third on the all-time list. Together, the storms—and the failure of the federal levee system which flooded an area nine times the size of Washington, DC—caused an estimated $100 billion in damages to homes, property, businesses and infrastructure *in Louisiana alone*. Katrina and Rita claimed the lives of nearly 1,500 Louisiana citizens, initially displaced more than 1.3 million more, and

destroyed more than 200,000 of their homes. More than 64,000 Louisiana families continue to reside in FEMA transitional housing.

Federal investments in Louisiana's recovery have been generous and crucial, but they regrettably leave considerable needs unfunded. Let me explain why. About $40 billion of the $100 billion losses are covered by private hazard and flood insurance. We also recognize and are sincerely thankful for the estimated $26 billion that has been allocated to the State to help us rebuild our homes and physical infrastructure. Nevertheless, there is a huge and obvious $34 billion gap in funding that is absolutely necessary to rebuild south Louisiana.

Some have asked how this is possible, given the federal commitments to the Gulf Coast that tally nearly $110 billion for disaster relief and recovery. Understand that this was spread out over five of the Gulf States, in response to the three major storms that devastated the Gulf Coast in 2005.[1]

While not all of this has been obligated, we estimate just over $60 billion in federal recovery funds have been committed to Louisiana. Of the $60 billion that has been committed to Louisiana, more than half of this was used to fund immediate disaster relief services such as FEMA individual assistance to victims, SBA loans and grants, and insurance payments made to policyholders who have paid premiums into the National Flood Insurance Program for the duration of their residency.

[1] This includes Alabama, Florida, Louisiana, Mississippi and Texas which were impacted by hurricanes Katrina, Rita and/ or Wilma.

This leaves approximately $26.4 billion that is available to Louisiana for rebuilding critical services and infrastructure, far short of our needs in such an unprecedented catastrophe.

Compounding the problems created by the insufficiency of federal assistance, much of the federal aid has unfortunately been delayed in coming and not equitably divided among states.

This has been the case from the very first rebuilding assistance legislation passed by the 109th Congress, which unfairly capped Louisiana's allocation at 54% of the total CDBG appropriation. Congress essentially passed a law forbidding HUD from allocating resources equitably based on damages, and the same disproportions have persisted in other federal recovery assistance. The inequities are obvious: Louisiana suffered 77% of all housing damage from the 2005 storms—Katrina, Rita, and Wilma. Compared to Mississippi, Louisiana had four times the housing damage, seven times more citizens displaced, seven times more university students displaced, five times more damage to electric utilities, three times the number of K- 12 schools destroyed, five times the number of hospitals destroyed, nearly ten times the number of businesses lost, and five times the decrease in employment. And the vast majority of our damage was caused by the catastrophic failure of federal levees that had been built and certified as being adequate to protect us by the Army Corps of Engineers.

The damage to the state's health care system was equally severe, and the story is not different when it comes to the pace and balance of federal funding for restoring essential health care services.

In Louisiana alone, Hurricanes Katrina and Rita initially closed thirty hospitals; the doors to seven hospitals remain shut, including five in New Orleans. A recent study reported in the American Medical Association's journal *Disaster Medicine and Public Health Preparedness* finds that about one-fourth of the physicians who left the Gulf Coast after Katrina had not returned six months later. The most concentrated disruption of the health care system occurred in the Greater New Orleans region, and the disruption continues today.

To be sure, the health care system's speedy, comprehensive, sustainable recovery is critical to the future of the city and all of South Louisiana. Uncertainty about health care access has slowed the recovery, undermining public confidence about returning home. Business owners will not bring investments and employees to a city without available health care services.

The question today is what we can and should cumulatively do to get the full continuum of care back on its feet.

I want to first address an issue that I am very passionate about—plans for a joint Medical Center of Louisiana – New Orleans (MCLNO) and Department of Veterans Affairs (VA) medical center. Let me be very clear—the joint venture between the state and the VA represents a recovery project that has no peer. Building the VA hospital in downtown New Orleans is *the best option* for the people of our city and surrounding region. Let me tell you why.

The joint medical centers are necessary to serve as the home to three critical elements of community recovery, and the benefits of their co-location are innumerable. First, and most

importantly, the joint facilities will serve as a critical provider of high-quality primary and specialty health care. MCLNO will also offer the region's only Level 1 trauma center, and will be home to inpatient psychiatric care accessible by veterans.

Accessibility is no small matter in weighing the options for placement of the VA hospital. Many of the region's residents and veterans depend on public transportation to reach medical services. As a member of the LRA and as a New Orleans resident, where I grew up and continue to live, I am very concerned that relocating the VA to another parish would negatively impact many residents, including veterans, who do not have the means to travel to other areas for treatment. The consolidation of the complete array of medical services in a centrally located area will enable access by residents of diverse means to services uniquely provided by the downtown medical centers. I am also concerned that relocating the VA could be destructive to the quality of care and diversity of treatments available at each institution by eliminating the sharing of LSU, Tulane and VA physicians that was so prevalent before Katrina.

Second, the medical centers will anchor the region's health professions education, including the LSU and Tulane medical schools and graduate medical education programs dependent on shared clinical space in MCLNO and the VA. Also benefiting from the collection of training assets in the downtown biomedical corridor will be the region's allied health and nursing training programs, which will be vital to addressing the workforce shortages that are proving to be the leading barrier to the recovery and improvement of health care delivery across Louisiana. Again, should the VA choose to relocate, the impact on medical education and the city would be

devastating, undermining the clinical capacity downtown and potentially driving the medical schools or GME programs away for good.

Third, the long-term economic diversity of the New Orleans region will greatly benefit from the MCLNO and VA facilities serving as the clinical cornerstone of the emerging downtown biomedical district. Legislatively created, the biomedical corridor will be the target of increasing public and private investment generating high-quality jobs in medical services and health sciences research and development. The Regional Planning Commission is currently overseeing a long-term land-use management plan for the district, and the state's commitment to enhancing the initiative already includes the development of a 60,000 square foot biomedical research incubator and an $86 million Louisiana Cancer Research Center. The cancer center will be located adjacent to the new proposed joint hospitals and will serve as the platform for pursuit of National Cancer Institute designation through coordinated cancer research and treatment programs that will serve all of the region's patients, including veterans. In short, the health sciences have a great future in downtown New Orleans, and veterans stand to benefit greatly from the activity.

Furthermore, as a recovery authority, we have spent considerable time evaluating the important factors that will make Louisiana a smarter and stronger place to live. Lesson number one that we have learned in working to improve on the economic and social fabric of a landscape destroyed in the 2005 storms is that you must replace what was there before as a platform for expansion. In short, the biomedical corridor cannot afford to lose the VA as a cornerstone of other pending investments or that area of downtown will be worse off than it was before Katrina and Rita.

I also want to address two criticisms that have been frequently leveled against the downtown site for the medical centers.

First, many have questioned the wisdom of building a new hospital in an area that sustained heavy flooding when the federal levees broke. My response is simple—it is no secret that the Greater New Orleans region, which includes Jefferson Parish, is at risk of flooding in the right kind of disaster, absent appropriate levee and coastal restoration protection. As the Army Corps of Engineers reminds us locally, we have the ability and the technology to mitigate that risk in a cost-effective and reasonable way. LSU, Tulane and VA officials can tell you in great detail that their ongoing planning efforts have taken future risk into account, placing all essential services out of harm's way, allowing for continual patient care and swift clean-up should, God forbid, our city ever be subjected to another nightmare like Katrina.

Second, some assert that building on the downtown site will unnecessarily delay the opening of the new VA medical center because the land is not yet owned free and clear by the state. From the information I've been given by the VA about the hospital design process, I do not believe this assertion holds true. The VA has said in prior Congressional testimony that the design process for any site it selects will likely run 18 months before groundbreaking can take place. State officials have already initiated land acquisition for the targeted downtown site using state general funds and have assured me that the site will be ready for construction before the end of that design process. I am confident that there is no unique delay in the timeline for opening the VA hospital downtown.

For all of the reasons I have listed, support for building a new teaching hospital in downtown New Orleans in partnership with the VA is strong, deep, and diverse. On any project of this size and importance, it is an unrealistic, and frankly, an impossible goal to expect 100% concurrence about where it should be built. What matters is that the pertinent leadership and a broad range of stakeholders agree on what is best.

The LRA, Governor Blanco, and the Louisiana Legislature have been consistent in their cumulative support for building a new MCLNO with the VA downtown. For the LRA, that commitment was clear during our negotiations for funding with Federal Coordinator for Gulf Coast Recovery Donald Powell, when $300 million in CDBG funds was set aside for the new hospital. When the Department of Housing and Urban Development tied up in red tape the state's proposal to use that $300 million for the hospital, putting the state's partnership with the VA in jeopardy, Governor Blanco and the legislature immediately made good on the state commitment to the project by appropriating two sources of state funding for the land acquisition and construction of the joint facilities:

- $74.5 million in cash for immediate land purchase and facility design, and
- $226 million in additional borrowing authority when needed for construction.

Support for the MCLNO-VA partnership does not stop with policymakers in Baton Rouge. A diverse set of community leaders have vocally expressed support for the project, including:

- American Legion;
- Secretary of the Louisiana Department of Veterans Affairs;
- New Orleans Regional Planning Commission, which consists of the chief executives of Orleans, Jefferson, St. Bernard, Plaquemines and St. Tammany parishes, who unanimously passed a resolution endorsing the downtown site for the VA;
- New Orleans Downtown Development District;
- New Orleans Mayor C. Ray Nagin;
- New Orleans City Council;
- New Orleans Chamber of Commerce;
- Baptist Community Ministries, operators of clinics and hospitals throughout the region;

Last week, many of these stakeholders restated their support in a single co-signed letter to Secretary Nicholson, including Dr. Norman Francis, president of Xavier University and chairman of the LRA. I have attached that letter and several supporting documents from these stakeholders as exhibits to my testimony.

Support for the MCLNO-VA project does not stop with the pertinent state and community leadership; the citizens of South Louisiana have also independently identified the joint medical centers as critical to recovery, prioritizing the initiative in the two most prominent long-term planning initiatives organized by the LRA:

- The Unified New Orleans Plan is the city's comprehensive guide to high priority recovery programs and projects to repair and rebuild the city over the next decade.

Created and revised through several rounds of neighborhood-level public forums, the plan identifies 91 programs or projects that promote the city's recovery; the downtown medical center and the restoration of affordable housing stock are the only two given perfect scores based on their value to recovery and breadth of impact on the region.

- The Louisiana Speaks regional plan, built on a platform of unprecedented public input derived from community forums, modeling charrettes and public opinion surveys, provides the priority projects and guidelines for rebuilding South Louisiana in a safer, smarter, more sustainable way. Louisiana Speaks identifies the MCLNO-VA project as one of its top priorities for bringing both world-class medical care and diverse economic opportunity to the region.

I want to finally respectfully urge Secretary Nicholson and his staff to heed a lesson that has become clear to me through the course of my recovery work—when making the toughest decisions about recovery investments, do not rely strictly on dollars and cents. While there is no question that the MCLNO-VA partnership will generate multi-million dollar administrative efficiencies for both parties, I cannot emphasize enough what damage would be inflicted on the progress of community recovery and public confidence if the partnership falls through. The joint partnership in downtown New Orleans would be a win for the community and for all citizens, as reflected in the recent letter from the nineteen signatories to Secretary Nicholson. For the past two years, our citizens have been attempting to recover from Hurricanes Katrina and Rita and their impact on human life, business, property, churches, neighborhoods, and overall quality of life. Now, our citizens are focused on rebuilding - not building back what was there before these devastating hurricanes, but building something better that will benefit the community. Because

of the developing partnerships between the two Louisiana medical schools, the coming Cancer Research Center, and a biosciences research corridor, combined with the strong support of the Regional Planning Commission, the Downtown Development District, and the Louisiana Department of Veterans Affairs, it is clear that rebuilding the VA medical center downtown would have the best and most positive impact on community recovery and public confidence in the future of this great city and state.

So let me repeat what Governor Blanco and the Louisiana Legislature have stated by their actions: Louisiana is committed to the building of a new academic medical center in downtown New Orleans and to the MCLNO-VA partnership. As he enters the final weeks of his tenure at the helm of the Department of Veterans Affairs, Secretary Nicholson has a chance to add a bright star to his legacy by clearly recommitting that the new VA medical center will be built in downtown New Orleans in partnership with the new MCLNO.

Now I would like to shift your focus to our short-term future. I want to be clear that the development of those medical centers and the biomedical corridor downtown is *not* what will solve the region's immediate health care woes.

Mr. Chairman, we need your help to address those immediate woes because unfortunately, like other recovery funding, federal health care recovery funding for Louisiana has been slow and insufficient. The $2 billion delivered by the Deficit Reduction Act in February 2006 relieved states of one of the more pressing challenges they faced in the aftermath of Katrina—providing funding to displaced citizens who were relocated after the storms. The DRA funds and the

related Medicaid demonstration waiver showed a welcome recognition of the fact that the effects of natural disasters are not confined to physical destruction in a given geographic region. The resulting allocation of nearly $700 million to the Louisiana Medicaid program, combined with the allocation of an additional $120 million for uncompensated services delivered by private providers, promoted the continuity of health care services to the most vulnerable storm victims in the months following the storm.

Unfortunately, such unique initiatives did little more than pay for temporary services for storm victims, and they have proven to be insufficient to restore consistent health care access in the affected communities. Category IV of the DRA authorized Secretary Leavitt to freely allocate funds for the swift restoration of the health care system in storm-impacted areas, but those funds were delayed in coming, were inequitably distributed and have fallen short of our needs. The first distribution of category IV discretionary funds came in February 2007; of the provider stabilization grants announced in that distribution, Louisiana hospitals received only 44%, despite having sustained much more significant damage and care disruption in the aftermath of Katrina. With the most recent category IV distribution, Louisiana has received only 54% of the total DRA health care recovery appropriation. Recall that Katrina and Rita initially closed thirty hospitals statewide; Louisiana's health care system still has significant, immediate holes, and we need the help of this Congress to patch them.

First and foremost, consistent evidence indicates that the post-Katrina labor shortage is the root cause of the deficient capacity and mounting financial pressure that plague the region's health care system. The paucity of labor resources, from physicians to nurses to medical

technicians, makes it impossible to unravel the kinks that are choking the system. Understaffed nursing homes and home health agencies reduce patient discharge options, creating backups in hospital beds. Hospital beds physically prepared for patients sit open while their owners search for nursing staff. The backup extends into emergency rooms, where people are forced to seek care because of the general shortage of outpatient care caused by the labor shortage.

The labor shortage imposes fiscal strain on recovering providers by forcing them to compete globally for workforce. Providers across the region are bearing increased uncompensated care burdens because the restoration of services at LSU University Hospital has been delayed by insufficient staffing for beds that are prepared for patient care Without that traditional anchor of the region's safety net system, uninsured patients are left to seek care from other providers.

To be clear Mr. Chairman, I do not believe we can meaningfully improve health care access for patients of any payer source, nor improve the financial stability of recovering providers, without addressing this most essential component of health care supply.

Progress is being made through the recruitment and retention incentives provided by the Greater New Orleans Health Services Corps. The Corps provides:

- Income assistance for primary care physicians, dentists, psychiatrists, registered nurses and licensed professional staff;
- Malpractice premium relief for physicians and dentists; and

- Incentive payments for physicians, dentists, registered nurses and licensed professional staff.

Funded by $50 million in Category IV DRA funds, the program has thus far placed 125 primary care medical professionals in the New Orleans region, and more applications arrive each week. Unfortunately, the program started a year later than it should have—Louisiana began requesting Category IV funds in Spring 2006—and the available funding will fall well short of meeting the regional labor demand. The state has consistently requested $120 million for these types of recruitment and retention incentives; we still need your help to address the shortfall.

Just as a short-term infusion of health care professionals is imperative, the sustainability of the state's health care workforce in years to come will depend on the strength of graduate medical education programs. The medical schools and hospitals that continue to assist residency programs in the aftermath of Katrina and Rita need action by this Congress to gain financial relief through an extended exemption from the traditional three-year rolling average. If we let our medical training programs die on the vine because of financial troubles, our health care system will slowly die with them.

Promoting uniform access for returning citizens will also require concentrating on maintaining and expanding community-based primary care capacity. Last week CMS made a critical $100 million investment of DRA funds that will stand up important primary care services around the New Orleans region. In the recently completed 2007 legislative session, the state appropriated $41.5 million for construction of new community clinics throughout the state, many of which

will be concentrated in storm-affected areas. In order to ensure the sustainability of such services, the state needs your help in acquiring the flexibility to use DSH payments for non-hospital and physician services to the uninsured. This request will not cost the federal government another dime and will help to permanently make preventive medicine widely available to all patients, an essential step in fundamentally improving the way the state provides health care.

Mr. Chairman, members of the subcommittee, thank you for your time and attention today. I look forward to working with you as we advance the resurrection and rebirth of one of America's treasured regions.

Number 07-1002

RESOLUTION

REGIONAL PLANNING COMMISSION
Jefferson, Orleans, Plaquemines, St. Bernard and St. Tammany Parishes

Retention of the VA Hospital in Downtown New Orleans

Introduced by Aaron Broussard, seconded by Thomas Capella on the 13th day of March, 2007.

Whereas, the Regional Planning Commission functioning in its capacity as the regional planning council and economic development district for Southeast Louisiana supports the retention of the Veterans Affairs (VA) Hospital in downtown New Orleans; and,

Whereas, the creation of a knowledge-based economy is of paramount importance to the redevelopment of the New Orleans metropolitan region; and,

Whereas, the investment of the Veterans Affairs Hospital in downtown New Orleans is key to enhancing the research and clinical capacities of both downtown New Orleans and the region; and

Whereas the location of the VA Hospital must consider the economic benefits associated with locating adjacent to existing research hospitals and institutions of higher learning; and

Whereas, the investment of the VA Hospital is independent of the current health care delivery debate.

NOW, THEREFORE, BE IT RESOLVED THAT:

The Regional Planning Commission for Jefferson, Orleans, Plaquemines, St. Bernard and St. Tammany Parishes encourages all parties to work collaboratively to develop a state-of-the-art VA Hospital within the New Orleans Downtown Medical District.

Whereupon, after discussion, the question was called and resulted in the following:

AYES: 21 NAYS: 0 ABSTENTIONS: 0

HENRY J. RODRIGUEZ
CHAIRMAN

BILLY NUNGESSER
SECRTARY

201 St. Charles Ave.
Suite 3912
New Orleans
Louisiana
70170-3912
504-561-8927
504-581-1765 (fax)

March 28, 2007

Louisiana Delegation to the U.S. Congress
The Honorable William Jefferson
U.S. House of Representatives
2113 Rayburn House Office Building
Washington, DC 20515

Re: Veterans Administration Hospital, New Orleans

Dear Congressman Jefferson:

I am writing on behalf of the Downtown Development District of New Orleans Board of Commissioners to express our concern and request your help regarding the status of the rebuilding of the Veterans Administration Hospital and a state of the art LSU hospital in downtown New Orleans. As you well know, downtown New Orleans is the heart of the city as well as the economic engine. A critical part of that economic engine is the medical district which prior to Hurricane Katrina included the Tulane and LSU Medical Schools, Veterans Administration Hospital, University Hospital, and Charity Hospital and Tulane Hospital. Since the hurricane, the reopening and rebuilding of the Medical Center has been lethargic to say the least. Now we understand that the prospect of having the VA Hospital rebuilt in downtown New Orleans is threatened, which could be a devastating blow to downtown New Orleans and the entire metropolitan area, and could threaten the location of the LSU hospital downtown as well.

I have attached for your review a resolution adopted by the DDD Board of Commissioners stating the DDD's support for building new VA and LSU facilities in the downtown Medical District, in order to provide the most advanced health care available to the citizens of New Orleans and to anchor the budding bioscience initiative currently underway.

We write to ask for your guidance and assistance in moving this project forward. The Downtown Development District is ready, willing, and able to provide any assistance to the Veterans Administration that may be necessary. We solicit your input as to how we could best help. We also ask that you consider making contact with the appropriate persons at the Veterans Administration to help get the project back on track.

If the DDD can provide you any additional information, please do not hesitate to contact us.

I thank you in advance for your assistance with this very critical project.

With kind regards,

Sincerely,

Kurt M Weigle
Executive Director
Downtown Development District of
New Orleans

Encl.

cc: Judy Barrasso, DDD Chair
DDD Board of Commissioners
Mayor C. Ray Nagin
New Orleans City Council
Louisiana State Legislature -
Orleans Delegation

201 St. Charles Ave.
Suite 3912
New Orleans
Louisiana
70170-3912
504-561-8927
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Downtown Development District of New Orleans
Resolution to Support Construction of State-of-the-Art LSU Teaching Hospital and Veterans Administration Hospital
21 March 2007

Whereas, the creation of a knowledge-based economy is vitally important to the redevelopment of New Orleans; and

Whereas, the medical and bioscience industries hold special promise for developing a knowledge-based economy in New Orleans; and

Whereas, a concentration of higher education research and education is necessary to support a medical and bioscience industry; and

Whereas, in particular, the proximity of and cooperation between LSU, Tulane, Xavier and other institutions in the downtown medical district are crucial to New Orleans' success developing its medical and bioscience industries; and

Whereas, access to high quality health care is critical to the retention, expansion and attraction of businesses and a highly qualified workforce to New Orleans; and

Whereas, the training of physicians and other health care professionals who will practice in New Orleans after training is necessary to rebuild a quality health care system for New Orleans; and

Whereas, the LSU Health Science Center and the teaching hospitals associated with it produce a disproportionate number of health care professionals for New Orleans; and

Whereas, the LSU Health Science Center needs, on behalf of the citizens of New Orleans, a state-of-the-art teaching hospital to continue to train physicians and other health care professionals; and

Whereas, investment in a state-of-the-art public teaching hospital is independent of and should be considered separately from current Healthcare Redesign discussions;

Downtown
Development
District

Downtown Development District of New Orleans
Resolution to Support Construction of State-of-the-Art LSU Teaching Hospital and Veterans Administration Hospital
21 March 2007

Now, therefore, the Downtown Development District of New Orleans endorses the creation of, and sufficient capital funding for the construction of, a state-of-the-art LSU hospital in the New Orleans downtown medical district, and, additionally, in the interest of using public funds efficiently while providing for all the health care needs of New Orleans, supports the construction of a new Veterans Administration hospital in collaboration with and adjacent to the LSU teaching hospital.

Judy Barrasso, Chair, Board of Commissioners — Date: 3/28/07

Tracie Boutte, Secretary/Treasurer, Board of Commissioners — Date: 3/28/07

[redacted]

THE AMERICAN LEGION
Louisiana Department Headquarters
89th ANNUAL LOUISIANA DEPARTMENT CONVENTION
ALEXANDRIA, LOUISIANA
JUNE 8, 9, 10 2007

RESOLUTION IN SUPPORT OF THE BUILDING OF THE

NEW ORLEANS VA MEDICAL CENTER IN DOWNTOWN NEW ORLEANS

WHEREAS the U S Department of Veterans Affairs Medical Center at New Orleans, Louisiana, herein after referred to as "VAMC", has been located in the downtown area of the City of New Orleans at 1601 Perdido Street since its establishment; and,

WHEREAS the VAMC has served as a teaching hospital with the Medical Schools of Tulane University, herein after referred to as "Tulane", and Louisiana State University, herein after referred to as "LSU", since its establishment; and,

WHEREAS, as a result of the location of the VAMC in the downtown area of the City of New Orleans in close proximity and walking distance with the Tulane Hospital and Medical School and the LSU Medical School and Center, the veterans of the Greater New Orleans Area and Southeast Louisiana have been the beneficiaries of the close working and teaching relationship between the VAMC and the said Tulane Hospital and Medical School and the LSU Medical School and Center; and,

WHEREAS, the VAMC and the LSU Medical School and Center that operated out of the Louisiana Medical Center at New Orleans, commonly known as "Big Charity", were severely damaged in Hurricane Katrina and Rita in the late summer and fall of 2005; and,

WHEREAS, the VAMC and the Louisiana Medical Center at New Orleans have been deemed to be damaged to the extent that neither is fit to be reopened as a hospital, requiring that new facilities be built through appropriations from the United States and the State of Louisiana; and,

WHEREAS, the United States Congress has appropriated and authorized an expenditure for the building of a new VAMC facility in union with a separate facility for the replacement of the Medical Center of Louisiana at New Orleans, all in proximity to the Tulane Hospital and Medical Center, which new VAMC. facility would restore the medical treatment benefits that were available to the veterans of the Greater New Orleans Area and Southeast Louisiana and restore the ability of all three facilities to continue their joint medical research and teaching, which further benefits the veterans of the area; and,

WHEREAS, despite the continued promises by the Secretary of the Department of Veterans Affairs and his Staff, as well as promises by Members of Congress and Governor Kathleen B. Blanco and Members of her Administration to the veterans community and the people of Southeast Louisiana, rumors continue to persist that despite these promises the real intent and desire of the U S Department of Veterans, some Members of Congress and the Blanco Administration, is to move the VAMC out of the downtown area of the City of New Orleans, which will threaten or terminate its relationship with Tulane and LSU causing a shortage of health care professionals working in the VAMC., all to the determent of the veterans community;

American Legion do urge the Secretary of the Department of Veterans Affairs and the Governor of the State of Louisiana to proceed without further delay to take the necessary steps to build the joint VAMC facility and Medical Center of Louisiana at New Orleans in the downtown area of New Orleans in close proximity to the Tulane Medical Center and the Louisiana State University Medical Center. That such will restore the proper health care and benefits that the veterans of the Greater New Orleans Area and Southeast Louisiana are entitled to and enjoyed before the impact of Hurricanes Katrina and Rita.

BE IT FURTHER RESOLVED that copies of this resolution be sent to the Secretary of the U S Department of Veterans Affairs, the Governor of Louisiana, Members of the Louisiana Congressional Delegation, the Joint Congressional Committee on Veterans Affairs, the Department of Veterans Affairs for the State of Louisiana, the Chancellors of the Tulane Medical School and the LSU Medical School, and the news media outlets in the State of Louisiana.

_____
FORREST A. TRAVIRCA, III
Commander

ATTEST:

_____
DAVID SIMON, Adjutant

FOR CONVENTION USE ONLY

APPROVED_____

REFERRED TO CONVENTION COMMITTEE ON: RESOLUTIONS

PASSED UNANIMOUSLY: June 10, 2007.

MITCHELL J. LANDRIEU
LIEUTENANT GOVERNOR

State of Louisiana
OFFICE OF THE LIEUTENANT GOVERNOR

POST OFFICE BOX 44243
BATON ROUGE, 70804-4243

July 25, 2007

The Honorable Bart Stupak, Chairman
Subcommittee on Oversight and Investigation
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Stupak:

As the city of New Orleans persists on its long, difficult road to recovery, all levels of government-federal, state and local-must continue to fulfill its obligation to the people of this great city. I ask that we NEVER forget them as we progress in this rebuilding process.

Hurricane Katrina devastated so much of the city's infrastructure: so much that almost two years later, we are still without many necessary services that are vital to our most needy citizens.

Education and health care are the bedrocks of our civil infrastructure. They are what set our country apart from the rest of its peers. If New Orleans were used as a test case example to compare our country's education and health care systems to those of other industrialized nations, we would rank at the bottom.

The proposed LSU-VA Hospital in downtown New Orleans will provide:

* Essential Health Care Services, including emerging disease management programs and emergency care provided in the region's only Level 1 Trauma Center;
* Health Professions Education, vital to addressing the workforce shortages that are proving to be a leading barrier to the recovery of health care systems throughout Louisiana; and finally
* Biomedical Health Sciences Research and Development, an emerging research alliance and economic sector in the region driven by a partnership of LSU, Tulane and Xavier.

New Orleans needs investment in both of these critical areas, and this is why I am asking you to support the construction of a first-class academic medical center to foster a foundation for these critical services.

If my office can assist you in any way, please do not hesitate to contact me.

Sincerely,

Mitch

Mitchell J. Landrieu

MJL/mjk

C: The Honorable Charlie Melacon

PHONE (225) 342-7009 FAX (225) 342-1949
WWW.CRT.STATE.LA.US/LTGOV
"AN EQUAL OPPORTUNITY EMPLOYER"

MITCHELL J. LANDRIEU
LIEUTENANT GOVERNOR

State of Louisiana
OFFICE OF THE LIEUTENANT GOVERNOR

POST OFFICE BOX 44243
BATON ROUGE, 70804-4243

July 25, 2007

The Honorable Ed Whitfield, Ranking Member
Subcommittee on Oversight and Investigation
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Whitfield:

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Sincerely,

Mitch

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C: The Honorable Charlie Melacon

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Mr. STUPAK. Thank you. I want to recognize the delegate, Donna Christensen, who is with us. She is not a member of our committee but she has been an ardent supporter of rebuilding the Gulf Coast regions, especially in the area of health care. She is a member of the Democratic task force. We appreciate your interest and being here with us today. Gene Green was here. He had to leave. Again, we are going to be going back and forth because we are in SCHIP on the floor today. Right now we have two votes. It is probably going to take us about 15 minutes. Let us recess for 15 minutes. We will be back and then we will start with questions with this panel. Hopefully it is not a day where we are going to be bound around all day because of procedural votes on the floor and we can get to our questions. Fifteen-minute recess. Thank you.

[Recess.]

Mr. STUPAK. For questions, Mr. Melancon is going to start off, 5 minutes, and we will probably go more than one round. Go ahead.

Mr. MELANCON. Thank you, Mr. Chairman. Let me start, if I could, with Mr. Neary. If you would, the first thing I need to ask you, and there has been politics being played with this VA Charity mess and what is going on with the site location and all; I would like to ask you very honestly, have there been people from the Hill, senators or representatives, that have called and injected their opinions as to how the VA should be proceeding in any way, shape or form, to your knowledge?

Mr. NEARY. Mr. Melancon, there has been a significant interest from the Louisiana delegation, of course, urging the VA to proceed as rapidly as possible to reach a conclusion. And other members of our oversight committees, I think have in hearings and by letter, I think, have urged the VA to take action to move as swiftly as possible to replace the VA medical center.

Mr. MELANCON. Has there been any one specifically directing or trying to instruct you as to what to physically do with that facility?

Mr. NEARY. Not that I am aware. I am not aware of any specific effort to direct us what to do with the facility.

Mr. MELANCON. I would appreciate it if you would check with the people in your office and find out. I don't think that is necessarily and totally true, that no one has been interjecting. You outlined that the VA is currently evaluating two sites, one in downtown New Orleans and the other in East Jefferson. On pages 5 and 6 of your testimony you outline a number of criteria that would be used to evaluate those two sites. Nonetheless, how does the VA intend to measure the cost to the psyche of the city if you choose to abandon the downtown location and move to a different parish? Isn't there significant value that must be ascribed to the decision to locate downtown? Doesn't this send a positive message that the Federal Government is willing to commit to rebuilding in the city? Similarly, what is the cost associated with moving the hospital to Jefferson Parish? Aren't you really saying you don't have faith in the city, the levees, maybe the Corps of Engineers or their ability to rebuild if you make that decision? And how are you accounting for the costs associated with the message that such a choice would send to the community? And let me preface before you say that I had not really intended on injecting myself into this debate but the more I look at it, I think as Ms. Boyle states, it is a recipe for dis-

aster to start stripping the economic engines out of the heart of New Orleans.

I have a lot of respect for the people and the elected officials and such of Jefferson Parish. They were very fortunate in a comparative way than were Orleans, and I just don't think that we ought to be playing political politics with a facility as important as the VA hospital. If you could respond to my question, please.

Mr. NEARY. Certainly, Mr. Melancon, thank you for that question. I think the best way for me to respond is to say that I am certainly not an expert in urban development and what contribution or project in the downtown area might make, but I certainly respect the opinions of a number of people who are here today who express the view that this project is critical to be in the downtown area. We do not have a cost or a value at this point that we think would contribute negatively or positively to a decision to locate elsewhere other than the downtown site, but we certainly recognize the value as has been said by others here of our association with the medical schools, Tulane, Louisiana State University, and literally medical schools all over America where we have close affiliations. We understand that value to the VA and will not lose sight of that as we move forward.

Mr. MELANCON. I have a letter here to Mr. Nicholson from the Governor, the legislature, the mayor, university presidents, and on down the line in Louisiana stating what they want. That is why I am still questioning why we are still debating it. Ms. Boyle, do you have any comments on what is going on with it?

Ms. BOYLE. Thank you, Congressman. I guess my primary comment would have been to focus on the letter that you have. I think that is the July 27 letter that is signed by Governor Blanco, Mayor Nagin, members of the city council, but more importantly for purposes of what the relevant stakeholders actually want is the fact that the American Legion, in its June convention, unanimously passed a resolution saying that they wanted the downtown site because of the synergy between the VA hospital as well as LSU and Tulane being there, as well as the fact that Major General Hunt Downer, who is head of the Louisiana's Department of Veterans Affairs, has signed on to that letter as being critical.

So I think if you look at what the citizens of New Orleans want as reflected in the UNOP plan what members of the State citizenry wants as reflected in Louisiana Speaks but more importantly as what the elected leadership appoints leadership and people actually represent what veterans want, I think the downtown site makes the most sense from every shape, form or fashion economically, delivery of quality health care, and more importantly the synergies that exist between those two medical graduate education programs, the VA hospital, and then the upcoming Louisiana Cancer Research Center.

Mr. MELANCON. What message do you think would be sent by not putting the facility down there?

Ms. BOYLE. I think the message that will be sent to the citizens of New Orleans will be extremely damaging and devastating. The citizens believe that this is something that needs to happen. And I know you are aware of this fact, Congressman Melancon, but in the UNOP Plan, United New Orleans Plan, that was the No. 1 pri-

ority. That was the only thing that was unanimously agreed upon by the thousands of citizens who participated in that neighborhood planning process that we needed to have the VA in conjunction with Tulane and LSU downtown. And I think if the VA bluntly pulls out and moves to another parish, it will be extremely damaging to our public confidence in rebuilding the city to our psyche in rebuilding the city, and it will be very detrimental to the economic vitality of the city of New Orleans.

Mr. MELANCON. Mayor, I have let you sit quietly too long. What are your comments about this?

Mr. NAGIN. Congressman, it is obvious that this is a significant economic tool for the city of New Orleans, and for the reason if they were to leave and not come downtown, I think it has the potential to cause a domino effect that would threaten maybe LSU's need for a teaching hospital downtown, which could further threaten Tulane University's will to stay downtown. It could start a domino effect that could decimate our medical district. Just the construction costs of this facility alone are estimated to be at least $600 million.

And the combined LSU and VA hospital could create 20,000 jobs. If LSU and the VA leave, I think there are estimates that there are at least 4,000 to 5,000 related families that would move from the downtown area. It would be devastating, and it would be very counter to the President's pledge in Jackson Square that said he would do everything it took to rebuild the city of New Orleans.

Mr. MELANCON. Thank you. Mr. Neary, this letter that was addressed to the VA from all the players that are affected, or not all of them but the major players in Louisiana are saying this is what we want. There was, I understand it, at one point some question about a plan or putting up the money, the State has put up their money, so they put their money where their mouth is. How soon can we move to get this thing started and why do we need to keep studying?

Mr. NEARY. Sir, as I indicated in my statement, we are required by law to complete environmental due diligence. We are doing that now and——

Mr. MELANCON. If you were building a new facility, not replacing a facility.

Mr. NEARY. This facility that we are planning to build, whether we build it on the original 37 acres that LSU and the State had identified, whether we were to build it on the adjacent parcel that has been proposed or elsewhere, we are required to comply with those environmental laws and are in the process of doing that.

Mr. MELANCON. So how long before you are going to get that completed so you can break ground?

Mr. NEARY. That takes about 4 months to complete.

Mr. MELACON. So that will put us about January when you will be ready to break ground?

Mr. NEARY. Well, no, sir. The facility will require design. First of all, there needs to be an acquisition of the property.

Mr. MELANCON. I will take just an announcement in January then.

Mr. NEARY. I would hope that there can be an announcement before January personally.

Mr. MELANCON. That would be better. We look forward to an October hearing maybe. Thank you.

Mr. STUPAK. Mr. Whitfield, questions?

Mr. WHITFIELD. Thank you. Mayor Nagin, I know that you and Ms. Boyle both stress that the No. 1 priority that you would have is locating the VA hospital in downtown New Orleans. And we all certainly understand the sense of frustration that you have had as the mayor and other people have had working on this issue in New Orleans. But if you were asked to list two or three things in addition to locating a VA hospital in New Orleans that you think would be most beneficial and helpful to improving the health delivery system in New Orleans, what would those be?

Mr. NAGIN. To improving the health care delivery system?

Mr. WHITFIELD. Yes.

Mr. NAGIN. Besides the VA and the LSU complex, I am very concerned about our private hospitals, and their inability to get uncompensated care done on a timely basis and at a reasonable compensation level. That to me is threatening the entire system in a different way but it is equally as devastating because many of our private hospitals are funding this care on their balance sheets. The second area that I would also ask for assistance is if there was a national call out to physicians and experts in the medical field that could come down and provide the critical services and fill the gaps that we would need on a year or 2-year basis and if there was some type of program to accommodate that.

Mr. WHITFIELD. So when you say on a timely basis you are really referring to the fact that there are not enough physicians or health care workers there to actually see people today?

Mr. NAGIN. Yes, sir.

Mr. WHITFIELD. So there are not enough providers to meet the needs right now?

Mr. NAGIN. Yes, sir.

Mr. WHITFIELD. Now, Ms. Boyle, would you agree with the assessment, if I were to ask you to list two or three things that need to be done immediately to help improve the situation other than locating the VA hospital in New Orleans, what would you say?

Ms. BOYLE. Yes, Congressman Whitfield, I would agree with the mayor's assessment, and I guess I would phrase it as such. The labor shortage, I think, is extremely dramatic. I think Dr. Cerise spoke about that a little bit during his testimony, and I think on the second panel that will be discussed in more detail, but the labor shortage is really the root cause of the deficient capacity as well as the mounting financial pressure that plagues the region's health care system. And it is a problem on all levels. Many of our elderly people, and I have elderly parents who are back in the city with me, many of our elderly citizens are having a hard time accessing good quality health care, not through any fault of the hospitals that are providing care. I think they are doing a yeoman's job and they are going almost above and beyond the call of duty, but there is a very, very strong labor shortage.

The mayor talked about the UCC issue. There is also the issue of community-based primary care which Mr. Williams can address certainly in more detail than I can, but for many of our citizens, I think that is going to be critical to rebuilding because, as you

know, prior to the storm many of our citizens had to access emergency care through what is called the Charity, and we need to move away from that system into having the community-based primary care system and the graduate medical programs which obviously Dr. Miller and Dr. Hollier will talk about on the second panel.

Mr. WHITFIELD. Now how many community health centers are operating right now in New Orleans?

Ms. BOYLE. I am going to defer to Mr. Williams on that number, sir.

Mr. WILLIAMS. In the four-parish region there are 27 primary care facilities, and there are mobile units as well.

Mr. WHITFIELD. How many community health centers?

Mr. WILLIAMS. How many federally-qualified centers?

Mr. WHITFIELD. Yes.

Mr. WILLIAMS. I need to get back to you with that exact number.

Mr. WHITFIELD. OK. Now, Mr. Williams, your organization is the one really responsible for the dispensing of the $100 million in DRA funds, is that correct?

Mr. WILLIAMS. In partnership with the Department of Health and Hospitals, yes.

Mr. WHITFIELD. And how does the disbursement work? Have you received the $100 million yet or is it in dribbles?

Mr. WILLIAMS. We received the notice of grant award, or the State received the notice of grant award, from HHS on July 23. So next week, and we have already publicly announced it to the providers of the region. We are having a public meeting on Friday. We will have all of the applications for eligibility by the end of next week, and hopefully have funds to those providers by September.

Mr. WHITFIELD. But the official announcement was only on July 23?

Mr. WILLIAMS. The notice of award from the Federal Government was on July 23. There was quite a bit that had to happen behind the scenes in order to make that possible.

Mr. WHITFIELD. Thank you.

Mr. STUPAK. Thank you, Mr. Whitfield. Mr. Neary, if I may go to exhibit No. 18 in the black book. This is the July 27, 2007, letter that Mr. Melancon mentioned that we have been talking about here. It seems like it is signed by every leader in Louisiana saying, "put this VA hospital downtown." My question is, who is going to respond to this letter, and who makes the decision whether or not the VA hospital goes downtown?

Mr. NEARY. When we complete the environmental review work and we have——

Mr. STUPAK. No, no. Who makes the decision whether the VA hospital goes downtown?

Mr. NEARY. The Secretary of Veterans Affairs.

Mr. STUPAK. So right now that would be Mr. Nicholson, right?

Mr. NEARY. Yes, sir.

Mr. STUPAK. So we should be going after Mr. Nicholson to get this thing moved, right?

Mr. NEARY. And I have spoken with Mr. Nicholson recently. He is very anxious to move this project forward as quickly as possible.

Mr. STUPAK. Then why are you looking at two sites? Why aren't you just looking at the downtown site for your environmental aspect? Why do have to look at two sites and waste money? Everyone is telling you to put it downtown but you are looking at a different site.

Mr. NEARY. Sir, there was a point in time when the site at Canal and I–10 that had been identified by the State prior to the storm, it became evident that that site was simply not workable. It doesn't have sufficient——

Mr. STUPAK. That was before the storm. We are talking about after the storm.

Mr. NEARY. After the storm——

Mr. STUPAK. They are all saying go downtown, so why are we looking at another site?

Mr. NEARY. The studies that are going on both in terms of——

Mr. STUPAK. That is just wasting time. If everyone says you go downtown why don't you study downtown and see if you can go there. If it doesn't work, then go. If I follow your timeline the soonest we are going to have a VA hospital in New Orleans, is 5 years, and that is if everything goes well. We know how quickly the Government moves. So it will be more than 5 years. It will probably be 10 years. So why don't we just cut to the chase, why don't we start studying this site that everyone agrees upon. The State of Louisiana has said we will put up the $300 million because the CDBG money last time when we were in New Orleans having our hearing in January 2006 HUD started screwing around with the money there. So New Orleans said we are sick of this game. We will give you the 300, we will put down the 300. We are willing to build it. We want it downtown. So why do we have these continual delays?

Mr. NEARY. Under the law the Secretary is not permitted to make that decision——

Mr. STUPAK. But the law doesn't say the Secretary has to look at two sites. He can look at one site if he wishes.

Mr. NEARY. Agencies are strongly encouraged to look at all available options when——

Mr. STUPAK. The law doesn't say strongly encourage. The law doesn't say you have to look at more than one site, does it? They just have to do a NEPA study on the proposed site, correct?

Mr. NEARY. That is correct.

Mr. STUPAK. When will that NEPA study be done?

Mr. NEARY. Approximately 4 months.

Mr. STUPAK. All right. It can't be done any sooner than that?

Mr. NEARY. The studies normally take 6 to 8 months, and we have it on an accelerated basis.

Mr. STUPAK. All right. Let me ask Mr. Williams. Mr. Williams, you said there is $100 million that was pledged to this area for the Louisiana LPHI. That is what you run, right?

Mr. WILLIAMS. Louisiana Public Health Institute, LPHI.

Mr. STUPAK. LPHI. You said they should be seeing some of that money by September?

Mr. WILLIAMS. Yes, if we stay on the schedule.

Mr. STUPAK. When the mayor says I haven't seen any money, the $100 million he is talking about, it is coming through your organization, right?

Mr. WILLIAMS. That is correct.

Mr. STUPAK. So after September 1, 30 days or so, the mayor should see some money, right?

Mr. WILLIAMS. Yes. They are already determined eligible.

Mr. STUPAK. Do you anticipate any roadblocks, any problems with moving that money?

Mr. WILLIAMS. No.

Mr. STUPAK. Is it real money or is it funny money? Do you actually have it coming to you or do you have to start applying for paperwork as of September 1 to get the money?

Mr. WILLIAMS. We have a contract with the State, and the notice has come from the Federal Government. We need to get the State legislature to budget the money through their process, and that is going to happen in the middle of August. Then we need to establish a contract with the city of New Orleans and there shouldn't be any further delay. They have $4 million carved out of the $100 million that they are already determined eligible for us, so it shouldn't—I don't anticipate any roadblocks.

Mr. STUPAK. OK. So September 1 we should see some money flowing to the mayor. Ms. Richter, there has been some testimony, and there will be some later today, in particular one CEO has provided written testimony to this committee regarding the impending financial pressures they are facing, and in that statement they say due to the continued closure of Charity Hospital, as well as several other hospitals, these five hospitals provide 95 percent of the hospital-based services in the metropolitan area. The five hospitals expect a combined loss of $135 million in 2007. This loss will grow to $405 million in 2009. What does Secretary Leavitt think of those numbers?

Ms. RICHTER. I think, as I said, we are concerned about that. We want to understand better——

Mr. STUPAK. You are concerned, but what are you going to do about it? We are all concerned. But you have some power to do something. What are you going to do?

Ms. RICHTER. Our short-term response really was in the provider stabilization grants that we already——

Mr. STUPAK. That was short term. We are 2 years out from this hurricane. What are we doing to help alleviate this? You have talked increased costs. Have you provided more money for increased labor costs? Nurses are more expensive, physicians are more expensive, insurance to even insure the hospital has gone sky high. Have you looked at any of these to do something? You mentioned in your testimony there are waivers that could be given but you haven't provided any other than the initial waivers. Why can't we continue these waivers? This area is still being devastated.

Ms. RICHTER. Are you referring to the GME waivers?

Mr. STUPAK. GME, a couple others you had, the DSH hospitals, all these waivers that HHS controls. It seems like it is pulling teeth every time you come here. You say you look at it. We get a nice letter saying we are going to respond and nothing ever hap-

pens, and now you see hospitals losing $405 million by 2009. They can't stay open like that.

Ms. RICHTER. I myself can't speak to Medicaid disproportionate share issues that were raised.

Mr. STUPAK. How about the area of wage index. According to your testimony, it will be fiscal year 2010 before it will be updated. Now, can't we waive that because it costs more money to provide services in New Orleans, because it is a premium to have a nurse or a doctor down there so the area wage index which they base their reimbursements on you say won't be updated until fiscal year 2010? That is 3 years from now. Can that be waived? Can't you do that sooner?

Ms. RICHTER. Medicare is designed as a national program——

Mr. STUPAK. Yes, but what is the Secretary's proposal in helping out with this shortfall?

Ms. RICHTER. Well, again, as I said the short-term response that was within the Secretary's ability was the provider stabilization——

Mr. STUPAK. I know the short-term, but we are 2 years out now. What is his long-term response?

Ms. RICHTER. I think as far as other things that could be done, we will have to get back to you on that.

Mr. STUPAK. Well, what about GME? You wanted to talk about GME, the 3-year rolling average.

Ms. RICHTER. Yes.

Mr. STUPAK. Yes. You waived it for 1 year. You stopped it in 2006. Why can't you waive it again? We are still having this trouble with the GME.

Ms. RICHTER. We have talked extensively with our Office of General Counsel, and they say that the——

Mr. STUPAK. But the mayor is getting tired of talking. He has been here 28 times. He hears this talk.

Ms. RICHTER. I understand, Mr. Stupak.I am sorry about that,but the statute is very clear about the 3-year——

Mr. STUPAK. But there is a waiver. There is a waiver in that statute, and you have a right to exercise it if you wanted to.

Ms. RICHTER. There is no explicit waiver within the 3-year rolling average portion which was why——

Mr. STUPAK. Under emergency circumstances you can waive it.

Ms. RICHTER. Just for closed programs, programs that are completely closed.

Mr. STUPAK. You would agree with me medical service in New Orleans is still an emergency situation, isn't it?

Ms. RICHTER. That is not the way the statute or the regulations are written.

Mr. STUPAK. I am not asking about the statute. I am asking you, do you believe the medical situation in New Orleans is still an emergency situation?

Ms. RICHTER. Yes, but——

Mr. STUPAK. Great. Now it is an emergency situation. I have established that. Now you can get a waiver, can't you, if you yourself believe there is an emergency situation. You got a waiver under GME, that 3-year rolling.

Ms. RICHTER. The emergency provisions are limited to entirely closed programs. That is the only situation we can——

Mr. STUPAK. Has the Secretary brought forth any legislation to address the issues, whether I need a 3-year waiver on the GME, I need a waiver on this wage index, have they proposed any of these if the waivers are only for a short period of time to correct the inequities we are seeing in Louisiana so they have a full working health care system? Has the Secretary brought forth any legislation like that?

Ms. RICHTER. Not legislation. We have discussed extensively with various representatives of the interests in Louisiana, both the hospitals, the medical schools, with Dr. Cerise and with others the possibility of doing a Medicare demonstration that could in a budget neutral way that could alter some of them.

Mr. STUPAK. We don't want demonstrations. We want health care. We have 3 minutes left to vote. I hate to do this to you but we are going to have to run and vote. We will be right back. It is only one vote, and when we get there they will spring another surprise on us, right? So we will be back as soon as we can. We will be in recess. We will be right back. Mayor Nagin, I know you are dying to answer some of these questions. I will give you a chance as soon as I get back.

[Recess.]

Mr. STUPAK. Let me again apologize for the interruptions. While these procedural games are being played on the House floor today, they are frustrating to us, but they are pale in comparison to the frustrations you must feel in New Orleans so we thank you for your patience, and I assure you that we will continue this hearing and get through this, and despite our continued interruptions we are going to stay with this issue no matter how long it takes. Congressman Jefferson, he is here. As you know, he has been at every other hearing we have had. He knows too well the problems you are facing, and we appreciate him coming to the hearing and sitting in. Thank you.

I was ending with Ms. Richter and I talked about how she was going to talk about a demonstration project. We will get to that later because my time is up, as Mr. Burgess informed me, but I know Mayor Nagin wanted to say something either on the VA hospital or on that $100 million that is going to come to you by September. Not all of it, right, Mr. Williams? But some of it is going to come. You wanted to say something, and I said before I broke that I would give you an opportunity.

Mr. NAGIN. The only thing I want to say is if the check is in the mail, we look forward to receiving it.

Mr. STUPAK. Very good. The check is in the mail from the Federal Government. OK. The gentleman from Texas, Mr. Burgess, please.

Mr. BURGESS. Thank you, Mr. Chairman. I scarcely know where to start. Let me start with you, mayor, since you spoke last. I referenced a logjam. You said you are stuck. Can you put your finger on where the problem is? If we are going to exert maximum congressional committee authority to fix the problem, where do we exercise it?

Mr. NAGIN. Well, I think there are many good people, good, competent people, working on these problems, but unfortunately many of the laws are not written in a way that allow the flexibility that is needed for a disaster of this magnitude, so I would advocate a look at the laws associated with emergencies and making sure those laws are written in a manner where the Secretary can exercise some latitude in expediting funds. The second thing I would also point out is that there is this route that money must travel, and once you get it through the Federal bureaucracy then you are dealing with the State bureaucracy before you even get to a local bureaucracy. And those three elements tend to slow down the delivery of resources because government is traditionally not built for speed.

Mr. BURGESS. Yes, how can you straighten out that route? How can you take all the curves out of there?

Mr. NAGIN. Well, there are several ways that are already written——

Mr. BURGESS. Let me ask you this. Do you have Mr. Melancon's private cell number? Can you just call him up and say, "I am having trouble with this, can you fix it?"

Mr. NAGIN. Yes, I can call him. I can call his wife. I know how to get him. Absolutely. I have both cell phones. So that helps.

Mr. BURGESS. Are you doing that?

Mr. NAGIN. Oh, yes. Yes.

Mr. BURGESS. OK. And they have been responsive to you?

Mr. NAGIN. He is very responsive.

Mr. BURGESS. I just got to tell you. I am a public servant, you are a public servant. I depend upon my constituency for the continuation of my employment as do you. I frankly don't understand why no one in an elective office has been held accountable. We beat ourselves up up here. We will beat up the Federal agencies some more in just a minute which is appropriate but at the same time from just the grass roots phenomenon, I don't get it.

Mr. NAGIN. Well, you are not alone in not getting it. And the only thing I can point to is nothing like this has ever happened before so we all are inventing solutions but unfortunately whereas we invent solutions, we always go back to laws that were created prior to a disaster like this.

Mr. BURGESS. Well, let me go to Ms. Richter. Let us talk about the laws just a little bit. You reference the wage index relief or the mayor did, through the wage index relief through the Deficit Reduction Act, but that was broadly dispensed throughout the State, maybe a little too broadly, and then went to some areas that weren't in as big a crisis as the Orleans parish, so do you need—does the Secretary need—the mayor said the Secretary may need some legislative fix, some latitude. Does the Secretary have all the tools he needs in order to get the money where it needs to be and not broadly disbursed to areas that are less in need? Do you need something from us in order to be able to do that? The other reference was made to this will be 2010 before there is more latitude. Is there anything we can do to condense that time frame? Is there anything we can do again to straighten out the curves in the road so the Secretary can get the money where it is needed?

Ms. RICHTER. I think I will say that we will probably have to respond to that for the record for HHS issues broadly. Certainly I think understanding the cost structure now, the summary data that the hospitals had in their testimony is a good starting place, but I think as several people have mentioned today having a better understanding of what is driving the costs and how the costs vary across the different payers to what extent it is a Medicare issue, to what extent it is an uncompensated care issue, to what extent it is something else I think would be very helpful to understand better where healp would be best targeted, and so I think that is a critical piece as well.

Mr. BURGESS. Well, I do look forward to that response in writing. And let me just ask you this. I know HHS is not a business and doesn't function as a business, but if it were a business and wanted to go to its customer and ask how are we doing, who would the customer be? Would the customer be Mayor Nagin? Is the customer us up here? Who would the customer be? How would you gauge whether or not you are doing an effective job?

Ms. RICHTER. I think we have a lot of customers. I think first and foremost the Medicare beneficiaries as far as our program, Medicaid——

Mr. BURGESS. OK. The Medicare beneficiaries.

Ms. RICHTER. The beneficiaries, the providers that would work with——

Mr. BURGESS. Would the Medicare beneficiaries in the city of New Orleans, how would they respond to the question are we doing a good job?

Ms. RICHTER. I would not presume to answer.

Mr. BURGESS. I wouldn't either but I think we can impugn an answer to that, and I don't think it is good and that pains me and I am sure it bothers people at the agency, and I do want to see us do our jobs better. Still no mistake about it, I think there is a lot of inertia on the ground and I heard a lot of talk about the discussion about the VA hospital, and I know Charity wants to build a new facility. Are we sacrificing the short-term improvement for what is happening with these larger projects? Are we sacrificing taking care of the patients for the sake of economic development in downtown New Orleans? Does anybody have an answer or a response to that? Dr. Cerise, do you have a feeling about that one way or the other?

Dr. CERISE. Are we sacrificing care of patients for economic development?

Mr. BURGESS. Well, postponing being able to do—here I have got a piece of paper that says there was $101 million left on the table end of fiscal year 2006. That doesn't sound like a good thing to leave money on the table here. We have been force feeding you dollars up here. Again, I get criticized for that back in Texas, and yet you guys aren't getting the help you need, and there is money left on the table. And why is there money left on the table? I don't know the reason but I am hearing today that, well, we are working about different sites and competing sites with the VA, we are worried about what Charity is ultimately going to look like, what it resurrects from the ashes, but are we sacrificing what we should be doing in the short term for what may happen in the long term

and as a consequence are patients suffering because we have our eye more on economic development or economic redevelopment rather than on patient care.

Dr. CERISE. I don't think so. I think those things are happening in parallel. I am not familiar with the $101 million number. I know that there are some grant funds. For instance, we got an extension in the social service block grant funding that we asked for assistance with and you all helped us with that. That is a factor that you have heard people talk about workforce here, and having funds and then getting those funds out to people. For instance, we have got mental health dollars in the city that we will have unspent because of workforce issues because we are trying to—you just can't go hire 300 social workers tomorrow.

Mr. BURGESS. Let me ask you about the workforce since that was brought up in the remaining time I have left, Mr. Chairman. How are you going to staff a new VA hospital and a brand new Charity Hospital if the workforce issues are so critical? What are you going to do to be able to overcome that? We build these gleaming new towers to medical science and if no one fills the halls that is a problem.

Dr. CERISE. Yes, that is a good question. There is going to be—first there is a significant period of time when that construction is going to happen and their expectations of population coming back and rebuilding the infrastructure. In addition, a fair amount of that space, and I think LSU could probably talk to this better, is going to be transitioned over from their interim hospital or temporary facility, at least on the State side of that facility, so some of that activity will move over.

Mr. BURGESS. And where do you get the people to put in the clinics and the offices to take care of the patients?

Dr. CERISE. And that is the work that is ongoing right now, the $50 million in workforce funds that we all are spending in the past 3 months. $11 million of those have been committed to over 127, I think about 127 positions, so they are just active trying to get people back into the area.

Mr. BURGESS. It is a long-term solution. Are you actively going into the high schools and colleges and trying to identify those people who would like a health care career whose families live in the area who aren't going to be pulled out by outside interests?

Dr. CERISE. Absolutely. A great point. Funds have been put into our allied health programs to train more of our own nurses particularly but other allied health programs also realizing that we are not going to be able—everybody in the country is struggling with the workforce not to the same degree so we are not going to be able to pull them all in. We have to do a better job of growing our own and that work is underway.

Mr. STUPAK. The gentleman's time is expired. Mr. Melancon for questions. We are going to go a second round here.

Mr. MELANCON. Mr. Burgess, I guess that is one of those things if you build it, it will come. But being serious, let me ask, Ms. Richter, where is the Secretary today?

Ms. RICHTER. He is in New Orleans for a long-standing commitment; he had to make a presentation.

Mr. MELANCON. Does he have any policy people down there with him?

Ms. RICHTER. He does, I believe.

Mr. MELANCON. I just wondered. We heard in your testimony discussion of the GME program and how it functions. Unfortunately, what does not come across in your testimony is a clear understanding of that the region's concerns are regarding this program and what options are available to address them. Now it is my understanding that the Secretary has a point person that is constantly on the ground to deal with ongoing health care issues, Sonya Madison, maybe, is that correct?

Ms. RICHTER. She is with him.

Mr. MELANCON. OK. So she is with him and you aren't. So what is Ms. Madison or whoever the Secretary has appointed saying to CMS are the main concerns of the med schools involving GME, and moreover what is this point person suggesting as policy approaches to address the GME issues in that region?

Ms. RICHTER. I think the information that we are getting about the concerns of the medical schools especially are very consistent with the white paper that they submitted to the subcommittee. They are very concerned about the 3-year rolling average again as I stated. Our general counsel believes we have no flexibility in that area so we understand their concerns but we don't believe we have any flexibility within the GME program to address those. They are also very concerned about the affiliation agreements that they need to sign in order to reallocate their residents to the hospitals where they can best serve folks from the hospitals that are either closed or partially closed.

A lot of those requirements really are an artifact of the fact that our——

Mr. MELANCON. Sorry to interrupt you, but I keep hearing the reasons why we are not moving forward. What you first need to do is go back and lock the ******* attorneys in a room and start talking to each other, the people that are policy people, and what it is that they brought you and suggest and what it is that the program doesn't allow you to do and find out how you solve the problem, and if you can't solve it you need to bring it to us here in the Congress and say this is what it is going to take to move things forward. We have been 2 years. Nobody is doing that. Mr. Cerise, have you all had any discussions where they said, OK, sit down with us and let us see if we can find some common ground to make it work?

Dr. CERISE. We have certainly had discussions about this. We haven't been able to solve this 3-year rolling——

Mr. MELANCON. And when you come back, basically you come back with some answers or suggestions or just technical gobbley gook of how the program runs.

Dr. CERISE. This one certainly is complex. We don't have a good pathway to how to solve this.

Mr. MELANCON. I am looking, Ms. Richter, at your testimony and on page 2 and on page 3, would you please bring that to the Secretary and ask him to read it and tell him if he can tell me exactly what it is that is in there because I will be damned if I can figure it all out. The Government and this Congress and the people that

are here serving in Washington are here to take leadership. We have got a catastrophic event that occurred 2 years ago, and if there are some people that don't want to rebuild New Orleans or don't want to rebuild the VA or don't want to rebuild the Charity or anything else, please stand up and tell us and quit playing games with the people in Louisiana, and you can send that message straight back to the Secretary because we have had enough time to move things forward and to find some common ground or at least to bring us some suggestions of what we can do legislatively to try and solve the problems.

Do we have any suggestions from the Department? Has the State given any suggestions to the Department?

Ms. RICHTER. I think the main suggestion that we have made to people that I mentioned in my opening remarks is that it may be appropriate for discussing whether a Medicare demonstration could address some of the regulations and rules that right now seem to be standing in the way of the situation, and we have already—I have already asked folks to make sure that that happens quickly.

Mr. MELANCON. How long have we been having those discussions within the Department?

Ms. RICHTER. We have had discussions on this issue internally and with people in Louisiana and the affected areas for a long time about demonstrations.

Mr. MELANCON. A year?

Ms. RICHTER. We have taken different——

Mr. MELANCON. Would a year be a reasonable time to say?

Ms. RICHTER. I think it may have been longer than that. I think that Dr. Cerise said——

Mr. MELANCON. You can have a baby in 9 months. What legislation do you think the Secretary will support? Does anybody have—do you all meet with him, do you advise him? What is he saying?

Ms. RICHTER. We would have to get back to you on that. We would be happy to.

Mr. MELANCON. When do you need to get back to me? Can you get back to me next week? I would ask you to go back and ask the Secretary when he can get back to us, please, with a formal letter and to give us an explanation what it is that the Department is doing. I would like some timelines on it, and I would like to know precisely what our expectations can be or should be. I think I have overrun my time. I yield back.

Mr. STUPAK. By nodding your head that was a yes, and then, Mr. Melancon, you will get a letter back to him?

Ms. RICHTER. Yes. We will talk to people when we get back about timelines and things and get back to you quickly about that.

Mr. STUPAK. Mr. Whitfield for questions, please.

Mr. WHITFIELD. Mr. Neary, back in February 2006, Secretary Nicholson issued a report to Congress about among other things the VA hospital in New Orleans, and in that report it said the VA believes that a new facility can and should be built within the city proper. Could you tell me if that position has changed at the Department or not?

Mr. NEARY. I think, as you know, we have narrowed the potential opportunities, potential sites, that we are looking at to two; one

of them is downtown, one of them is in Jefferson Parish just across the line from Orleans Parish.

Mr. WHITFIELD. We are assuming since they said this in the report that that must still be their goal to have it in the city of New Orleans. That was in the report to Congress in 2006. Ms. Richter, Mayor Nagin and Ms. Boyle and others who live in New Orleans talk about the lack of health care providers, and he talked about a national call to bring physicians in and not able to provide health care on a timely basis. What about the public health service, are there physicians being sent there to assist in this effort or what is the situation on that?

Ms. RICHTER. If I could ask Dr. Moritsugu.

Mr. WHITFIELD. OK.

Mr. STUPAK. Doctor, before you answer you have to be sworn in.

[Witness sworn.]

Mr. STUPAK. Go ahead, Doctor. If you would spell your name, please, and then answer the question.

Dr. MORITSUGU. Yes. My name is Kenneth Moritsugu. I am the Acting Surgeon General of the United States, and I understand the question, sir. Thank you very much, Congressman, for the question. As you are probably aware, the United States Public Health Service leaned forward and responded on behalf of the Department during the immediate crisis situation. We have continued to have presence within New Orleans although on a much lower level because the intent of the United States Public Health Service Commissioned Corps was never meant to be a longstanding presence in large numbers within the area. If anything, one might argue that that would be counter productive to the economic recovery of the area because by having external providers in the area, we would probably be taking services or providing services that otherwise private sector individuals would be providing.

And so we have been very careful in terms of providing that recovery assistance but not necessarily being there in large numbers.

Mr. WHITFIELD. But since everyone is saying that they don't have enough health care providers, can you on your own initiative provide additional physicians there for a period of time without any legal problems for the health service?

Dr. MORITSUGU. It is possible for us to assign health care providers to areas within the authority of the United States Public Health Service, sir.

Mr. WHITFIELD. And so why haven't you done that?

Dr. MORITSUGU. Well, again, working together with the local and State leadership, we have been trying to make sure that we balance what I described earlier was coming in and otherwise undercutting the strategies to develop a robust community of providers who would settle there and remain there. If I might, sir, there are other resources obviously that might be available in addition to the Commissioned Corps of the United States Public Health Service that I think the Secretary and the mayor and the local communities have also been looking at.

For example, the medical reserve corps who are a number of volunteers in the immediate area who in fact respond——

Mr. WHITFIELD. Well, I know there are a lot of options but there does not seem to be the number there to meet it. Secretary Cerise, this has got to be one of your priorities. How do you address it?

Dr. CERISE. Well, I appreciate the approach that was described because early on we did run through a transition phase where we had local providers who wanted to come back, and it was this balance between having people come in to provide the services and then being able to pay our own people to come back. We are at a different point right now. In fact, just over the past week or so we restarted the conversations with the Public Health Service to look if it is possible to deploy some teams to help provide some immediate relief while we take advantage of the workforce development grants that we have got to recruit people in, so as we grow our own and kind of replace those teams because we are in this position where we continue to have the workforce shortage.

So I think it is something that we have begun to re-explore. We went through that phase where you had a lot of bodies on the ground. We thought we could transition to local providers, but we continue to have a gap in a number of areas and so I appreciate Jean Bennett in your office, who has been with us over the past week talking to us about how we might do that.

Mr. STUPAK. The gentleman's time has expired. If I may just follow-up on that, Mr. Under Secretary, you heard the mayor testify there is a 47 percent increase in the deaths in New Orleans. Senior citizens have just given up and are dying. There is increased stress and increased mental health problems. Mr. Secretary, wouldn't you consider that a public health issue?

Dr. CERISE. There is no doubt that we have got gaps in the delivery system down in New Orleans so we do have a public health——

Mr. STUPAK. Dr. Moritsugu, could you answer that? It is a public health issue in New Orleans, is it not?

Dr. MORITSUGU. Yes, it is, sir.

Mr. STUPAK. Well, would you consider it an emergency health situation with 47 percent increase in deaths since before?

Dr. MORITSUGU. I would consider it an emergency situation, sir.

Mr. STUPAK. OK. Then in an emergency situation can you go to the President or the Secretary of Health and Human Services to get some of this red tape cleared up to get the services they need down in New Orleans?

Dr. MORITSUGU. If you are talking about the assignment of Commissioned Corps officers to provide short-term relief, that is certainly possible at the request of the local communities.

Mr. STUPAK. OK. So Mayor Nagin would just have to request you to bring in more mental health people to help out with the mental health aspect of it?

Dr. MORITSUGU. Assuming we had those resources that we could bring in, sir.

Mr. STUPAK. Do you have mental health resources? We heard testimony that nine people left in one mental health facility here at the VA. Do you have those resources available?

Dr. MORITSUGU. We have mental health resources. I am not exactly certain the extent of the absolute need but would be willing to enter into discussions with Mayor Nagin and with the Secretary.

Mr. STUPAK. OK. We don't like long discussions.

Dr. MORITSUGU. I understand, sir.

Mr. STUPAK. OK. Very good, very good. Thank you. Ms. Richter, you said for the last year you have been discussing about doing a pilot program or demonstration project. Why can't you use your demonstration project you used in Utah when they had problems for graduate medical education, GME, you ended up allowing—CMS allowed the States to receive the money and then they disbursed it to the hospitals. Why can't that system work here in Louisiana?

Ms. RICHTER. That is certainly a model that we would be prepared to discuss with the hospitals.

Mr. STUPAK. I don't want discussions. You have been talking about it for a year.

Ms. RICHTER. Demonstrations are voluntary under the Medicare statute and the hospital——

Mr. STUPAK. OK. So if Mr. Cerise would ask that, you would do that, use the Utah model? You already got it demonstrated. It worked in Utah. Why can't it work in Louisiana?

Ms. RICHTER. The hospitals would have to agree to particpate in it and there are differences. Utah, for instance, has one medical school and so there are different issues in Louisiana because of the two medical schools and the interrelationship between them.

Mr. STUPAK. But the money wouldn't be going to the medical schools. It would be going to the State to reimburse for the residents so we don't have to have this 3-year rolling average because they are at different hospitals who have not been part of this GME before. That is what happened in Utah. Why can't it work in Louisiana? Mr. Cerise, could it work in Louisiana?

Dr. CERISE. We have had discussions of that. There are potential——

Mr. STUPAK. So you talked about the Utah plan?

Dr. CERISE. We had someone from Utah come down and speak to folks in Louisiana.

Mr. STUPAK. So it won't work?

Dr. CERISE. There are issues with hospitals that own slots right now that would be put at risk with a model like that so you would have to have broad agreement to do that. And so what is being proposed on this 3-year rolling average is something that is less—I would say less risky for the hospitals and much more straightforward, and that is for a limited time period give relief of these partial payments as residents move from one site to the other.

Mr. STUPAK. It could be tweaked. It could be worked out, right? The issue is the money going to the hospital that doesn't have established GME, therefore, they are on a 3-year average. They get about one-third of the money they should be receiving so why can't we just give it to the State like you did in Utah where they have a program and you just send it to the hospitals? The hospitals are willing to do this but they don't want to do it at two-thirds hit.

Dr. CERISE. We are certainly open to solutions that will allow the 3-year rolling average issue to be adequately addressed in the program. If the State can play a role in that, we would welcome the ability to do that.

Mr. STUPAK. Ms. Richter, Dr. Cerise testified at our last hearing that the State has been seeking a waiver so it can use the DSH

money that I talked about earlier, mentioned that to you earlier, that otherwise would go through the State's public health system, and it uses this DSH money to support physicians seeking to keep their practices open in the area. Why can't CMS work with the State on making that happen?

Ms. RICHTER. I really don't have the ability to respond to that right now. It is not a Medicare issue, but I would be happy to get you a response.

[Ms. Richter responded for the record:]

Although HHS has made considerable strides in addressing the continued health system recovery problems in the greater New Orleans area, the Department is currently not in favor of approving the use of Medicaid disproportionate share funds for physician reimbursement in region 1 because such funding is not consistent with the Medicaid statute.

Section 1923(g)(1)(A) of the Social Security Act imposes a cap or hospital-specific limit on the amount of DSH payments that may be made to a hospital in a fiscal year. This annual payment is equal to a hospital's uncompensated costs of furnishing hospital services to persons eligible for Medicaid or who have no source of third party coverage. The components of the hospital-specific DSH limits were further clarified in a 1994 all-State Medicaid Director letter to include the unreimbursed costs of allowable inpatient and outpatient hospital services. A recent decision from the Departmental Appeals Board (Docket No. A–06–05, decision No. 2084, May 18, 2007) upheld this definition of allowable hospital costs under the hospital specific limit. This decision upheld a disallowance taken against a State that included physician costs in their calculation of DSH eligible costs.

Generally, physician services are not recognized as inpatient or outpatient hospital services. They are usually separately billed and reimbursed under a fee schedule for physician professional services. Moreover, under Medicare cost and payment principles, physician services are recognized as professional costs, nit hospital costs. Because of these statutory limitations, Louisiana may not use DSH funding to pay for uncompensated physician costs or other uncompensated costs eligible under the hospital-specific DSH cost limit.

Mr. STUPAK. OK. Who would be the person we would direct this to? Whose desk does it fall on?

Ms. RICHTER. The Director of the Center for Medicare and Medicaid State Operations is Dennis Smith. The Acting Deputy Administrator is Herb Kuhn. The Secretary would also be an appropriate person.

Mr. STUPAK. OK. So Secretary Leavitt would be able to answer that for us?

Ms. RICHTER. I would assume technical help——

Mr. STUPAK. He is in New Orleans today, right, the Secretary?

Ms. RICHTER. Yes, he is.

Mr. STUPAK. Is it true that today HHS just announced changes to the inpatient perspective payment system? Do you know if they did that today, Health and Human Services announced changes in perspective payment system?

Ms. RICHTER. It is imminent, yes.

Mr. STUPAK. Believe me, they did, and that provides a major source of Medicare revenue for the hospitals. Is Louisiana going to take about $2 million, $3 million, $100 million, hit underneath this program? Is the Secretary down there announcing that program?

Ms. RICHTER. He is not announcing the inpatient perspective payment system rule, I don't believe.

Mr. STUPAK. So places like Louisiana are going to be cut, right, underneath this new system?

Ms. RICHTER. I think you are referring to the proposed rule. I don't believe that the final rule has been announced yet, and I can't really comment on——

Mr. STUPAK. A proposed rule takes place, right, takes precedent there over the current rule?

Ms. RICHTER. The current rule is modified in response to the public comment and we can't really say what is in it until it is announced.

Mr. STUPAK. Well, take it back to the Secretary if they put in the inpatient perspective payment system as proposed today that is a $300 million hit for Louisiana, it goes contrary to the President's promise to restore this area. Mr. Melancon, you had a question?

Mr. MELANCON. Yes, I just needed to ask, is Ms. Madison the person that is on the ground that is supposed to be the person that is working between Louisiana's hospitals and medical center, the VA, and whoever else to solve the problems?

Ms. RICHTER. She is certainly the Secretary's representative, yes.

Mr. MELANCON. Does she not talk to you all?

Ms. RICHTER. We talk.

Mr. MELANCON. Do you talk about Louisiana?

Ms. RICHTER. Yes, we do, sir.

Mr. MELANCON. We are 2 years out. Is the sense of urgency gone?

Ms. RICHTER. I don't believe it is, sir. I think it takes time to work something out as complex as the Medicare Program but I don't think it is for a lack of effort or lack of interest.

Mr. MELANCON. But I haven't seen anything put forward. Local hospitals have come up with suggestions and thoughts that they wanted to bring the people at CMS but we don't hear anything after that. Are you all just—what actually happens when you get an idea, when somebody brings you in a thought, a suggestion, an idea of how to make something work? What is the process from there?

Ms. RICHTER. I think we assess it both for policy reasons and for legal reasons about what the appropriate response would be. I would say that I think the Department——

Mr. MELANCON. Is there a step in there that says take action? Would you please go back and see to get one in there. That seems to be the problem. Bureaucracy wants to talk but we need to be doing more than talking. In a statement from Dr. Quinlan with Ochsner, he had addressed issues affecting the hospitals and long-term what our needs are. I don't think this is a new piece at all, and I just wonder have you seen it, have you read it, have you discussed it, have you taken any action on it?

Ms. RICHTER. I read it recently when I got a copy of it in the past several days. I think we are aware of their concerns. We discuss things frequently, both Ms. Madison and her staff, working through the entire Department, not just the Medicare Program to address issues of concern to health care providers in Louisiana. I think that the provider stabilization, the workforce fulfillment, all the DRA grants are an example of the Department taking action and aggressive action within its capabilities to respond to some of the crises in the area. The $100 million primary care grant that was announced on July 23 is an example of that.

Mr. MELANCON. A while ago we talked about responding. What I would like for the Secretary to respond to is the red ink that is bleeding at these hospitals and what it is that the Department proposes to do or suggests that we do, or help to do so that we can solve this problem. We have to solve the GME, and I would like to see in writing what it is that he suggests we do or hope that we do and give that to us in writing, and with the DSH dollars to compensate physicians. You ought to bring the folks down here to meet with our staff. They seem to move more in 6 months than the Department has moved in 2 years, and I would hope that if maybe you can meet with them, we could help you all find ways to solve the problems or to suggest to us ways that we can help solve the problems, so if you could take those suggestions. And, Mr. Chairman, I would like to ask that that be given back to us within probably some time in September and if you would consider an October, November hearing with the Secretary.

Mr. STUPAK. We will certainly look forward to another hearing on this whole issue, and I am sure that HHS will get you those answers and that letter. Before I yield to Mr. Burgess, Mr. Mayor, the Under Secretary indicated that if asked he would be able to provide some services for you to cut down on that 47 percent increase of deaths, the increased mental health, the stress, and other things that senior citizens giving up down in New Orleans. Hopefully you will take him up on that offer.

Mr. NAGIN. I heard an offer of sorts. I am not sure what the offer is. It would be nice if we could get a letter from them outlining exactly what is available so that we could respond to it. If not, I will send a letter of request but I heard if, maybe, possibly, we think we can.

Mr. STUPAK. I would suggest, Mr. Under Secretary, if you would, would you write the mayor and tell him what services you could help out especially in the mental health area to cut down on these deaths, 47 percent increase. We have to see what the cause. What can we do? As you agree, it is a public health emergency. That is what the corps is for. We should do it. Mayor, you may want to express your concerns there. And if necessary, the Energy and Commerce Committee, Subcommittee on Oversight and Investigations will do a letter to try to keep you guys all talking together. With that I will turn to Mr. Burgess of Texas for questions, please.

Mr. BURGESS. Thank you, Mr. Chairman. Is there anyone on the panel who can speak to the state of the Louisiana State budget currently? Is it a budget that—is the State budget in crisis also or is it doing OK? Are Federal funds the only source of funds to help Mayor Nagin, help the hospitals? Are there any State funds available to restoration of health care in New Orleans?

Dr. CERISE. There was roughly over a billion dollars in health care related appropriations in the past legislative session ranging from pure State funds for things like mental health primarily to extend services not only in the New Orleans area but around the State dealing with the Medicaid program and being able to pay higher rates for providers of all sorts to be able to address some of these issues that we are talking about today, extending insurance coverage to individuals, so there has been a significant invest-

ment of State funds coming out of this past legislative session as well.

Mr. BURGESS. Our investment was $100 billion and the State spent a billion. That is a startling ratio but is the State budget itself, is it in balance? Is the State able to do the work that it is going to be required to do as far as rebuilding?

Dr. CERISE. I am not the best person to talk to in terms of rebuilding. The State budget is certainly in balance.

Mr. BURGESS. Mr. Mayor, how is the city budget?

Mr. NAGIN. The city budget is in balance but it is primarily being balanced by the continuous support from the Federal Government through community disaster loans.

Mr. BURGESS. So the city is basically doing everything, all that it can right now with the resources that it has available. We really shouldn't look to the city to be able to provide any additional help, is that correct?

Mr. NAGIN. Yes, unless you want to buy some swamp land in New Orleans east. We are using every available resource that we have.

Mr. BURGESS. If it is packaged along with the kind of physicians deal that we heard about earlier maybe so. Let me ask you this. We are sitting here. It is August 1. And we are kind of in the middle of hurricane season, but we are just coming up to the worst part of it. So I guess, Dr. Cerise, if I could ask you, as bad as things are we all know they could be made worse by another bad weekend so what are you doing currently to prepare for that? Do we have some things that we have done differently now where we won't look to see this same sort of activity again? We have ways to get people out of the hospitals that are there?

Dr. CERISE. Certainly there has been a large amount of work that has been done at the local level, at the State level, and at the Federal level, looking at the issues you are describing. There have been laws enacted that put a different set of requirements on our health care facilities in terms of how they will have plans in place and report on those plans, more burden put on the State agencies to monitor those plans to see if they are actionable, and each individual plan can be carried out and it is not relying on the same set of resources. And HHS has given an enormous amount of support in this process as well with the State putting people on the ground, looking at individual facilities, counting people, counting assets that you would need, and so we are counting on the local providers to have primary responsibility, the local government——

Mr. BURGESS. They are pretty stressed and you got a workforce issue, right?

Dr. CERISE. What is that?

Mr. BURGESS. If you are counting on local providers you got a big workforce issue.

Dr. CERISE. Right, and to complete, where there are gaps the State is being asked to address those gaps, and where we realize there are gaps too big for the State to address we are asking the Federal Government to address those gaps. And so I do believe that we are in a much better place and we have learned from the experience of Katrina, and I believe that we are in a much better place if something were to happen this weekend.

Mr. BURGESS. I just have to tell you from the perspective of someone who got a call in the middle of the night because a friend of a friend who used to date someone who knew a mayor in one of my towns called me and said, "Can you help us get patients out of New Orleans who are ventilator patients?" And I asked aid where are they and they said "I–10 and the causeway." That didn't make any sense to me until I saw the news the next night and saw indeed that there were ventilator patients at I–10 and the causeway. And I just have to tell you that can't happen again.

I think in your position with the State, and certainly, I know Mayor Nagin is sensitive to this as well, there has to be a way to get the help to the people who need help because if the same thing happens again your city is already in despair, and you would have a lot more people who would need help getting out of the tough situation. We didn't do a good job last time. Let us be darned sure we are not caught in that same maelstrom again. And that would be the only thing I would offer additionally, Mr. Chairman. I will yield back. Thank you.

Mr. STUPAK. Thank you, Mr. Burgess. That concludes the questions of this panel. Let me thank each and every one on the panel. Mr. Mayor, thank you for coming. I am sure we will be seeing you again. We will keep on this issue. This panel is excused. I would hope that Ms. Richter and the Surgeon General Moritsugu would stay and listen to the second panel and answer any additional questions that may arise and also to learn a little bit more of the plight of these hospitals and providers that are on our second panel. Thank you all for coming. We will have the next panel.

I will call our second panel of witnesses to come forward. Our second panel, we have Ms. Diane Rowland, Kaiser Family Foundation; Mr. Mark Peters, West Jefferson Hospital; Mr. Leslie Hirsch, Touro Infirmary; Mr. Patrick Quinlan, Ochsner Health Systems; Mr. Gary Muller, West Jefferson Hospital; Mr. Mel Lagarde, Tulane University Hospital, Chancellor Larry Hollier, LSU Medical School; Dr. Alan Miller, Tulane University Medical School; and Dr. Gary Peck. Would they all please come forward? It is the policy of the subcommittee to take all testimony under oath. Please be advised that witnesses have the right under the rules of the House to be advised by counsel during their testimony. Do any of you wish to be advised by counsel? Seeing no one make an indication, I take it you do not have counsel with you.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect all the witnesses answered in the affirmative. We will hear from this panel. Before we do that, I am going to have to run down to the floor. I have been asked to come to the floor on SCHIP. I am going to ask Mr. Melancon to take the Chair. I will be back as soon as I can but I have to run down. And with that, Dr. Rowland, would you like to start with your opening statement, please, 5 minutes. Your full statement is part of the record. And please give your opening statement.

TESTIMONY OF DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION; EXECUTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, WASHINGTON, DC

Ms. ROWLAND. Thank you, Mr. Chairman, Mr. Whitfield, Mr. Melancon, and members of the committee for this opportunity to be with you today to focus increased attention on the health care needs of the people of New Orleans. We have just completed an analysis that looks at the health care challenges facing the population based on a survey we conducted in the fall of 2006 of 1,500 adults over the age of 18 in Orleans, Jefferson, St. Bernard, and Plaquemines Parishes. It was clear from the survey responses that the priority of the population of the city of New Orleans is to get medical facilities up and running. It was their top priority after repairing levees. What we saw in this survey is that nearly half of the residents report health care coverage and access problems; key components of an accessible quality health care system are not there.

One in four have no regular provider of care other than an ER. Many face new health and mental health challenges and problems since Katrina. One in 10 households with children reported to us that they had a child in their home who was troubled or not getting needed medical care. Even though some of the most frail and vulnerable may not have been able to return home to New Orleans, the population in the city still faces physical and mental health challenges that underscore the importance of improving the availability of services as well as improving access to both health and mental health services.

Predominant among the health problems, health coverage remains a major obstacle to obtaining access to health care. One in four non-elderly adults in the area is uninsured. In Orleans Parish, nearly a third of the adult population is without health insurance and 70 percent of those uninsured are African-Americans. There is also a brighter story in Louisiana, however. The Medicaid and LaCHIP programs have helped to provide coverage to children. So, we see no difference between African-American households and white households in the percent of uninsured children; less than 10 percent are uninsured documenting the importance of health care coverage to both reduce racial disparities as well as improve children's access.

For residents using the health care system, most report that they had more difficulty with relocated doctors, fewer hospitals open, and those open with strained capacity. One of their major worries is that they will not be able to get the health care they need in post-Katrina New Orleans. Many of the previous users of Charity Hospital together with the broader uninsured and Medicaid population were disproportionately affected especially with the closure of Charity Hospital, but they are not alone. What we saw was a leveling effect of Katrina on all of the people of the New Orleans region, reducing their access to health care services and further creating barriers for them to obtain needed care especially preventive health services that are so important to maintaining health.

As the people struggle to rebuild their lives, establishing a health care system that provides preventive and primary care services and

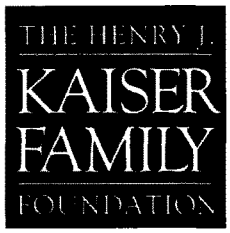
specialty care when needed is essential to recovery efforts. Among the things that can be done and should be considered are ways to broaden coverage especially for adults to both promote their access to care but also to reduce the uncompensated care burden, especially that physicians will feel. This will help bolster financing for physician and clinic services as well as hospital care. We need to be able to provide alternatives to health care for those now relying on ERs. The health care payment policy needs to be used as a tool to help reshape the way health care is delivered by allowing flexibility in the use of the Medicaid DSH funds for non-institutional services and to reimburse physicians and by providing additional support to rebuild the inpatient and outpatient mental health services that are now facing chronic shortages.

Obviously, investing in rebuilding a high quality health workforce is a critical component for the health care system. Facing the higher labor costs, the need for GME reforms as so adequately discussed in the prior panel are critical to having a health care system that will work for all residents of the New Orleans region.

Determining the future scope and role for the public hospital, the VA hospital, and the academic health centers is essential both to establish a source of care for the poor and uninsured as well as to enable recruitment and training of health professionals so critical to a future health care system.

I think, in closing, that we have learned many lessons from the New Orleans experience, and one of them is that we are not prepared to deal with the aftermath of a major disaster such as the Katrina event and the failure of the levees in New Orleans. We need a program that can respond quickly and that can provide more than short-term assistance. Cobbling together little solutions from programs like Medicare and Medicaid will not respond to some of the most immediate needs and the longer term needs that the city of New Orleans continues to face. So the lesson that I take away from our work is that we need to look in disasters at a way when the health care system has been fractured to rebuild that system perhaps with more demonstration authority and broader use today even of the Medicare as well as the Medicaid waiver authority to get some of these services going. The needs are great, and the time to fix them is not just 1 year, but 2 or 3 years, so we need to look at long-term solutions but also to provide immediate care to address the needs of the population. Thank you.

[The prepared statement of Ms. Rowland follows:]



Health Care in New Orleans from the People's Perspective

Testimony of Diane Rowland, Sc.D.
Executive Vice President, Henry J. Kaiser Family Foundation
Executive Director, Kaiser Commission on Medicaid and the Uninsured

Before the U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

"Post-Katrina Health Care in the New Orleans Region:
Progress and Continuing Concerns, Part II"

August 1, 2007

Mr. Chairman and members of the Oversight subcommittee, I want to thank you for your ongoing attention to the health care needs facing the people of New Orleans as they seek to rebuild their city and their lives. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation, and serve as the Executive Director of the Foundation's Kaiser Commission on Medicaid and the Uninsured. From 2004-2006, I served as a national member of Louisiana's Health Care Reform Task Force that endeavored to develop a plan for improving health and long-term care services in Louisiana, a process unfortunately overtaken by the aftermath of Hurricane Katrina and the levee failures in New Orleans.

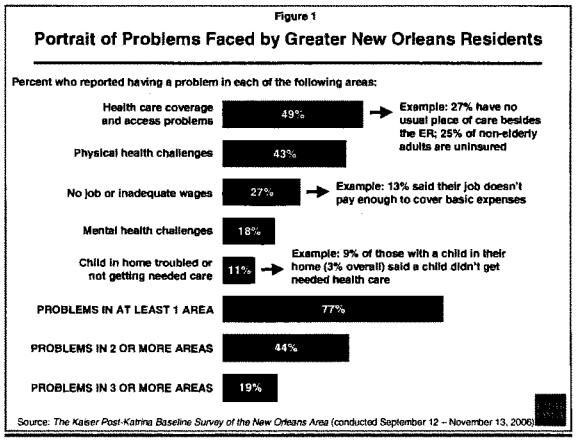
I am pleased to join the proceedings today as you continue to focus on the impact of Hurricane Katrina and the subsequent flooding on the people of New Orleans and the health care system. My statement today will focus on health care needs and access to health services in the New Orleans area, drawing on findings from the Kaiser Family Foundation's post-Katrina survey of residents of New Orleans, conducted in the fall of 2006—more than one year after Katrina made landfall.

You will hear today from government officials and health care providers in New Orleans about the continuing shortfalls in meeting the health needs of the residents of New Orleans and efforts to restore health care services and restructure the health system. I hope my testimony will provide additional insight into the challenges facing the health care community from the perspective of the many residents living in Orleans, Jefferson, St. Bernard, and Plaquemines Parishes who participated in our survey and voiced their concerns and experiences obtaining health care in post-Katrina New Orleans.

HEALTH NEEDS IN NEW ORLEANS

Our survey findings highlight both the health needs of the people living in the New Orleans area and the priority they place on restoring health care services as part of the recovery efforts. Four in ten adults ranked getting medical facilities up and running as one of their top priorities, making it the public's top priority after repairing the levees and controlling crime.

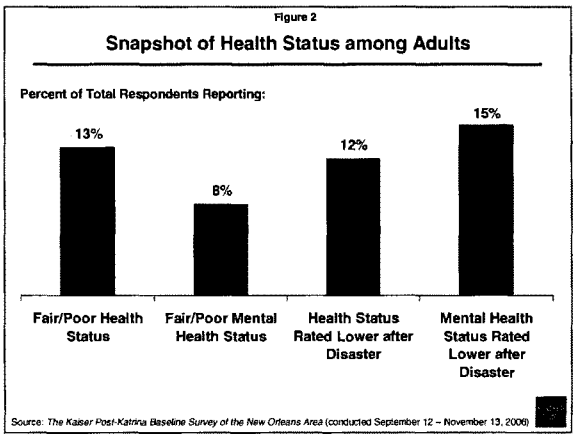
Nearly half (49%) of adults report health care coverage and access problems, with 27% of adults saying they have no usual source of care other than an emergency room and a quarter of nonelderly adults without health insurance (Figure 1). In addition to their own health and mental health problems, one in ten residents reported a child in the home who was troubled or not getting needed care. Overall, three quarters of the adults living in New Orleans post-Katrina experienced one or more of the problems asked about in the survey.



Prior to Katrina, Louisiana had some of the poorest health statistics in the country, with high rates of infant mortality, chronic diseases such as asthma, diabetes, and AIDS,

and large disparities in health status for minorities. The African American population had higher mortality rates from heart disease, cancer, stroke, and diabetes compared to whites.[1] These health challenges were not washed away by the floods.

More than one in ten adults in our survey rated their physical health as fair or poor, and over four in ten adults in the area reported having a chronic condition or disability (Figure 2). Among the elderly, two-thirds reported having a chronic condition or disability, and almost one in five households with children said they had a child in the household who had been diagnosed with a chronic condition or disability. One in twelve adults rated their mental health as fair or poor, with symptoms of depression and Post-Traumatic Stress Disorder (PTSD) present in the population.



Though health problems are widespread across the population, some groups are facing even greater health challenges than their neighbors. Most notably, the

[1] United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 1999-2003, Series 20, No. 2I 2006 on CDC WONDER On-line Database, queried October 2006. Data available at www.statehealthfacts.org, last accessed July 17, 2007.

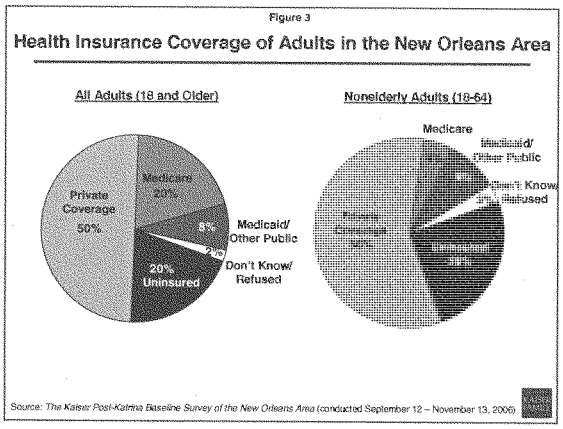
economically disadvantaged and the uninsured had relatively higher rates of physical and mental health problems than others, and health disparities for African Americans persist.

Many adults noted the impact of life after Katrina on their health status—12% reported a decline in overall health and 15% rated their mental health status lower after Katrina. Post-Katrina, African Americans, the uninsured, the economically disadvantaged, and especially those in fair or poor health were the residents most likely to report a decline in their health status. Even though some of the most frail and vulnerable may not have been able to return home, the population remaining in the Greater New Orleans area still faces physical and mental health challenges that underscore the importance of improving the availability of health services and providing access to both health and mental health services.

HEALTH COVERAGE

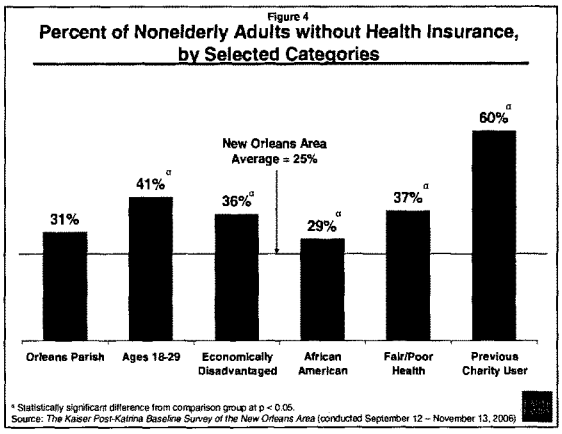
Health insurance coverage is a critical factor shaping how well health care needs are addressed. In the fall of 2006, our survey found roughly half of adults in the New Orleans area reported that they received their health coverage through the private market, with the majority receiving coverage through their employer (40%) and the balance buying coverage on their own (10%, Figure 3). One in five respondents reported coverage through Medicare, and roughly 8% reported primary coverage through Medicaid or other public programs. However, 20% of adult residents age 18 and older reported no source of insurance coverage whatsoever – a rate significantly above the 15% of adults who are uninsured nationally.[2]

[2] Source for national statistics: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of the March 2006 Current Population Survey, available at www.statehealthfacts.org/r/coverage.cfm, last accessed July 17, 2007.



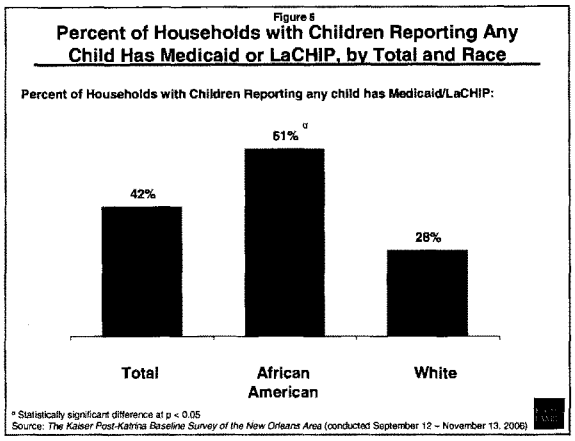
Since most elderly Americans have coverage through Medicare and low-income children are assisted by Medicaid, adults under age 65 comprise the bulk of both the nation's and Louisiana's uninsured population. In New Orleans, one in four adults between age 18 and 65 (25%) reported no source of insurance coverage, substantially higher than the national average of 17% for this group.[3] African Americans, the economically disadvantaged, and former users of the Charity Hospital system were most at risk of being uninsured (Figure 4). In Orleans Parish, where three in ten non-elderly adults were uninsured, 70% of the uninsured were African American.

[3] Ibid.

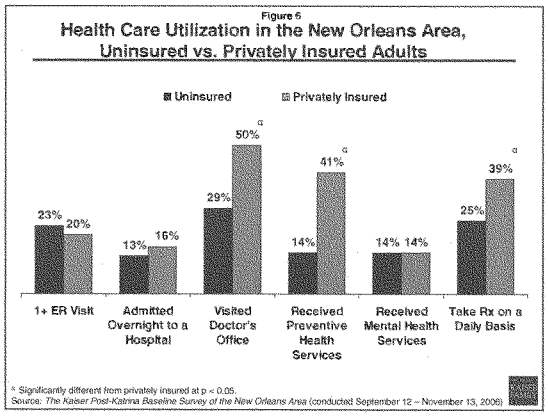


However, in Louisiana the story is quite different for children due to the availability of coverage through Medicaid and LaCHIP. Louisiana has been most successful in reaching out and providing coverage to low-income children, substantially reducing both the share of children without coverage and disparities in coverage. Only 9% of households with children reported having an uninsured child, a comparable rate for both African American and white households despite the substantially higher rate of uninsurance for African American adults compared to whites.

Public coverage through the Medicaid and LaCHIP programs has thus helped to close the coverage gap for Louisiana's children. Overall, four in ten households with children—61% of African American households compared to 28% of white households—report a child with coverage through Medicaid or LaCHIP (Figure 5). The extensive reach of these programs and low level of uninsurance for children highlights the importance of these programs in reducing racial disparities in coverage and care and giving children a healthy start in life.



Having health care coverage helps to promote access to health care services. Multiple studies have documented that the uninsured use fewer services, are more likely to delay or do without care, and suffer poorer health outcomes than those with insurance. Our survey findings mirror the national studies—uninsured adults in the New Orleans area were significantly less likely than the privately insured to report visiting a doctor or receiving preventive health care in the past six months or to take a prescription medicine on a daily basis, despite being in worse health (Figure 6). For example, only 14% of the uninsured compared to 41% of privately insured adults reported receiving preventive health services in the previous 6 months.



While the high rates of uninsurance in the New Orleans area prior to the storm remain a problem after Katrina, availability of health care for the uninsured has changed. Pre-Katrina, nearly 90% of the healthcare delivered to the area's uninsured was provided by the state-run public hospital system through the Medical Center of Louisiana at New Orleans (MCLNO), which consisted of Charity and University Hospitals. With more than one in five New Orleans residents uninsured and Charity Hospital closed with only limited services available at University Hospital, access to care for the uninsured poses a serious challenge in post-Katrina New Orleans.[4]

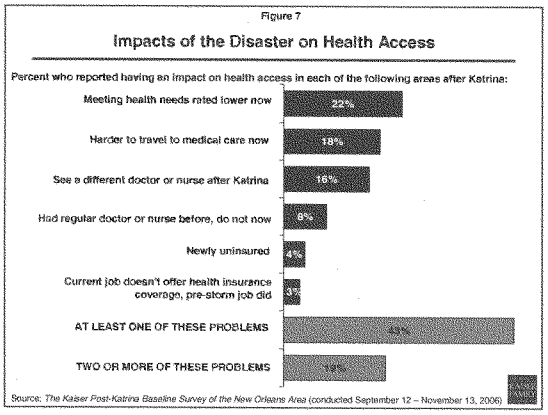
ACCESS TO HEALTH CARE

Because Katrina caused such profound disruption to nearly all aspects of life in the New Orleans region, individuals face a range of challenges in accessing needed care post-Katrina. Individuals were relocated within the region to areas where they did not know the doctors or hospitals; hospitals themselves were shuttered or offered greatly

[4] Rudowitz, R; Rowland, D; Shartzer, A. "Health Care in New Orleans Before and After Hurricane Katrina" *Health Affairs* 25 (2006): w393-w406.

reduced services; and physicians and their medical staff left the area in significant numbers.

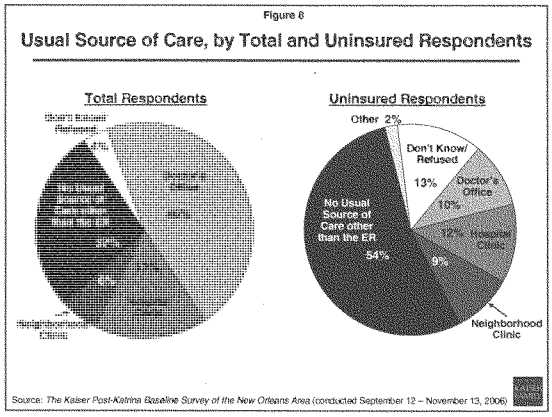
Taken together, these factors made it difficult for many New Orleans area residents to maintain their connections to their usual hospital, clinic, and physicians. Overall, 43% of adults say their access to care was negatively affected by the storm's aftermath, with nearly one in five (18%) saying it was harder to get to their place of medical care now (Figure 7). Some noted they see a different doctor or nurse after Katrina and others reported they no longer had a regular nurse or doctor.



Having a doctor or clinic one views as a usual source of care helps to promote access to needed care in an appropriate and timely fashion. Research has demonstrated that those with a usual source of care are less likely to experience unnecessary hospitalizations or visits to the emergency room for conditions that could more appropriately be treated in a clinic or doctor's office.[5] Yet in post-Katrina New Orleans,

[5] Petersen, et al. 1998. "Nonurgent Emergency Department Visits: The Effect of Having a Regular Doctor", *Medical Care*, 36(8):1249-1255; Bindman et al. 1996. "Primary Care and Receipt of Preventive Services," *Journal of General*

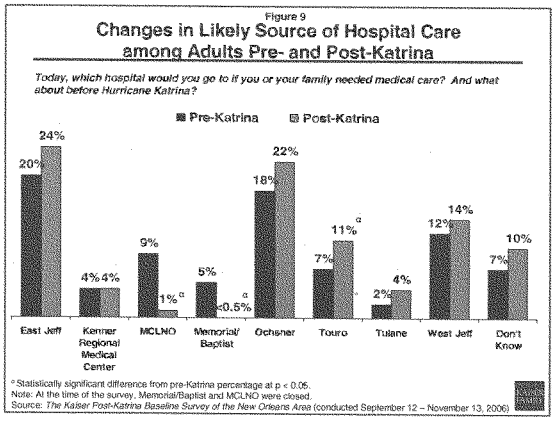
one in four adults (27%) said they had no usual source of care other than an emergency room. Less than half (46%) of respondents identified a doctor's office as their primary usual source of care, compared to two-thirds of adults (66%) who do so nationally (Figure 8).[6] Given the loss of provider capacity in post-Katrina New Orleans and the widespread disruption to the health care system, this lower rate of identifying a physician's office as the usual source of care is not surprising.



Access to a usual source of care is even more problematic for the uninsured. More than half of uninsured area residents (54%) reported no usual source of care other than the ER (roughly the same as the proportion nationally), and only 10% reported a physician's office as their usual source of care (compared to 27% of the uninsured nationally).[7] Given the closure of the Charity Hospital system after Katrina, it is also not surprising that 61% of previous users of the Charity Hospital system reported they had no usual source of care besides an ER.

Internal Medicine, 11(5):269-276; Sarver, J et al. 2002. "Usual Source of Care and Nonurgent Emergency Department Use," *Academic Emergency Medicine*, 9(9): 916-923.
[6] Ibid.
[7] Ibid.

Because Katrina's waters caused hospital closures and widespread population migration within the New Orleans area, many residents also reported a change in the facility they considered "their hospital," i.e. where they would likely turn should they need hospital-based care. At the time of this survey, only three of the nine acute care hospitals that operated in Orleans Parish pre-Katrina had re-opened, and, due in part to difficulty finding workers to staff beds, only 48% of the pre-Katrina hospital beds in the region were staffed as of November 2006.[8] For the residents living in the Greater New Orleans area at the time of the survey, 38% of residents identified either East Jefferson (20%) or Ochsner Hospitals (18%) as their likely source of hospital-based care prior to Katrina; post-Katrina, nearly half of residents identified these hospitals as where they would go if their family needed medical care (Figure 9).



There was a significant increase in the proportion who identified Touro Hospital as the hospital they would be likely to use, up from 7% pre-Katrina to 11% after the

[8] Source: Louisiana Public Health Institute, "NOLA Dashboard" November 29, 2006, http://www.noladashboard.org (Archive accessed July 6, 2007).

storm. Touro was the first inpatient facility to re-open in Orleans Parish after Katrina, reopening its emergency department on September 28, 2005. Pre-Katrina, 9% of current residents said the Charity Hospital complex was their care source, dropping to 1% after Katrina with the hospital still shuttered.

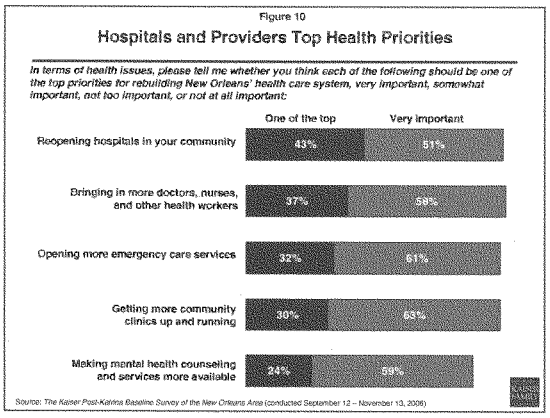
Findings from this survey document that previous users of the Charity Hospital system, together with the broader uninsured and Medicaid populations, were disproportionately affected by Katrina's devastation. But they were not alone. Hospital closures and the loss of medical professionals appear to have affected nearly everyone who lives in post-Katrina New Orleans. Indeed, the storms of 2005 had a leveling effect across some health access and utilization measures, creating new access to care barriers for many still living in the region.

PRIORITIES OF THE POPULATION

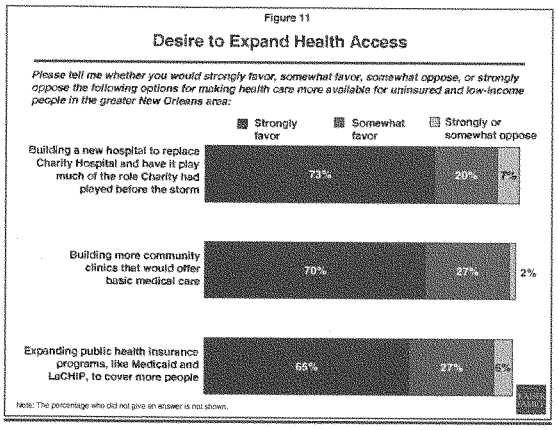
The aftermath of Katrina disrupted the lives of most residents of the New Orleans area across a variety of measures—finances, employment, housing, social networks, physical and mental health and access to health care. Getting medical facilities up and running ranked as one of the top priorities for the public. More than a year after the storm, nine in ten adults in our survey said they did not think there were not enough hospitals, clinics, and doctors in the area to take care of the people living in New Orleans or enough health services available for uninsured and low-income people.

Rebuilding the health care system in New Orleans was thus a high priority for more than eight in ten survey respondents (Figure 10). Reopening hospitals in their community was one of the top priorities for 43%, with another 51% stating it should be very important. There was also very strong support for other steps to rebuild and expand

health capacity—bringing in more doctors, nurses, and other health workers, getting community clinics operating, and making mental health services more available.



Adults in the New Orleans area appeared to be supportive of several different scenarios that might make health care more available for the low-income and uninsured population (Figure 11). About three-quarters (73%) strongly favored rebuilding Charity Hospital and having it play much the same role it played before Katrina. Seven in ten strongly supported building more community-based primary care clinics, and 65% were strongly in favor of expanding public health coverage through programs like Medicaid and LaCHIP.



STEPS TO ASSIST WITH THE RECOVERY OF HEALTH CARE IN NEW ORLEANS

As the people in the New Orleans area continue to struggle with a wide range of challenges rebuilding their lives and their city in the aftermath of Hurricane Katrina and the subsequent flooding, establishing a health system to provide ongoing preventive and primary care services—and specialty care when needed—is an essential component of recovery efforts. In the time period since the committee's last hearing in March 2007, some additional progress has been made in making health services more available for the residents of the New Orleans area, but the task is far from complete.

To reduce the number of uninsured children, Louisiana has expanded health coverage through LaCHIP for children in families with incomes up to 300% of the federal poverty level (about $51,510 for a family of three in 2007). This expansion builds upon the past success of Medicaid and LaCHIP in providing coverage to low-income children in the state and will help children both statewide and in the New Orleans area to access the preventive services and medical care they need to have a healthy start

in life. However, coverage for the one in four nonelderly adults who are uninsured remains a challenge.

To help address primary care and workforce shortages, in May, the Department of Health and Human Services released $100 million in funds for the Gulf Region authorized in the Deficit Reduction Act. These funds are to be used to help support public and non-profit clinics that provide primary care to low-income and uninsured residents in the area and assist with recruiting much-needed health workers back to the area through the Greater New Orleans Health Services Corps. This support for primary care services provides an important foundation for building a community-based system but is only one component of reestablishing the full range of health care services for the city.

While these recent steps are important, many issues in reshaping the health system remain unresolved and will affect access to care in the future for the people of New Orleans. The health challenges for coverage and access to care for the poor and uninsured long pre-dated Katrina's devastation, but the impact of the hurricane and the subsequent flooding further compromised their access to care and also affected the health services available to all New Orleans residents. Rebuilding health capacity is a critical component to bringing back New Orleans as a viable and desirable city for those who live there.

The rebuilding efforts need to address a wide range of issues in redesigning the health care system and upgrading access to care for residents. Among the options that could be considered:

- Broadened health insurance coverage, especially for adults, to promote access to care, reduce uncompensated care burdens, and help bolster financing for physician and clinic services. Broader health coverage for the population could help ensure that dollars follow the patients to their place of care with compensation to providers to enable health services to remain available in the New Orleans area.

- Providing alternatives to care for those now relying on ERs. Hospitals' emergency rooms have been busy places over the last two years, as they have cared for those with mental health crises, those with other emergent health problems, and those who have no where else to turn for medical care, but delivering this care and other health services to people without adequate compensation has strained the fiscal viability of health care facilities and threatened their ability to continue operating at current levels. With health services already at reduced levels, the closure of additional health facilities could aggravate the health access problems described previously.

- Using health care payment policy as a tool to help reshape the way health care is delivered by allowing flexibility in the use of Medicaid DSH funds for non-institutional services and to reimburse physicians. This would provide a funding mechanism to reimburse physicians (not just hospitals) for treating the uninsured and help deliver additional to support to clinics providing primary and preventive care.

- Providing additional support to rebuild both inpatient and outpatient mental health services. The number of inpatient mental health beds is critically low, creating backlogs for emergency rooms and cycling acutely ill patients through the system with no place to go. Bringing more inpatient beds online in the area and providing access to outpatient care and counseling before patients reach a crisis stage could help alleviate mental health challenges facing the population in New Orleans after the storm.

- Investing in rebuilding a high quality health workforce in New Orleans. The impact of the dislocation of the workforce has made recruitment and retention of health professionals critical to rebuilding efforts. In the short-term, adjusting payment rates to account for above-average labor costs and providing incentives to providers in critical specialties are important. Reforms to Graduate Medical Education (GME) payments to help reestablish medical training programs as a pipeline for future health professionals are essential to building a future health system that can meet the needs of the population.

- Determining the future scope and role for the public hospital system, the VA Hospital, and academic health centers in New Orleans to enable recruitment and training of health professionals as well as provide a source of care for the poor and uninsured. The debate over rebuilding Charity Hospital and the Veteran's Hospital in New Orleans needs to be resolved so that an integrated health care system can be developed to meet the needs of the academic health centers and medical schools for training and accreditation and to provide acute and specialty care for those in need.

In summary, federal, state, and local policymakers need to determine how to restore health care services and capacity and address the health care challenges facing the people of New Orleans. Rebuilding the health system will require stable financing for health care services, which includes defining the role of public coverage through Medicaid and LaCHIP, determining through what means broadened health coverage might be achieved, and reaching consensus on future financing for primary care, uncompensated care, and medical education.

Thank you for the opportunity to testify today and for your continued attention to monitoring the progress in rebuilding the health care system in the region.

Mr. MELANCON [presiding]. Thank you so much, Dr. Rowland. I appreciate that. Mark Peters with the East Jefferson General Hospital.

TESTIMONY OF MARK J. PETERS, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, EAST JEFFERSON GENERAL HOSPITAL, METAIRIE, LA

Dr. PETERS. Thank you. Good afternoon, Mr. Chairman and committee members. I am Dr. Mark Peters. I am the president and CEO of East Jefferson General Hospital located in Metairie, Louisiana. I serve as the chairman of the Metropolitan Hospital Council, as well as the current chairman of the Coalition of Leaders for Louisiana Healthcare. And I have been designated to present an overview of the specific problems facing five of the hospitals testifying here today. East Jefferson is a publicly-owned, not-for-profit hospital on the east bank of Jefferson Parish adjacent to New Orleans. We are a 450-bed tertiary care facility with more than 700 medical professionals. We employ more than 3,000 people and are one of the largest employers of the parish.

On behalf of the five hospitals represented here today from the greater New Orleans region, East Jefferson, Ochsner Health System, Touro Infirmary, Tulane Medical Center, and West Jefferson Medical Center, we appreciate the opportunity to speak to you about the severe and continuing consequence of Hurricane Katrina on our five hospitals. The region's health care infrastructure was decimated by Katrina and remains a very fragile shell. Due to the continued closure of Charity Hospital, as well as several other hospitals, these three hospitals provide 95 percent of the hospital-based services in the metropolitan area. We anticipate a combined loss of $135 million in 2007. This loss will grow to $405 million by 2009.

Nearly 2 years after Katrina, we testify today to share with you one very simple message. Our hospitals need your help. None of these five hospitals are financially secure. We are all coping with cash, cost, and staff issues on a daily basis. Our problems are similar even though we represent a broad spectrum of health care delivery. We stand together today to implore you to protect the patients in the New Orleans area from yet another crisis, one that is immediate, preventable, and that you can help us address. Over the past 2 years all five of our hospitals have testified before this committee and numerous other Louisiana and congressional committees explaining the dire circumstances we face. We have all received some form of Federal and State assistance but that assistance is simply not enough to sustain us.

As the primary economic engines of the area these hospitals are not only important because of the patients we serve but also the people we employ and the economy we support. Without continuing and sufficient Federal assistance these hospitals must all consider making very difficult decisions that will negatively impact the quality of care and services we provide as well as employment to many in our region. As you will see, on page 10 of my written testimony when we compare the first 5 months of 2005 to 2007 for these five hospitals, we have gone from a $13 million profit to a loss of $56

million. That is a negative swing of $70 million. Of that $70 million swing, $53 million went to labor costs alone.

Since the storm, our five hospitals have been working with Members of Congress, our State Department of Health and Hospitals, specifically the Louisiana Redesign Collaborative and the U.S. Department of Health and Human Services, as well as Chairman Donald Powell. I know that many members of this committee visited our area, some to provide direct assistance, others to learn, so that what happened to us never again happens on American soil. For these efforts we are extremely grateful. We are active and supportive partners in a long-term redesign effort. However, all who have analyzed our region's needs have reached the same logical conclusion, redesign must first begin by addressing immediate needs.

While we have asked Congress to either adjust current programs for unique circumstances or for specific targeted funding neither approach has resulted in our financial stability. Therefore, we five hospitals have identified five problem areas and potential solutions for Congress' consideration that each of us will detail in turn. We, of course, gladly welcome your creative assistance on these or other funding sources. Relief from wage costs, help with rising non-labor costs, suspension of the 3-year rolling average for graduate medical education, nursing immigration relief and help recruiting and retaining nurses and physicians, and consistent, adequate funding for uncompensated care.

The assistance from the Deficit Reduction Act for uncompensated care and from CMS to alleviate the wage index inadequacy was greatly appreciated. However, the funds were distributed equally among 31 parishes and 65 hospitals. Some of the hospitals that received funds are having very profitable years while the hospitals in the New Orleans metropolitan area struggle to remain financially viable. If the current Medicare wage index is not extended to reflect actual costs, East Jefferson General Hospital will continue to lose $2 million to $3 million per month. Using our current appropriate cost my hospital should see $18 million annually in wage index assistance. Instead, we received a one-time, $5 million payment through the DRA.

Moving forward, we need a predictable, multiple year commitment to our region's health care providers. Also, our Nation will be 1 million nurses short by 2020. The situation is much worse for us. Before Katrina, East Jefferson had a 2 percent nursing vacancy. Now it is 12 percent or some 90 positions vacant. In 2006 we hired 60 American-trained, Filipino nurses. Due to immigration caps and stalls, we continue to wait for these new hires. These nurses will save us $300,000 per month in labor costs or $3.6 million a year. Filling all 90 positions would save East Jefferson $4.5 million per year.

Every tragedy and disaster provides lessons to either avert the next one or mitigate the consequences. This disaster is no exception. I am often asked by my health care colleagues throughout the Nation, how can I help my hospital financially survive a disaster like this, a hurricane, an earthquake, a floor or a tornado. I would advise them that it is their best, long-term economic interest to close their doors. Why would I offer this advice? It was in our com-

munity's best interest to stay open and provide services to desperately needed. However, considering our financial outlook my hospital would have been better off closing than waiting for Federal and State relief. This is an appalling dilemma to face. Choosing between providing care for people in their time of greatest need or insuring the long-term viability of the hospital. Doing the right thing for our community meant that our hospital and the patients we serve may soon become victims of Katrina again.

I urge you to use the lessons learned from Katrina to not only protect our fragile health care infrastructure but to adopt policies that improve disaster response in the future for all Americans. Thank you for the opportunity of speaking.

[The prepared statement of Dr. Peters follows:]

Testimony of Mark Peters, MD, CPE,
Chief Executive Officer, East Jefferson General Hospital

before the

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives

August 1, 2007

Hearing: Post-Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns – Part II

Good morning, Mr. Chairman and Committee Members. I am Mark Peters, M.D., president and chief executive officer of East Jefferson General Hospital in Metairie, Louisiana. I also serve as the chairman of the Metropolitan Hospital Council of New Orleans, as well as current chairman of the Coalition of Leaders for Louisiana Healthcare. This collaborative of healthcare stakeholders is interested in designing and implementing a modernized health care delivery and financing system for Louisiana. I also have been designated to present an overview of the specific problems facing five of the hospitals testifying here today. Thank you for the opportunity to testify before the Committee.

East Jefferson General Hospital is located on the east bank of Jefferson Parish, adjacent to Orleans Parish. We are a 450-bed tertiary care facility with more than 700 professionals on our medical staff. We employ more than 3,000 people, and are one of the largest employers in the parish. Our publicly owned, not-for-profit hospital offers the clinical expertise and cutting-edge technology that our community expects and deserves. We offer a range of outpatient services as well as numerous primary care services including cardiovascular, rehabilitative, oncology, and women and child services.

Hospitals Continue to Face Severe and Continuing Crisis

On behalf of the five hospitals represented here today from the greater New Orleans region, East Jefferson General Hospital, Ochsner Health System, Touro Infirmary, Tulane Medical Center, and West Jefferson Medical Center; we appreciate the opportunity to speak to you and your colleagues about the severe and continuing consequences of Hurricane Katrina on our five hospitals. These five hospitals represent the majority of the health care infrastructure in the immediate New Orleans area.

The region's healthcare infrastructure was decimated by Katrina and remains a very fragile shell. Due to the continued closure of Charity Hospital, as well as several other hospitals, these five hospitals provide 95% of hospital-based services in the metropolitan area. These five hospitals expect a combined loss of $135 million in 2007. This loss will grow to $405 million in losses by 2009.

Nearly two years after Katrina, we testify before you today to share with you one very simple message: **our five hospitals need your help.** None of these hospitals here today are financially secure. We are all coping with cash, cost, and staff crises on a daily basis. Our problems are similar even though we represent a broad spectrum of healthcare delivery in the community. East Jefferson General Hospital and West Jefferson Medical Center are community-owned, not-for-profit hospitals. Touro Infirmary is a faith-based, not-for-profit hospital. Tulane Hospital is a privately held, for-profit hospital. And Ochsner Health System is a private, not-for-profit academic multi-hospital system.

Despite our apparent differences, we stand together today to implore you to protect the patients of the New Orleans area from yet another crisis, one that is immediate, preventable, and that you can help us address.

Current State and Federal Funding is Insufficient to Sustain Fragile Infrastructure

Over the past two years, all five of our hospitals have testified before this committee and numerous other Louisiana and Congressional committees explaining the dire circumstances we face. We have all received some form of federal and state assistance. But, that assistance is simply not enough to sustain our hospitals and the region. As the primary economic engines of the area, the hospitals in this region are not only important because of the patients we serve but also the people we employ and the economy we support. Without continuing and sufficient federal assistance, these hospitals must all consider making very difficult decisions that are very likely to negatively impact the quality of care and services we provide as well as employment to many people in the region.

The combined financial statement of the five hospitals (attached to my testimony) shows a $70 million decrease that begins with marginal revenues and ends in catastrophic losses when comparing the first five months of 2005 to the same time period of 2007. During this time period for these five hospitals,

- Salary and contract labor costs are up $53 million (17%).
- Utility costs are up 32%.
- Insurance costs have increased 35%.
- Interest expense is up 20%.
- And, bad debt has increased by 30%.

It is noteworthy that financial analysts conclude that these cost pressures are not expected to flatten or diminish in the future.

Targeted Solutions Necessary to Sustain Hospitals

In the nearly two years since "The Storm," our five hospitals have been working with Members of Congress; our State Department of Health and Hospitals, specifically, the Louisiana Redesign Collaborative; and the U.S. Department of Health and Human Services, as well as Chairman Donald Powell. There is no end to the kindness and sympathy that many of you have shared with us. In fact, I know that many Members of this committee visited our area, some in efforts to provide direct assistance, others to learn and study so that what happened to us never happens again on American soil. For these efforts, we are extremely grateful.

All five hospitals are active and supportive partners in a long-term redesign effort for our region's health care; however, all who have analyzed our region's needs have reached the same, logical conclusion -- redesign must first begin with immediate needs. While we have all worked with Congress to ask that you adjust current programs for our unique circumstances or to ask for specific, targeted funding, neither approach has begun to meet our needs. With that said, we five hospitals have identified five problem areas and potential solutions for the Committee's or Congress' overall consideration (below). I expect each of today's witnesses to address in varying details each area of concern. We, of course, also gladly welcome your creative thoughts on how else we might begin to resolve these critical problems:

PROBLEMS/ISSUES	TARGETED SOLUTIONS FOR HOSPITALS
• Relief from Wage Costs	Extend the wage index values for these specific areas
• Non-Labor Costs	Increased funding to assist these hospitals
• Graduate Medical Education	Suspend the 3 year rolling average for these hospitals
• Other Workforce Issues	Nursing immigration relief, help recruiting, retaining nurses/physicians
• Uncompensated Care (UCC)	Increase funds for multiple years to these hospitals

Wage Index/Uncompensated Care

For my part, I will focus on a few of these areas that are of the greatest concern to East Jefferson. The assistance from the Deficit Reduction Act (DRA) for uncompensated care and from the Centers for Medicare and Medicaid Services (CMS) to alleviate the wage index inadequacy to our hospitals was greatly appreciated. The hospital area wage index is used by CMS to adjust prospectively set Medicare payment rates for regional variation in labor costs. While this assistance was warmly welcomed, the funds were distributed equally across thirty-one parishes and sixty-five hospitals. Some of the hospitals that received funds are having very profitable years, while the hospitals in the New Orleans metropolitan area struggle to remain financially viable.

Our Medicare patients total approximately 60% of all EJGH hospital admissions. We lose money on each and every Medicare patient we care for. If the current Medicare wage index is not extended to reflect actual costs, East Jefferson will continue to lose $ 2 to $3 million a month. If the wage index were calculated using our current appropriate costs, my hospital would add $1.5 million to its bottom-line every month or $ 18 million annually. Our actual needs -- $18 million annually for wage index -- are in very stark contrast to the one-time, $5 million payment we received through the Deficit Reduction Act.

East Jefferson's payments from state and federal agencies for Katrina-related Uncompensated Care totaled $22 million, including $5.4 million from the Wage Index Grant payments. This amount also consists of UCC pools from HHS and CMS for care provided in the immediate aftermath of Katrina equaling $2.3 million, and $14 million from the Deficit Reduction Act. I feel this has been a reasonable response to the costs associated with Uncompensated Care of patients. Moving forward, my request is that the federal government and the state of Louisiana will make a multi-year commitment, instead of ad hoc payments, to help stabilize healthcare providers in the immediate New Orleans area.

Workforce/Labor Issues

Regarding our medical and nursing labor issues, a recent survey conducted by the Louisiana Health Works Commission reported 969 nursing and certified nurse aid vacancies in the region, over half of which were in hospitals. Although licensing data alone is not a good predictor of health care supply, the Louisiana Board of Nursing reports a 27% decrease in the number of nurses who renewed their license as of July 2006 in Region. Based on LHA and DHH hospital data and qualitative data reported from area hospitals, it is evident that there is insufficient operational acute hospital bed capacity in the region. Further, the supply of operational nursing homes beds in Region 1 is less than the national average.

Nurse Immigration

The Louisiana State Board of Nursing recently reported that 4,800 nurses changed the address on their license in the 10 months following Katrina and nearly half of them moved out of the state. Before Katrina, East Jefferson had a 2% nurse vacancy rate. Today, the vacancy rate is 12% - a loss of between 100 to 120 nurses. Nationally, hospitals report nurse vacancies at 116,000 (most recent data from Dec. 2006). HHS has projected that our nation will be 1 million nurses short by 2020. Even HHS has acknowledged that nursing programs would have to increase enrollment by 90% over the long-term in order to meet our nursing needs.

Many hospitals around the country are trying to bring in well-qualified American-trained nurses to help fill nurse vacancies. East Jefferson is not alone in this pursuit, but it is unique in its greater, immediate need. We sponsored 60 Filipino RNs in 2006 and need another 30 to fill current vacancies alone. Due to immigration issues and caps on visas, these nurses remain in the Philippines instead of in New Orleans where we desperately need their help.

EJGH has pleaded with Congress to lift immigration quotas and exempt the New Orleans area from taxes that would be imposed on employers who must rely on foreign nurses. However, this legislation has been stalled. With no fast-track immigration process for the 60 Filipino nurses hired by East Jefferson in 2006, we continue to use contract nurse labor, an additional $300,000 per month cost. Filling all 90 positions with these nurses would save us $450,000 per month, or $5.4 million annually.

Consequences of Not Focusing on the Immediate Health Care Infrastructure

Every tragedy and disaster provides lessons to either avert the next one, or, if that is not possible, mitigate the consequences. This disaster is no exception. During the almost two years and, the past few weeks in particular, we have learned a number of valuable lessons and gained some insights on how best to work together toward solutions.

East Jefferson General Hospital, as well as the other four hospitals represented here today, maintained our commitment to serving the residents of our communities. I speak for the thousands of people who work at East Jefferson and live in our community, who are dealing with loss and tragedy, and through it all have remained steadfast in their mission of caring for the illnesses and injuries of their neighbors.

I am often asked by healthcare colleagues throughout the nation, "How can I help my hospital survive a disaster like this – a hurricane, an earthquake, a flood, a tornado?" Based on my

experience, I would advise them it's in their long-term economic interest to close their doors. Why would I offer such advice?

Looking at the situation from the perspective of our mission, it was in our community's best interest to stay open and provide the necessary services so desperately needed. However, looking at it from a financial perspective, my hospital would have been better off to close during Katrina.

Why? We would have been funded through business interruption insurance, slowly bring beds back into service based on the financial payments received. At least this way, we would not be in the tenuous financial situation our hospitals face today. This is a horrific dilemma we all faced -- choosing between providing necessary care for people in their time of greatest need and waiting patiently for help to arrive or serving as a financial steward for the long-term viability of the hospital for the entire community into the future. In this case, doing the right thing for our community meant that our hospital and the patients we serve may soon become another of Katrina's victims.

Mr. Chairman, I appreciate the opportunity to tell you about the situation in my community. I urge you to use the lessons learned from Katrina to not only protect our fragile health care infrastructure today, but to adopt policies that will improve disaster response in the future for all Americans.

LHA/MHCNO Hospital Survey (7-27-07)
Region 1 Totals

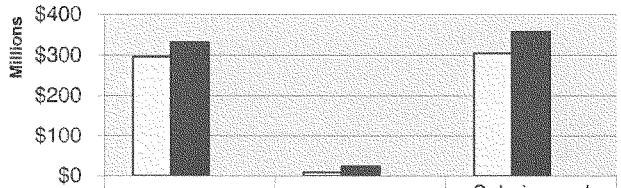
Financial Statement (Pre vs. Post Katrina)	Pre Katrina (Jan. 2005 - May 2005)	Post Katrina (Jan. 2007 -May 2007)	% Change
REVENUES			
Total Net Patient Revenue	$ 738,276,993	$ 770,246,257	4.3%
Other Operating Revenue	$ 20,423,893	$ 25,662,346	25.6%
Total Operating Revenue	$ 758,700,886	$ 795,908,603	4.9%
EXPENSES			
Salaries	$ 295,858,364	$ 330,842,427	11.8%
Contract Labor	$ 9,060,558	$ 23,793,548	162.6%
Salaries and Contract Labor	$ 304,918,922	$ 357,635,976	17.3%
Employee Benefits	$ 57,989,802	$ 60,579,635	4.5%
Supplies	$ 134,827,325	$ 147,032,803	9.1%
Utilities	$ 10,337,319	$ 13,687,096	32.4%
Insurance (P&C, Business Interruption, etc.)	$ 15,565,095	$ 21,077,574	35.4%
Interest Expense	$ 14,087,738	$ 16,925,303	20.1%
Depreciation and Amortization	$ 42,976,693	$ 49,000,494	14.0%
Bad Debts, included in net revenue	$ 37,123,268	$ 48,412,532	30.4%
Other Operating Expenses	$ 127,347,702	$ 137,910,137	8.3%
Total Operating Expenses	$ 745,171,764	$ 852,261,550	14.4%
Net Gain/Loss from Operations	$ 13,529,122	$ (56,352,947)	-516.5%

14.413516

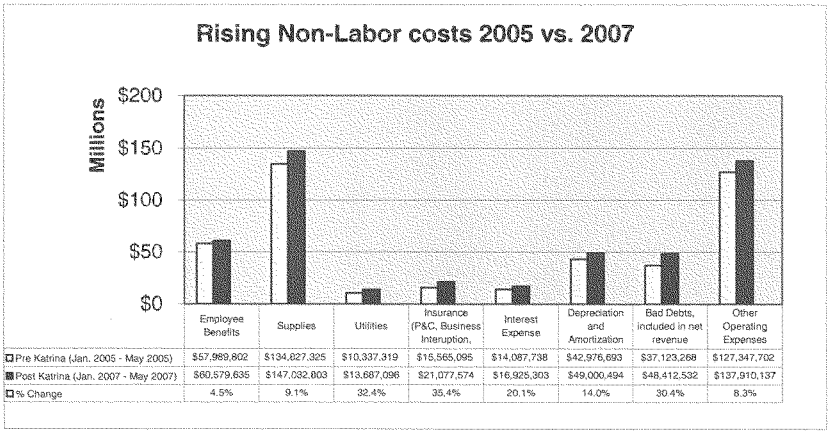
Notes:
Includes adjustments for one-time revenues and expenditures. The HHS Wage Stabilization grant funds
were excluded as one-time revenues. Uncompensated care funding recorded during the January through
May 2007 period was included as net revenues.
Includes employed physician revenue and expenses.

Hospitals Included:

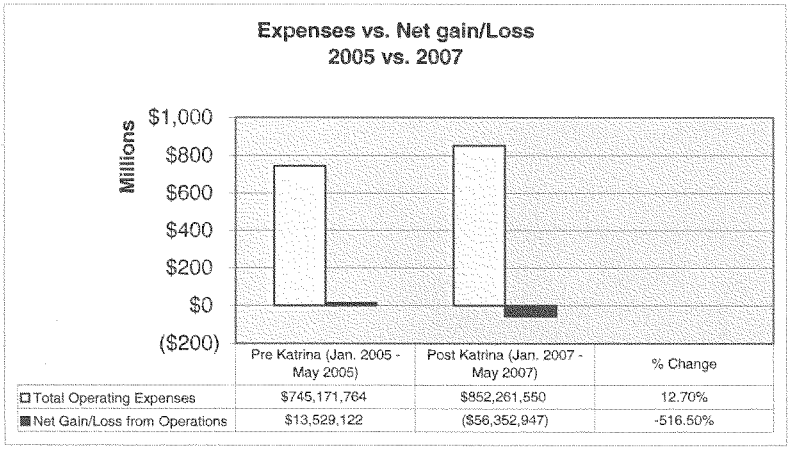
East Jefferson General Hospital
Ochsner Baptist Medical Center (included in 2007 only)
Ochsner Medical Center-Kenner
Ochsner Medical Center-West Bank
Ochsner Medical Center
Ochsner Clinic - South Shore
Touro Infirmary
Tulane University Hospital
West Jefferson Medical Center



	Salaries	Contract Labor	Salaries and Contract Labor
Pre Katrina (Jan. 2005 - May 2005)	$295,856,265	$9,060,558	$304,916,823
Post Katrina (Jan. 2007 - May 2007)	$331,233,428	$23,745,550	$357,635,976
% Change	12.80%	162.60%	17.30%



	Employee Benefits	Supplies	Utilities	Insurance (P&C, Business Interuption,	Interest Expense	Depreciation and Amortization	Bad Debts, included in net revenue	Other Operating Expenses
Pre Katrina (Jan. 2005 - May 2005)	$57,989,802	$134,827,325	$10,337,319	$15,565,095	$14,087,738	$42,976,693	$37,123,268	$127,347,702
Post Katrina (Jan. 2007 - May 2007)	$60,579,635	$147,032,803	$13,687,096	$21,077,574	$16,925,303	$49,000,494	$48,412,532	$137,910,137
% Change	4.5%	9.1%	32.4%	35.4%	20.1%	14.0%	30.4%	8.3%



	Pre Katrina (Jan. 2005 - May 2005)	Post Katrina (Jan. 2007 - May 2007)	% Change
Total Operating Expenses	$745,171,764	$852,261,550	12.70%
Net Gain/Loss from Operations	$13,529,122	($56,352,947)	-516.50%

Mr. MELANCON. Thank you, Dr. Peters. I appreciate it. Leslie Hirsch with Touro.

TESTIMONY OF LESLIE D. HIRSCH, FACHE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TOURO INFIRMARY, NEW ORLEANS, LA

Mr. HIRSCH. Mr. Chairman and members of the subcommittee, thank you for inviting me to tell you about the continuing health care crisis in New Orleans. Each of my colleagues here today will speak to this crisis from their own perspective. Mine is that of the president and CEO of Touro Infirmary, an organization that in its 155 years of existence has overcome such challenges as yellow fever epidemics, Civil War, and the Great Depression. We are community based and not-for-profit. But now Touro, along with the entire New Orleans Hospital community, is facing a crisis unlike any other in our history or for that matter in the history of American health care.

Never before has the entire medical infrastructure of a major American city been in danger of collapse but that is precisely what could happen if we continue on the present course. After temporarily closing 3 days after Katrina and opening less than 1 month later, we made the decision to forge ahead to restore Touro's operations, irrespective of the economic consequences. People were, and continue to be, in urgent need of medical care, and for us it was then, and it is now, a matter of mission and doing the right thing. That is our job and we are proud of it. But 2 years have passed since the greatest natural disaster in American history devastated the New Orleans area, and Touro and other continue to play a pivotal role in supporting New Orleans' recovery but the cost is staggering and if unchecked puts our future viability in jeopardy.

Since Katrina, Touro's operating losses have mounted totaling many millions of dollars with no end in sight. Our bond rating has suffered, increasing the cost of borrowing. We are depleting cash reserves at an alarming and unsustainable pace. In post-Katrina New Orleans, the economic fundamentals of the health care market are broken. Our cumulative costs of uncompensated care, personnel, property and casualty insurance, and utilities have all dramatically increased and have outpaced any rate increases or one-time grants that have been provided. Touro's property and casualty insurance is up 342 percent. Utilities are up 48 percent, post-Katrina. I believe, however, that the unprecedented rise in the cost of health care personnel is the biggest challenge and the most costly. Recruiting and retaining nurses, physicians, and other health professionals is a daily struggle for Touro and everyone else at this table.

However, the nursing shortage has had the greatest impact post-Katrina forcing us to heavily depend on contract labor, a very expensive form of staffing. And at Touro, for the first 6 months of 2007, our costs of contract labor increased by $4.6 million over the same time period the year before. Our full time equivalent contract registered nurse cost is dramatically higher than when they are our own staff. Our costs went up 366 percent during that period. The Medicare wage index methodology won't recognize this as previously mentioned until 2010, but exacerbating the problem is that

Medicare does not pay hospitals their full cost nor does Medicaid, thus, our hospitals are not paid full costs to begin with and we are falling that much further behind.

Graduate medical education has been discussed at length today, and I will keep my comments brief here, and simply just say that we stepped up during a time of need when we needed to protect the graduate medical education system in New Orleans, and it was the right thing to do, but we are paying a heavy price today. We have reduced several residents, about 12 going into this academic year, but even with that this 3-year averaging which must be addressed is still costing us nearly $4 million this year. During the last hearing, some of you mentioned what has been done, and some of those comments have been made here today. I would like to add to what Dr. Peters just said about the provider stabilization grants.

In some respects it belies logic, and I think in retrospect if we look at the present circumstance of our hospitals and the losses that have mounted where was the logic and the methodology of distributing $90 million to hospitals, more than 60 of them in 31 different areas designated by FEMA, different parishes, and as was stated some of those very hospitals are continuing to operate at a surplus. I don't begrudge them of that. They should. Every organization needs to operate at a surplus if it is going to continue to reinvest and move forward. But those monies would have been better spent in New Orleans. Touro received some $3.6 million of that money and for that we are very appreciative. Our annual need is three times that amount.

In closing, I just would simply like to say that I agree, I won't repeat all the recommendations that Dr. Peters made, I agree with everything that he said so I won't be redundant in that respect. I will just simply say that the present situation facing Touro as well as the other hospital in Orleans and Jefferson Parishes is very critical. While I do not speak for the other institutions, I can say that if some change in our financial condition does not occur soon, we will be forced to re-evaluate the level of services provided to the community. In the long term we simply will be unable to sustain ourselves. Thank you for the opportunity to be here today.

[The prepared statement of Mr. Hirsch follows:]

Testimony of Leslie D. Hirsch, FACHE
President and Chief Executive Officer
Touro Infirmary, New Orleans, Louisiana

Before The

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives

August 1, 2007

Hearing: Post-Katrina Health Care in the New Orleans Region:
Progress and Continuing Concerns – Part II

Mr. Chairman and members of the subcommittee thank you for inviting me here today and for your continued interest in the healthcare crisis that exists in New Orleans. As President and CEO of Touro Infirmary, a 155 year-old not-for-profit, faith-based community teaching hospital and one of the very few fully functioning hospitals currently operating in New Orleans, I have direct insight about this crisis. I recently testified before this committee in March, and am here today along with my colleagues to update about the distressed financial condition of the hospitals in Orleans and Jefferson Parishes, and Touro Infirmary in particular. It is nearly two years since Katrina devastated the New Orleans area causing the worst natural disaster in the history of our country. Unfortunately, we are far from being fully recovered. Because of Touro's commitment as a safety net provider we have suffered severe financial consequences. The future viability of Touro and the hospital system in Orleans and Jefferson Parishes is in real jeopardy if we continue on the present course! We truly need your help!

Touro Infirmary temporarily closed on September 1, 2005, just three days following Katrina, and after safely evacuating 238 patients, as well as hundreds of staff and family members, and remained closed for twenty-seven days. It was my eleventh day as Touro's new CEO. Touro reopened its doors on September 28, 2005 and in less than a year re-established operations to pre-Katrina levels. We were the first hospital to reopen in Orleans Parish and played a critical role in the City's ability to reopen. We were also the only adult acute care hospital in operation in the City for five months following the storm.

When it was time to pick up the pieces after Katrina, we made the decision to forge ahead as quickly as possible with the hiring of staff and other necessary expenditures without hesitation. We needed to move quickly to keep up with the heavy demands of caring for a rapidly growing patient population in need of medical treatment, and those demands have never eased. We did not have a real business plan and we did not have the time to stop to consider the possible consequences of moving forward without one. For us it was simply a matter of mission and, doing the right thing,

Two years later, Touro continues to play a vital role in supporting New Orleans' recovery, but the cost of doing so to say the least, has been devastating. Since Katrina, Touro has experienced unprecedented operating losses amounting to many millions of dollars. This negative trend continues in 2007 at a rate of approximately $1.3 million per month. Our bond and credit rating has been negatively impacted causing a substantial increase in borrowing costs. To sustain current operations we have been forced to deplete precious cash reserves critical to Touro's present and future financial stability, and at a pace that is unsustainable. We simply cannot go on with the present course without at some point making the kind of changes that will impact the level of services provided to the community. In retrospect one has to ask, "Was doing the right thing, the right thing to do? At this point I'm not certain about the answer to this question given the present

circumstance in which we find ourselves. I believe the answer to this question in large part depends on the outcome of these proceedings.

During the last hearing several Committee members asked why does there continue to be ongoing financial problems and what financial assistance has been provided to assist the hospitals?

I have been in health care administration for nearly thirty years and have never been in a more challenging health care market especially from a financial standpoint. The economic fundamentals of the post Katrina New Orleans market are broken. Touro's cumulative cost of uncompensated care, labor, property and casualty insurance, and utilities has dramatically increased in an aberrant way and at a markedly faster pace than any rate increases granted by Medicare and Medicaid during the same period. The usual wage index methodology utilized by Medicare won't recognize the extraordinary increase in labor costs that has occurred in the New Orleans area until 2009 or 2010. In the interim we cannot raise our rates to governmental payers to offset these significant cost increases. Also, exacerbating the problem is that Medicare and Medicaid do not pay hospitals their full cost; therefore beneficiaries of these government programs are really an *under-insured* patient population. Revenues from other payers such as commercial insurance companies and managed care organizations are dictated by contract and must be renegotiated to achieve higher rates. Rate increases are not guaranteed.

The key issues negatively impacting Touro's present financial status are discussed in greater detail below.

COST OF LABOR and OTHER WORKFORCE ISSUES

Prior to Katrina Louisiana was designated by the federal government as a health manpower shortage area. Shortages of critical health manpower in the New Orleans metropolitan area post Katrina are significantly more acute. These shortages have caused labor costs to rise sharply. Recruiting and retaining qualified nurses, physicians and other allied health professionals is a daily struggle for Touro and other hospitals in the area.

While there is a shortage of Registered Nurses nationally, Katrina exacerbated the problem in New Orleans. Touro's total labor cost per man-hour paid increased 18.7% from 2005 to 2007. This increase was driven largely by the cost of contract labor the vast majority of which is for nursing. For example, from January to June 2005, Touro's cost of contract labor was $1.3 million compared to $5.9 million for same period in 2007, an increase of $4.6 million or 366%. Touro's cost per full time equivalent Registered Nurse is substantially higher than the cost of salary and benefits for an RN that is employed by us. This issue is a very costly one for Touro and all of the other hospitals in Orleans and Jefferson Parishes, and has had a severe negative impact on our financial situation. However, with respect to the use of contract labor, there are a number of other associated issues in addition to the

excessive cost, not the least of which includes issues related to continuity of patient care.

Various studies and news reports have noted the exodus of physicians from the New Orleans area post Katrina. This has caused shortages in many specialties and particularly in the supply of physicians trained in certain "hospital-based" specialties such as Emergency Medicine, Radiology and Anesthesiology. Similar to the situation with respect to nursing and other health care personnel noted above, these shortages have substantially driven up Touro's cost for the services provided by hospital-based physicians by hundreds of thousands of dollars annually.

COST OF OTHER NON-LABOR EXPENSES

Touro's cost of property and casualty insurance post Katrina has severely increased and is up 342% from pre Katrina levels and now costs approximately $2 million annually. At the same time our coverage has declined from $337 million to $230 million. Touro's cost for utilities has also increased dramatically by 48% since 2005, an annualized rate of $1.3 million.

We are very grateful for the support that we have received from FEMA in reimbursing Touro for storm related damage and other mitigation projects. I am very pleased to recognize the efforts of U.S. Secretary of Homeland Security,

Michael Chertoff; FEMA Director, David Paulison; and FEMA Deputy Director-Gulf Coast, Gil Jamieson, all of whom have been of great assistance to us.

However, while not an issue that has contributed to Touro's present financial condition, we are greatly concerned about a recently announced change to FEMA's policies with respect to future funding of disaster grants and the treatment of insurance deductibles. We believe that these changes if permitted to be the policy of FEMA will effectively deny New Orleans private not-for-profit institutions, such as Touro, Stafford Act relief if we have another hurricane.

The wording on FEMA Disaster Assistance Fact Sheet DAP 9580.3, Revised effective June 4, 2007, states, "however, a deductible is not eligible for the same facility in a subsequent disaster of the same type." This change to the fact sheet wording has major implications for Touro and others—another hurricane could cause an extreme financial hardship for Touro of a catastrophic magnitude that could potentially cause its demise.

Graduate Medical Education (GME)

After Katrina,Touro and some other local hospitals expanded their residency training programs to absorb as many resident physicians as possible, thereby supporting and protecting the future of graduate medical education in New Orleans. Touro more than doubled the size of its GME program from eighteen to fifty-two residents. Our decision to help secure the future of graduate medical

education in New Orleans has been very costly one because of a federal rule that does not permit hospitals to be fully reimbursed for allowable costs in the first year by Medicare. Instead these costs must be averaged over a three-year period. In effect, hospitals expanding their GME programs are financially penalized during this initial period and must absorb these added costs. The *three-year averaging rule* clearly did not envision the hardship created by Katrina.

Our understanding is that CMS attempted to address this concern through a partial waiver of the *three-year averaging rule* for an initial period that ended on June 30, 2006, however CMS denied a waiver of the *three-year averaging rule* beyond that date. Consequently, Touro and other hospitals that stepped up to support and protect the future of GME in the aftermath of Katrina without regard to the negative financial consequences are being penalized financially to a substantial extent over a period of three years. If left unchecked Touro's incremental support of GME post Katrina, as revised would cost approximately $3.8 million dollars. Consequently to help defray some of this cost we have reduced the number of residents for the 2007-08 academic year by twelve slots.

Uncompensated Care (UCC) and the Uninsured

Nationally, the uninsured population has been reported at about 16%. Even prior to Katrina the percentage of the uninsured population in Louisiana and New Orleans significantly exceeded the national rate. Post Katrina this situation has dramatically worsened. A report by the Louisiana Public Health Institute prior to

Katrina indicated that the rate of uninsured in Orleans Parish was 26.1% (see Table 1.) Orleans Parish also had the largest increase in adults without insurance in the State of Louisiana. The high concentration of uninsured in Touro's immediate service area continues to put us at significant financial risk.

Since Hurricane Katrina devastated the healthcare delivery system in the New Orleans area Touro and the other hospitals in Orleans and Jefferson Parishes have provided an unprecedented amount of uncompensated care. Pre-Katrina, Touro was marginally profitable and was better able to sustain uncompensated care at a rate of 4.5% (see Table 1.) However, a spike in uncompensated care to 8.5% in 2006 dealt Touro a huge financial blow from which we still have not recovered. Thus far in 2007 we have seen some downward movement in the rate of UCC to under 6% however, this amount of UCC is still a very heavy burden to carry even though Touro and other community hospitals are now receiving some limited financial support from the State of Louisiana as noted below. When considering the fact that Medicaid and Medicare do not pay hospitals their full cost this is another form of uncompensated care that is not reflected in the figures presented above.

To date there has been some financial support from the state of Louisiana and the federal government, to help address Touro's and other hospitals' negative financial condition and is outlined below.

STATE SUPPORT FOR HOSPITALS

The State of Louisiana's budget in FY 06/07 for the first time included funding of $120 million to provide an Uncompensated Care (UCC) pool for community hospitals that when fully expended will provide funding for a significant portion of each respective community hospitals' approved UCC cost. Touro has received $5.9 million thus far from this fund and expects to receive an additional $1.8 million. In the State's 07/08 budget another UCC pool of approximately $87 million has been approved that will provide for some partial payment to community hospitals for their approved UCC costs. The amount Touro will receive from this fund is yet to be determined but we anticipate that it will be at a rate of about 50% of our approved UCC costs. The State's FY 07/08 also provides for a 4% increase in hospital in-patient Medicaid rates equal to about $33 million and an increase of about $68 million to increase physician Medicaid fees, to about 90% of Medicare. These are certainly positives steps in the right direction and are greatly appreciated. However, Touro and especially the community hospitals in Orleans and Jefferson Parishes need the security of knowing that funding for UCC will be provided over the long term without having to be concerned with this issue on a year-to-year basis. Sound financial planning cannot occur otherwise and without a constant funding mechanism for UCC we continue to be at great risk especially considering how tenuous the economic environment is here. Secondly, it is important to note that both Medicaid and UCC pay an amount substantially below cost.

FEDERAL SUPPORT FOR HOSPITALS

We very much appreciate the federal funding that has been provided thus far and particularly the efforts of U.S. Secretary of Health and Human Services, Michael Leavitt. But the impact of the funds that have been approved to date on improving Touro's financial position and that of the other hospitals in Orleans and Jefferson Parishes has been very limited.

Several grants utilizing Deficit Reduction Act (DRA) funds have been awarded to help Louisiana. A grant of $100 million was recently awarded to increase access to primary care. Two grants totaling $50 million have been awarded to help recruit and retain health care professionals including physicians, nurses, technologists and other healthcare personnel. Both of these grants are specifically earmarked for Region 1 (Orleans, Jefferson, Plaquemines and St. Bernard Parishes), the areas hardest hit by Katrina.

Several appropriations of DRA funds have been made for hospitals in the form of a Section 1115 Waiver ($123 million) to provide short-term UCC relief for a brief period following Hurricanes Katrina and Rita, and two Provider Stabilization Grants ($71.6 million and $26 million) to provide funding to help offset the wage increases experienced by hospitals. Of the combined amount of the stabilization grants (approximately $98 million) hospitals received just less than $90 million and the balance was distributed to nursing homes.

In retrospect, given the present financial distress of the hospitals in Orleans and Jefferson Parishes, one has to question the methodology by which the $90 million in Provider Stabilization Grants was distributed and wonder whether these grants really achieved what should have been the intended purpose, that being to provide relief for hospitals with the greatest need. Collectively, the hospitals in Orleans and Jefferson Parishes are presently operating at a substantial loss. For the period of January to May 2007 the hospitals there combined had an operating loss of $56.4 million compared to an operating surplus of $13.5 million for the same period in 2005 pre Katrina (see Table 3.) On an annualized basis this would amount to a projected aggregate operating loss in 2007 of $135 million.

Unlike the other grants noted above that were specifically earmarked for Region 1, the Provider Stabilization Grants were distributed to more than sixty (60) hospitals in the thirty-one (31) parishes designated as disaster areas by FEMA. Many hospitals in parts of the State that were not nearly devastated by Katrina and Rita the way we were in Orleans and Jefferson Parishes received substantial sums of money this year from these grants. At the same time, some of these hospitals continue to operate profitably.

Touro received two Stabilization Grants totaling $3,567,000 and we are grateful for having received these funds. But the magnitude of the challenge we face goes well beyond the potential impact of this one time grant. As previously noted, the Medicare Wage Index will not catch up for three years. If Touro's Medicare wage

index were to be adjusted for current salary costs this would have an annual positive impact of approximately $10 million per year.

In conclusion, the present situation facing Touro, as well as the other hospitals in Orleans and Jefferson Parishes is very critical. While I do not speak for the other institutions, I can say that if some change in our financial condition does not occur and/or if some other relief is not provided soon we will be forced to reevaluate the level of services provided to the community. We simply will be unable to sustain ourselves long term if we do not take some action soon to alleviate the situation.

We respectfully offer the following recommendations for the Committee's consideration.

Recommendations

Given the magnitude of the operating losses projected over the next three years we are asking that a relief package of as much as $400 million be funded for the hospitals in Orleans and Jefferson Parishes, and in consideration of the following issues:

- **Medicare Wage Index Adjustment**: To provide relief from the substantial growth in wage costs, extend the current wage index values for Region 1 hospitals.

- **Non-Labor Costs**: Provide funding to off-set the extraordinary costs that Region 1 Hospitals have experienced for property and casualty insurance, and utilities.
- **Other Workforce Issues**: Provide additional funding for Region 1 for manpower recruitment and retention, particularly to increase the number of Nursing Educators needed to increase the annual number of nursing school graduates. Provide flexibility in the rules governing immigration to allow greater numbers of foreign trained nurses to immigrate to the U.S.
- **GME Three Year Averaging Rule**: Approve a waiver of the three-year averaging rule so that hospitals that have stepped up in support of graduate medical education during this time of need will not suffer adverse financial consequences.
- **Uncompensated Care (UCC)**: Provide additional federal assistance in collaboration with the State of Louisiana to fund a greater percentage of the cost of uncompensated care for hospitals in Region 1.

Appendix:

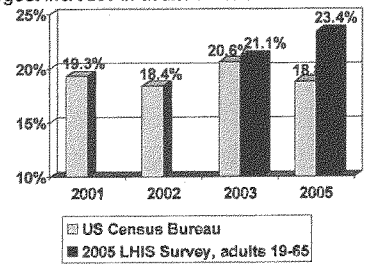
Table 1. Self Pay on Admission

Table 2. Touro Self Pay and Medicaid

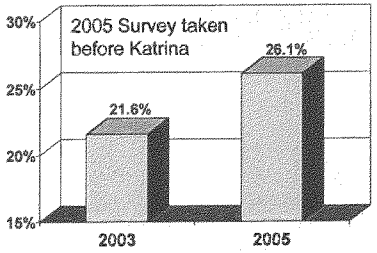
Table 3. LHA/MHCNO Hospital Survey 7/27/07

Table 1: Self Pay on Admission

Louisiana Uninsured – *Orleans Parish has the largest increase in adults without health insurance*

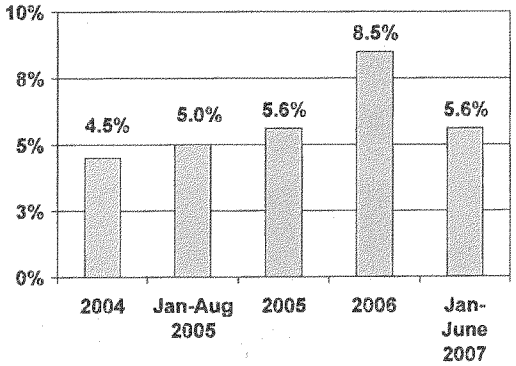


Orleans Parish Uninsured Adults



Orleans Parish had the largest increase in adults without insurance in the state of Louisiana, according to the 2005 DHH Louisiana Health Insurance Survey

Touro Self Pay Percentages by Year

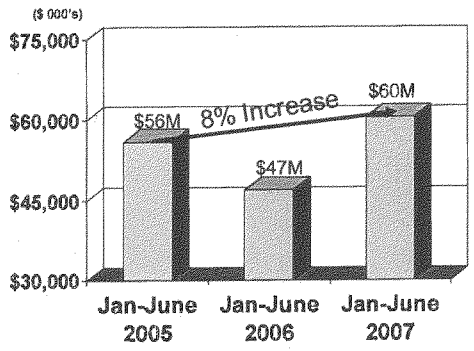


- Pre-Katrina, Touro averaged 4-5% self pay and is currently averaging 6% self pay.

SOURCE: Touro Financial Statements, US Census Bureau, 2005 DHH LHIS Survey adults 19-65

Table 2: Touro Self Pay and Medicaid

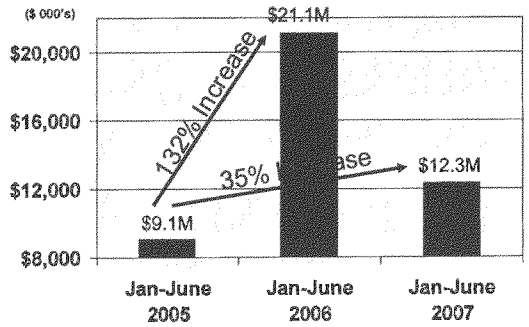
Touro Medicaid Charges



Touro has seen an 8% increase in Medicaid charges from the first 6 months of 2005 as compared to the same time period 2007.

SOURCE: Touro Financial Statements, Patient Accounting, 2007 Budget

Touro Self Pay Charges



Self Pay account balances increased from $9.1M for the first 6 months of 2005 to $12.3M for the same period in 2007.

Approx. **87%** of Touro Self Pay originates in the ED in which **9%** are admitted as inpatients.

Table 3: LHA/MHCNO Hospital Survey (7/27/07)

Region 1 Totals

Financial Statement (Pre vs. Post Katrina)	Pre Katrina (Jan. 2005 - May 2005)	Post Katrina (Jan. 2007 - May 2007)	% Change
REVENUES			
Total Net Patient Revenue	$ 738,276,993	$ 770,246,257	4.3%
Other Operating Revenue	$ 20,423,893	$ 25,662,346	25.6%
Total Operating Revenue	$ 758,700,886	$ 795,908,603	4.9%
EXPENSES			
Salaries	$ [illegible]	$ [illegible]	[illegible]
Contract Labor	$ [illegible]	$ [illegible]	[illegible]
Salaries and Contract Labor	$ [illegible]	$ [illegible]	[illegible]
Employee Benefits	$ 57,989,802	$ 60,579,635	4.5%
Supplies	$ 134,827,325	$ 147,032,803	9.1%
Utilities	$ 10,337,319	$ 13,687,096	32.4%
Insurance (P&C, Business Interuption, etc.)	$ 15,565,095	$ 21,077,574	35.4%
Interest Expense	$ 14,087,738	$ 16,925,303	20.1%
Depreciation and Amoritization	$ 42,976,693	$ 49,000,494	14.0%
Bad Debts, included in net revenue	$ 37,123,268	$ 48,412,532	30.4%
Other Operating Expenses	$ 127,347,702	$ 137,910,137	8.3%
Total Operating Expenses	$ 745,171,764	$ [illegible]	14.4%
Net Gain/Loss from Operations	$ 13,529,122	$ [illegible]	[illegible]

Notes:

Includes adjustments for one-time revenues and expenditures. The HHS Wage Stabilization grant funds were excluded as one-time revenues. Uncompensated care funding recorded during the January through May 2007 period were included as net revenues. Includes employed physician revenue and expenses.

Hospitals Included:

Ochsner Baptist Medical Center (included in 2007 only)
Ochsner Medical Center – Kenner
Ochsner Medical Center – Westbank
Ochsner Medical Center
Ochsner Clinic – South Shore
East Jefferson General Hospital
Touro Infirmary
Tulane University Hospital
West Jefferson Medical Center

* PREPARED IN CONJUNCTION WITH CONGRESSIONAL HEARING

Mr. MELANCON. Thank you, Mr. Hirsch. I appreciate it. Dr. Quinlan, we have got one floor vote. It will probably be unless something changes about 15 minutes so we will take a break and then we will have—one procedural vote so we should be back in about 15 minutes. Thank you.

[Recess.]

Mr. MELANCON. I want to apologize for the delays. We are having on the floor SCHIP which I think I don't need to explain to most people in the medical field, and there is debate and ongoing motions or as we would say commotions, so I think Mr. Stupak is still on the floor to speak and we will just go ahead and get started, and if he comes back I will move out of the chairman's way. I think when we stopped Mr. Hirsch had given testimony, and Dr. Quinlan was up to be next. And if you would, please, Dr. Quinlan.

TESTIMONY OF PATRICK J. QUINLAN, M.D., CHIEF EXECUTIVE OFFICER, OCHSNER HEALTH SYSTEM, NEW ORLEANS, LA

Dr. QUINLAN. Thank you. We understand these things happen. We appreciate your being here, and I want to thank the committee members for their obvious interest and continued commitment. The commitment is the part that I really feel that, and that means a lot to us. And I would also like to recognize the staffers whose involvement who clearly searched for understanding and meaningful, timeful action, and that is why they are recognized by the participants here. I would like to just edit my comments today. Obviously, it is kind of a difficult time for everybody and rely on my submitted testimony for much of the detail of which most of you are exquisitely already familiar, but I would like to take this time to focus on the essential issues because often the more information we get the more confusing things become, and I would like to redirect the attention in the time we have to the plight of the five hospitals that, as it was mentioned, take care of the bulk of people in New Orleans, and I am talking about the region of New Orleans.

Please focus on our immediate needs. If you took home one statement that would be it, the immediate needs, the immediate needs of our hospitals, the physicians and other health care professionals. The system consists of more than the building. It is all the people that work together to take care of people. The critical nature of the short-term needs have been recognized since the beginning by everyone. Unfortunately, it has been more about words and deeds but has been relatively lost in the search for long-term solutions. And you saw it happen here today. Most of the efforts and energy was expended about these long-term questions when we live with the immediate needs on a daily basis, and the consequence of that misplaced focus, I think has been expressed by my colleagues amply well rather than repeating it. The consequences are severe.

Please lead the efforts to correct this problem. I felt the emotion that has to be focused around the things that we talked about or others and as the staffers have rightly done focusing on what can we do soon to make the effects felt immediately. Anything other than that is actually a distraction from the immediate needs. We were reminded that the hurricane season is upon us, and I promise you that in the event there is another disaster the people sitting here at this table, these three hospitals will be in the middle of it

again. And unfortunately I hope that the same results don't occur for everyone. I did want to emphasize a few points that first there is virtually no money at present that is available for clinical care givers. Currently, and I will speak to my particular situation, currently we employ about 600 physicians and more than 120 licensed mid-level health providers who receive no payment for the care of the uninsured.

This acts as a significant drain for our health system because the lack of funding for both hospitals and Ochsner physicians and is a special problem for Ochsner. We have been successful in the recruitment of physicians and nurses. Currently we are bringing about 40 physicians on towards the last half of the year so we continue to do our job in the absence of payment. Second, well intended money to help our hospitals is not reaching us on a timely basis. That is a recurrent theme I know you have heard and will act on. Specifically, only $21.9 million of the $1.4 billion allocated by HHS and FEMA for Louisiana has reached the Ochsner Health Care System, the largest system in the State with 9,000 employees, and who was really one of the anchor points in the crisis and since then for the region, and I emphasize region.

Despite this generosity, we have experienced $65.5 million of additional un-reimbursed operating losses from Katrina, and that is the other issue is about operating losses. The problem is that dollars intended to help us and the immediate folks around us have gone to help a wide variety of providers who were not as impacted by Hurricane Katrina as Ochsner and the other hospitals testifying here today. These are important things for us. I will emphasize that we need to address Katrina-related expenses, specifically the cost of workers as it has been repeatedly emphasized. This cost has exploded, as well as the cost of utilities and insurance. These are direct operating costs of which we have no control and to which we have not contributed to any of the problems. You have heard about GME reimbursement.

Immigration assistance is a real issue for us. Our system has 300 open nursing positions. We too have hired additional foreign nurses from the Philippines, and we have 100 now waiting for visas. So, if we need special action to address the critical issue of increasing the work pool, all we will do is aggravate the inflation spiral, which is one of the major contributors to our economic crisis today. Half of our expenses are worker related. We need to blunt that spiral and new workers are the only way in number that will affect that. And, finally, we need to consider new mechanisms for distributing appropriations in a way that is tied to things that are clearly in the public interest, to promote those kind of behaviors that are economically sound, and to and promote health for our patients. That is it in brief. I do feel that in view of the effect of the distraction of the downtown issues, I need to make a few comments.

With regard to the VA, health care and economic recovery is important to us all. All of us together. We must and we need to find constructive solutions together rather than create an all or nothing alternative. This should not be a contest as it was characterized but I think in many ways it was accurately characterized because we are the ones who represent those who are in the middle which is the patients. It is easy to become energized about this. It is easy

to become frustrated. We all have ample reason to be frustrated, but I find in my own position frustration doesn't make me smarter. What I need to do is settle down and find solutions together. I think Kaiser Family did an important study for us all, and you notice it is regional. New Orleans is a regional problem. The solutions have to be regional in nature, not just in word but in deed, and that is an essential issue here. Dollars and patients and disease do not respect political boundaries.

We need to remember that because we are on the point. I chair GNO, Inc. I live in New Orleans Parish. GNO, Inc. is a development group, and I have spent a great deal of scarce time to promote the development of the city in particular. And my sentiments are simply that we have to learn to ask the right questions and make sure our understandings are current so that we don't find solutions that in fact don't fit the problem, that don't solve the problem. One of the few things I have learned as CEO is not that I have to find solutions. The art is to find the right question so that when it is addressed the problems are in fact resolved. So I would ask us to re-examine the factual basis of all of these things to make sure they are current and that what we do is consistent with those goals for the region.

My major interest is in taking care of patients. That is what we do, be they veterans or anybody else, so whatever solutions we have need to go with those in mind. In particular with regard to the VA it became evident to me as I was trying to unravel this issue with everybody else that no one had asked the veterans what they thought, so we did. Now we have been criticized for asking the veterans. That escapes me. But that's OK. I don't mind that kind of criticism because it is our duty when you have a captive population to find out what their needs are and meet them as quickly as possible. I hear the need for speed, and we do it in a way that would be as accurate as possible to remove bias, so we had two independent surveys of 1,200 veterans asking them where they wanted to get their care and from whom they would get it.

That is a legitimate question and it is a kind of thoughtful approach we need to engage in as we sort out these problems so in terms of location for the VA which has become an issue in itself what I would like to say is let us put it in proper perspective of health care for everybody, economic recovery for everybody, but not losing sight that they are all patients. In my business as we do in our system is asking the patients of how we are doing, what their interests and needs are, and making sure that is first. And I hope that we can reboot here in a sense and become constructive together. The problem is too large and too complicated to attack successfully in a piecemeal fashion. We will live with those consequences long after we are all out of office and the consequences of good decisions will be great, the consequences of poor decisions will be lasting and destructive. So let us be constructive and let us be current. Thank you.

[The prepared statement of Dr. Quinlan follows:]

Statement of Patrick J. Quinlan, M.D.

Chief Executive Officer, Ochsner Health System, New Orleans, LA

Subcommittee on Oversight and Investigations, Committee on Energy and Commerce

U.S. House of Representatives, Wednesday, August 1, 2007

Mr. Chairman, members of the Subcommittee, thank you for this opportunity to update you on our progress and continuing concerns Post-Katrina.

I would like to thank the many Members of Congress, including members of this Subcommittee, who have traveled to the Gulf Coast over the past twenty-three months to see for themselves the overwhelming devastation wrought on our City and our State as a result of the disasters associated with Hurricanes Katrina and Rita. Your personal presence and concerns are certainly appreciated by our citizens.

Ochsner Health System is an independent non-profit organization made up of seven hospitals and thirty-two clinics employing over 9,000 people. Ochsner is the largest private employer in Louisiana. Ochsner Medical Center was one of only three hospitals to keep its doors open despite the ongoing interruption of its business, during and after Katrina to care for all patients. We made this decision despite the fact that physical damage to our facilities caused us to suffer a significant interruption of our business both during and after the storm.

We are one of the largest private non-university based academic institutions in the country with over 350 residents and fellows, proven research including bench research, translational research and clinical trails. In addition, we provide training for approximately 400 allied health students and over 700 medical students from LSU and Tulane with little funding to support this mission. The importance of

Ochsner's graduate medical education program has increased greatly since Katrina because we are the only fully functional academic center in the greater New Orleans area.

As part of its ongoing contributions to the recovery of the greater New Orleans region, Ochsner purchased three community hospitals in Orleans and Jefferson Parishes in October 2006 from Tenet Healthcare Corporation that were temporarily closed and significantly disabled in the aftermath of Katrina.

I wish I had more positive news to report to you since we last met in March but the reality is that all five hospitals represented here today continue to bleed red ink as a result of holding this fragile healthcare system and medical education system together in the Post-Katrina world we live in. We are all facing significant pressures because of these skyrocketing costs. Simply put we are challenged to continue our current level of services because of increased labor and non-labor costs, graduate medical education costs, increasing uncompensated care costs and lack of a workforce to maintain and address the increasing demand for health care services.

Currently Ochsner employs over 600 physicians and more than 120 licensed mid-level health providers who receive no payment for the care of the uninsured. This acts as a significant drain for our Health System because of lack of funding for both hospital and Ochsner physicians.

Well-intended money to help our hospitals is not reaching us on a timely basis. Only $21.9 million of the $1.4 billion allocated by HHS and FEMA for Louisiana has reached Ochsner Health System. Despite this generosity we have experienced $65.5 million of additional unreimbursed operating losses since Katrina. A problem is dollars intended to help us have gone to a wide variety of providers that were not as impacted by Hurricane Katrina as Ochsner and the other hospitals testifying today.

Unlike other disasters in this country, a short-term fix is not possible for the greater New Orleans area. Katrina was a disaster of untold proportions.

We need your help immediately to address issues affecting our hospitals on a more long-term basis. Therefore, I offer the following targeted solutions for your consideration: address spiraling wage costs by adjusting the Medicare Wage index to reflect the current, not retrospective wage index; increase funding for increasing non-labor costs; eliminate the three-year rolling average for Graduate Medical Education which currently reduces payments to participating hospitals by one third; and help us address workforce shortages by authorizing waivers to address immigration of foreign nurses and other allied health professionals for the short term and provide funding to increase the capacity and faculty of nursing schools in the region in the long-term. Ochsner currently has 300 nursing vacancies. To address our short-term needs, we have hired 100 nurses from the Philippines only to find there is a limit on visas to allow them to enter this country. There are currently hundreds of people on waiting lists to enter nursing school if only the schools locally had the capacity and faculty for training.

Unfortunately, Medicare payments under the current system are not adequate and we have not felt much relief from recent federal grants. Therefore, I would recommend an appropriation through HRSA or another federal agency to cover these increased costs due to Hurricane Katrina, using the Medicare cost reporting and payment system to ensure accountability. Since all the affected hospitals treat a significant number of Medicare patients this method of distributing funds would assist the hospitals in covering their increased costs. Such a grant could be provided over a three-year period until the Medicare wage index "catches up" to our real costs. The current financing system does not provide the regulatory flexibility needed to address our issues and is too complex to meet our needs in a timely manner as our hospitals face immediate consequences.

What are the implications if we don't get relief? Ochsner will be forced to re-evaluate services and programs that we provide that are not profitable. Examples of such services are 24-hour emergency departments, obstetrical programs, psychiatric services, medicine services, and community outreach programs such as health fairs and screening services. Ochsner will be forced to limit access, and reduce services because of the need to reduce contract labor and other expenses. Our two greatest expenses are people and supplies. Ochsner would have to take a serious look at our capacity to provide graduate medical education going forward as one of the largest private non-university based academic institutions in the country. We know that a significant number of physicians locate to practice where they train, so the next generation of medical doctors for the area could be severely limited as a result of cutbacks in their training.

This is a balancing act for all of us represented here today. Ochsner Health System stepped up without reservation to assist the citizens of our region during and after the storm. We have suffered as a result of the greatest disaster to ever hit this country. We are not looking for the federal government to subsidize our bottom line but we are looking for help to address Katrina-related expenses. And to do so in a way that is consistent with good public policy such as expanding capacity to attract seniors back to the area and to allow all the hospitals to maintain high levels of a wide array of healthcare services. Please don't forget us; the healthcare needs of our community are in your hands. The regrowth of the greater New Orleans area depends on your immediate action to save our healthcare infrastructure and ensure our ability to provide care to all our citizens.

Thank you for your time and consideration. I am happy to respond to any questions.

Additional Statement of Patrick J. Quinlan, M.D.

Chief Executive Officer, Ochsner Health System, New Orleans, LA

Subcommittee on Oversight and Investigations, Committee on Energy and Commerce

U.S. House of Representatives, Wednesday, August 1, 2007

Much has been made during today's hearing testimony about the need for the new VA Medical Center to be located in downtown New Orleans completely ignoring the facts that veterans overwhelming support a suburban location across from Ochsner Medical Center on Jefferson Highway.

The Veterans Administration sought alternative sites for its Southeast Louisiana hospital due to delays anticipated at the proposed downtown site. Understanding the vital importance of bringing quality healthcare to veterans as well as the facility's importance for our region's overall redevelopment, Ochsner responded by offering a 28 acre site adjacent to its main hospital. Ochsner also made it clear that it was willing to discuss the provisions of additional acreage if needed by the VA as it planned its new facility. The Ochsner site is located 800 yards from the Orleans Parish line, has a New Orleans address and is four miles from downtown New Orleans. The site is above sea level, not in a flood plain and is owned free and clear by Ochsner. It provided an alternate for veterans that is safe, ready for construction and conveniently located adjacent to numerous highways and public transportation.

Our veterans have waited far too long for the services of a new VA facility and it is time to make our veterans the number one priority in the decision making process, followed by the potential cost of such a project to the taxpayers of this country. Ochsner commissioned an independent research study of 600 veterans including 300 current and former VA patients and 300 potential patients living in eighteen parishes in South Louisiana to determine the optimal location for a new VA facility. The following is a direct quote by the researchers of their key findings: "Seldom do the results of survey research speak so

clearly as they do to the preference for a suburban Jefferson Parish location for a new VA health facility. Over three quarters (76%) of veterans indicated that they prefer a suburban location to one in downtown New Orleans." In a follow-up survey conducted in July 2007 by the same research company the researchers said, "As was the case with the original study, conducted in April 2007, veterans express a strong preference for a Jefferson Parish (Jefferson Highway across from Ochsner) location over a downtown New Orleans location. Over three quarters (77%) of veterans indicated that they prefer a Jefferson Highway location to one in downtown New Orleans. In a question not asked in the original study, veterans also expressed a strong preference in receiving treatment at Ochsner as opposed to the Medical Center of Louisiana (the "new Charity") in the event that the VA hospital could not provide care. Ochsner was preferred by a 70% to 19% margin." (Copies of both research studies and the methodology used are attached as part of this written testimony.)

In summary, any decision made about the location of the new VA facility should be made based on the facts, not rhetoric or politics. We all now know overwhelming veteran preference for the Ochsner location that can be prepared for millions of dollars less, that is located out of the flood zone, owned free and clear, will work for the Universities according to their own testimonies before the VA field hearing held in New Orleans, and still creates the same economic growth for the region now not years from now with a more certain partner. We welcome the Energy and Commerce Committee's complete review and analysis based on the facts not hopes.

The VA Hospital study conducted by Market Dynamics Reserach Group, Inc. (MDRG) for Ochsner Health Systems consisted of 600 telephone interviews administered to 2 groups of equivalent size:

1. Military veterans currently receiving medical care at a VA hospital or clinic
2. Military veterans who have in the past used a VA hospital or clinic for healthcare services

The sample was drawn at random from a list of military veterans purchased by MDRG for a sample vendor. The sample vendor is a company completely unrelated to Ochsner Health Systems as is MDRG.

MDRG purchased a list of self-identified Veterans in one of 18 Louisiana Parishes. The list provider is Marketing Systems Group Genesys Sampling Systems. The list includes all households with a listed phone number in the United States. The file is multi-sourced to provide the most complete coverage possible, while mitigating the potential bias associated with single source household lists. Inputs to the database include telephone directories, automobile and motorcycle registrations, real estate listings, and driver's license data. Updated bi-monthly, this database consistently provides a current resource for sampling the ever-shifting U.S. population.

The parishes included in the survey are:

Plaquemines	Orleans
Lafourche	Jefferson
Terrebonne	St. Bernard
St. Helena	St. Charles
Livingston	St. John the Baptist
West Baton Rouge	St. Tammany
Ascension	Tangipahoa
Assumption	Washington
St. James	East Baton Rouge

The sample size of n=600 yields a statistical margin of error of ± 4%, and each n=300 sample segment yields a statistical margin of error of ± 5.7%, computed in both instances at the 95% confidence level.

As an independent research company, MDRG's reputation depends on its ability to provide clients with accurate, unbiased information. Questions for the survey were developed by professional survey researchers with advanced degrees in survey design and survey research. The questions were designed in such a way as to provide the most accurate results possible and eliminate any potential sources of bias.

VA Health Facility Location Study #2 Final Report July 24, 2007

mdrg
Market Dynamics Research Group, Inc.
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Research Objectives and Methodology

Objective

◊ The chief purpose of the research is to help determine an optimal location for the new VA health facility.

Methodology

◊ The research was conducted using a standard telephone interviewing methodology. Interviewing was done using a CATI system (computer assisted telephone interviewing) and professional interviewers.

Time Frame

◊ Interviews were conducted from July 16-19, 2007.

Sample

◊ Respondents were selected at random from a list of area veterans. Respondents were screened in order to ensure their veteran status. Quotas were maintained to ensure that the sample consisted of 50% current or former patients and 50% non-patients ("potential patients").

◊ The following parishes were included in the survey based on the anticipated service area for a greater New Orleans area VA health facility: Orleans, Jefferson, St. Bernard, Plaquemines, Lafourche, Terrebonne, St. Charles, St. John the Baptist, St. Tammany, Washington, Tangipahoa, St. James, Assumption, West Baton Rouge, Ascension, Livingston, East Baton Rouge, and St. Helena.

Key Findings

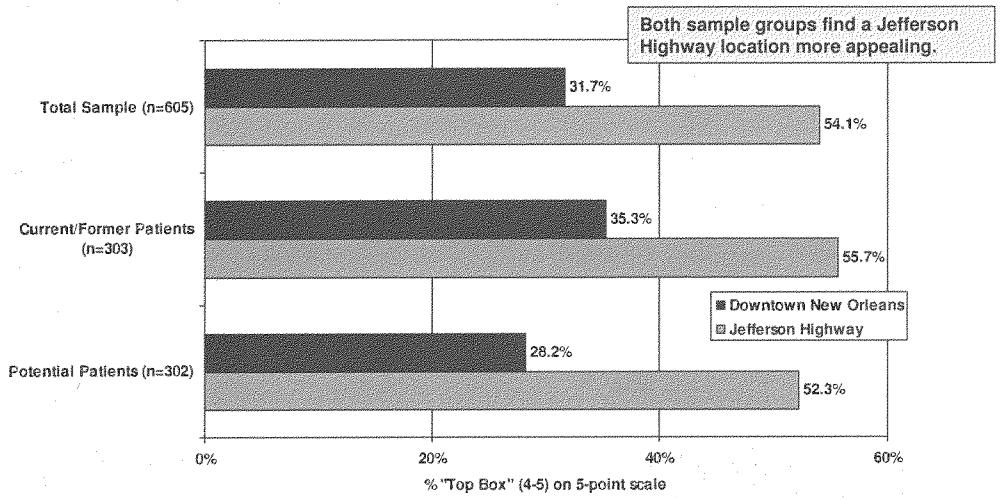
As was the case with the original study, conducted in April 2007, Veterans express a strong preference for a Jefferson Parish (Jefferson Highway across from Ochsner) location over a downtown New Orleans location. (see charts at pp. 5-7).

- Over three-quarters (77%) of veterans indicated that they prefer a Jefferson Highway location to one in downtown New Orleans.

In a question not asked in the original study, Veterans also expressed a strong preference for receiving treatment at Ochsner as opposed to the Medical Center of Louisiana (the "new Charity") in the event that the VA Hospital could not provide care.

- Ochsner was preferred by a 70% to 19% margin.

Appeal of Downtown New Orleans vs. Jefferson Highway Locations



Q1. Thinking about the location for a new VA facility, how appealing would it be to locate the facility in downtown New Orleans? It would be near the site of the VA facility that was used before Hurricane Katrina, which was in the center of the city, just a few blocks from the Superdome. How appealing would that location be to you for a new VA facility?
Q2. Thinking about the location for a new VA facility, how appealing would it be to locate the facility on Jefferson Highway, across the street from Ochsner Medical Center?

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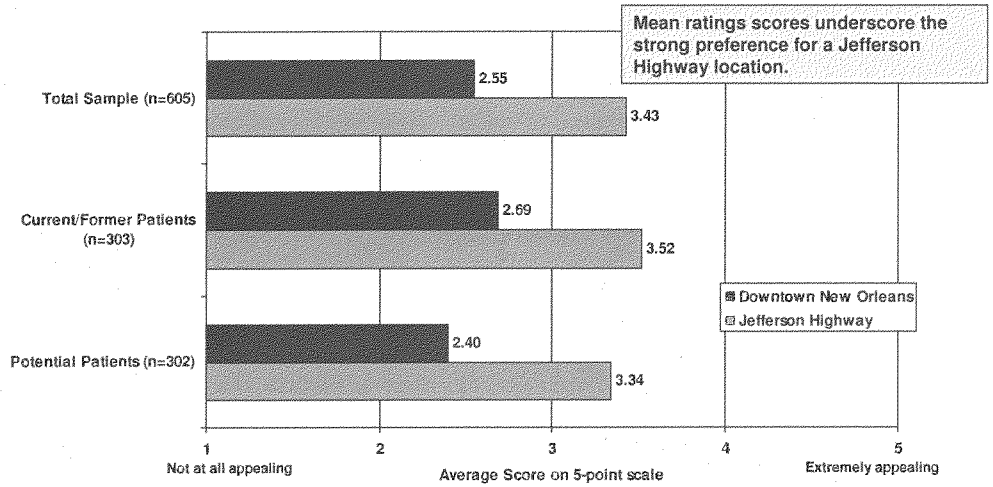
Appeal of Downtown New Orleans vs. Jefferson Highway Locations



Q1. Thinking about the location for a new VA facility, how appealing would it be to locate the facility in downtown New Orleans? It would be near the site of the VA facility that was used before Hurricane Katrina, which was in the center of the city, just a few blocks from the Superdome. How appealing would that location be to you for a new VA facility?
Q2. Thinking about the location for a new VA facility, how appealing would it be to locate the facility on Jefferson Highway, across the street from Ochsner Medical Center?

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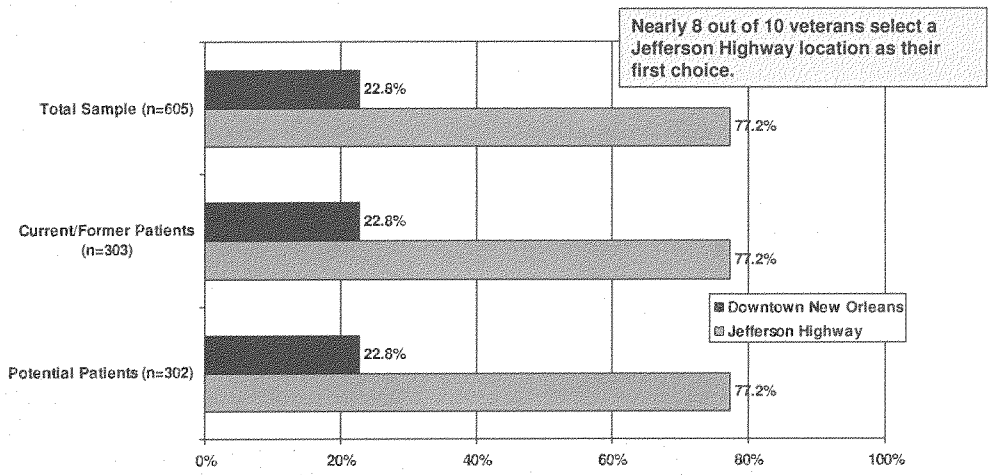
Preferred Location



Q3. Of the 2 locations, which do you prefer? That is, would you prefer the new VA facility be located in downtown New Orleans or Jefferson Highway across from Ochsner Medical Center?

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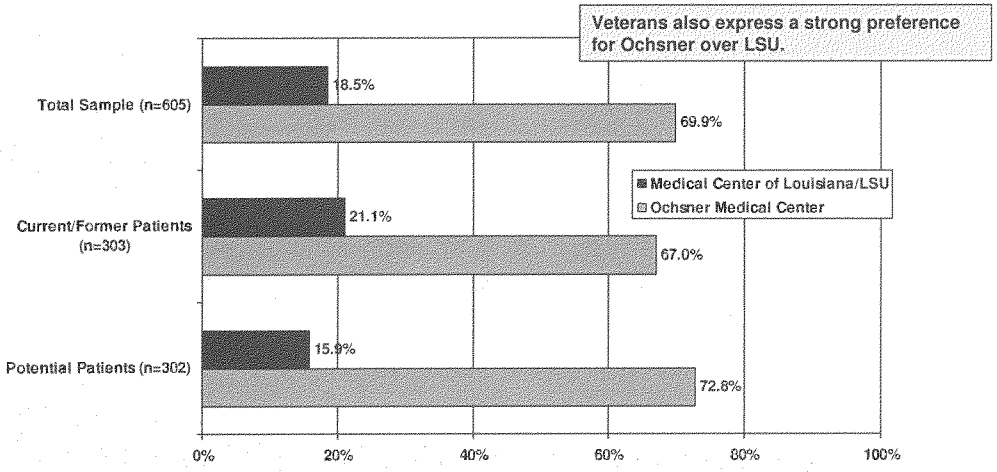
Preferred Provider



Q4. Once the new VA hospital facility is rebuilt, if you were in need of a type of medical care that the facility did not offer, would you prefer to receive such care at Medical Center of Louisiana/LSU Hospital, the proposed replacement for Charity Hospital on Tulane Avenue in New Orleans, OR Ochsner Medical Center?

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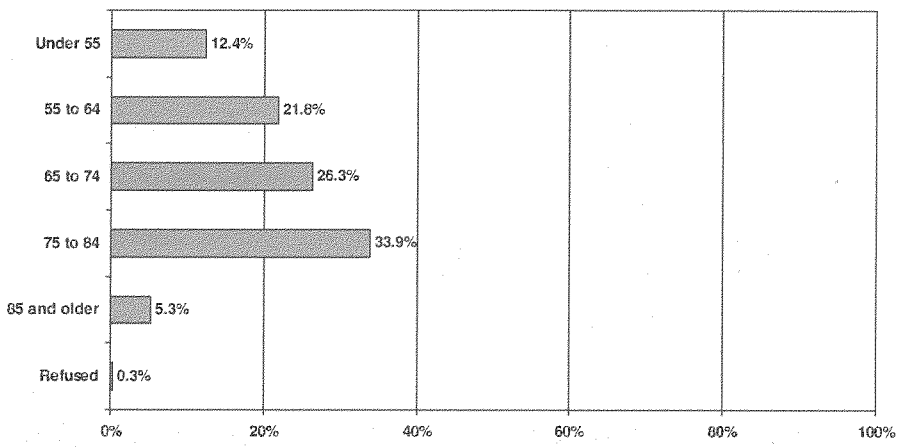
Respondent Profile

Respondent Age

Base = 605



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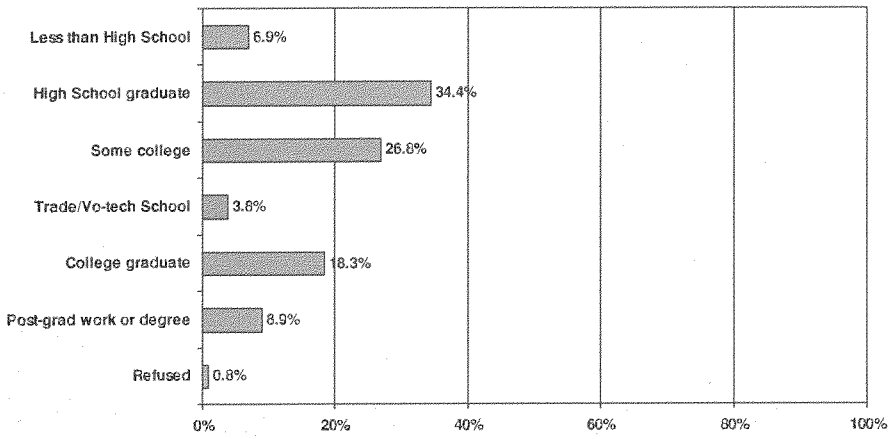
Respondent Education

Base = 605



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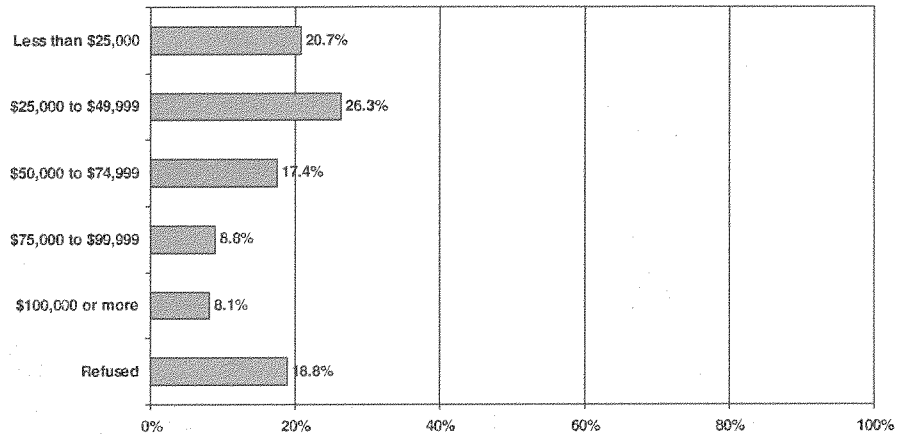
Total Household Income

Base = 605



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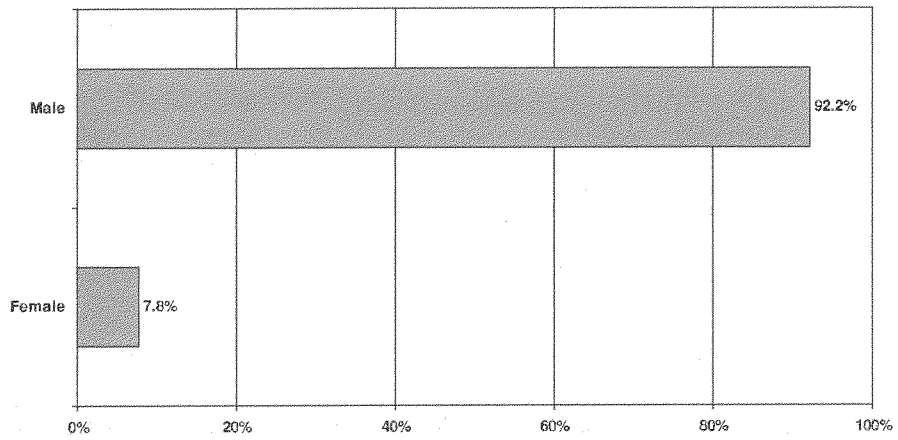
Respondent Gender

Base = 605



mdrg
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Appendix: Questionnaire

Mr. MELANCON. Thank you, Dr. Quinlan. Mr. Muller, if you would be next, please.

TESTIMONY OF GARY MULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, WEST JEFFERSON MEDICAL CENTER, MARRERO, LA

Mr. MULLER. Good afternoon. It is a pleasure to be here. I am Gary Muller, CEO at West Jefferson Medical Center, and I feel like I am with my family who is the committee and who is the staff of the committee and who are my colleagues, every one of these people sitting at the table because we are 2 years post-Katrina and our situation is getting worse and we are all in this together to try to help to fix it. In the interest of time and not reiterating what a lot of people have said, I am going to focus on some issues that are specific to our common goal of the five hospitals and continuing to focus on that because that is the issue that is the problem. We can't get off that.

West Jefferson was in good financial standing before Hurricane Katrina, and I think your charts and the graphs you have seen of the pre-Katrina numbers are specific to how good it was in terms of making a business work before and how horrible it is today. West Jefferson has had $48 million worth of operating losses since Katrina and since this subcommittee met, in March we have had $6 million more losses. If we were to meet again in 4 months, we would have at least $6 million more. We cannot continue like that. We are trying to solve our own issues as best we can. From a CEO standpoint you can only control so much, and what we can do is spend money wisely. We have implemented business improvement plans. We have negotiated with doctors in win-win situations to create cost savings programs. This month West Jefferson became the first hospital in Louisiana's history to receive the Energy Star award for energy efficiency from the Environmental Protection Agency.

We can only trim costs so far. We have all done that. We hope not to do anything that affects patient care but what we need now is additional grant dollars and payment increases in some of the areas we have talked about today. I would like to explain to you five of the issues that are really a financial crisis for Orleans and Jefferson Parishes. Again, get your thinking down to the area. This is not a Louisiana problem. It is Orleans and Jefferson. For example, high labor costs are specific to us. Immediately after the storm we hired contract nurses, and we had almost 100 of them. We spent $12 million that year. The previous year we had spent $2 million, so we were already in a negative $10 million, and we did that to replace employees who left after Katrina but also to open more beds. We felt that the public needed to have access to health care. Nine hospitals closed. Three were left open. Several have opened since then. But without us doing that, people literally would not have been able to get care.

To keep the doctors and the nurses in New Orleans, we can only do so much by hiring them but we are being put in a difficult position because it is also the levees, the schools, the businesses are not opening. What we are doing to get more nurses in the future, we are partnering with Our Lady of the Lake up in Baton Rouge,

and they are going to open a nurse training program on our campus to groom our own nurses because we can't go and hire enough from the Philippines or from Texas and Kansas City to bring into Louisiana. We need to grow our own. We can do that but we need something like a wage index adjustment because the wages have gone up 25 percent, and our recruitment costs have gone up also.

West Jefferson predicted that without operating income that our bond insurance companies would be asking questions why you are not making money, and it might seem sort of obvious to all of us on the team here, but they are very focused on making sure bonds get paid so they put us in technical default of our bonds at West Jefferson, and they put a mortgage on West Jefferson. They actually have a mortgage. That is costing us money, at least a million dollars in consultants and at least a million dollars in interest during the year, plus we don't know what they are going to do next. Now when they come in, they don't provide services to the community. They cut costs. And we are trying to do the best we can, and we continue to look at utilities, supplies, and all the other things, so we are going to continue to do that, andhope that we can get money to offset our operating losses very soon.

So we are sort of a little different from everybody else in that respect. We are under a lot of pressure. Non-paying patients, the primary care clinics in our region received the $100 million grant which we support, but you need to be aware that this assistance should greatly increase the number of clinic patients which is great. You need to also realize that this will increase demand for inpatient and outpatient specialty care services at our five hospitals and at LSU further adding to our financial losses. In other words, if somebody comes in as an unreferred, we call them, uninsured patient to look for cancer care without insurance nobody else in town has these services so we are the ones, we are going to get into it even deeper with uninsured because of that.

Graduate medical education. We were proud to have opened one of the two new teaching programs. The others continued, and I think Touro expanded and others did. We are working with LSU and Tulane to increase that, but we are losing money on that because of the 3-year rolling average, and you guys are focused on how to maybe get CMS to re-look at that. I can tell you, we can't continue to take more residents without having the funds to do it so we appreciate your help on that. Doctors, we made a commitment to keep doctors by giving them a subsidy after Katrina, and we had $2.5 million coming out of hospital funds in those six. We have also chosen to pay our doctors in full for their services in the emergency room, but it comes out of West Jefferson's budget, which is not funded by anybody except the funds that we have for patients. So it is deepening our bottom line, but I think Dr. Burgess continues to try to help us, but help doctors stay. We are doing all we can but we are getting further behind but we feel that is a commitment to the community.

We are facing a category 5 financial storm which can result in the same thing. I think if it came again during August or September this year it would be worse. Even if ground were broken today on a new Charity Hospital, VA hospital, whatever, we are all talking 6, 8, 10 years to do something. We just can't hold out much

longer. Again, our losses continue every month as all the hospitals do here. We want to continue to serve the community. We support everything you guys can come up with. If we have other ideas, we will continue to come up with those. I would welcome a GAO audit tomorrow. It can't be long. I would ask them also to look at the funds that have previously been spent and why they are not focused on region 1. They went all over the State. A lot of the hospitals in the State are doing very well. Let us spend the Government's money wisely and focus any funds that come on our region, Orleans and Jefferson Parishes.

We really appreciate every one of you all, your staff, our colleagues here. We look forward to working into the future to solve this problem. Thank you.

[The prepared statement of Mr. Muller follows:]

TESTIMONY OF GARY MULLER

Mr. Chairman and members of the subcommittee, thank you again for the opportunity to testify before you. Your continued support and dedication to our cause is truly appreciated. We are thankful for the work of your staff to maintain conversation with us with concern for our deepening wounds. Thank you, and the other members of Congress, for your visits to the area and your understanding of the full and long-lasting consequences of the most devastating natural disasters in American history.

West Jefferson Medical Center is a 451 bed community hospital located 10 miles from downtown New Orleans. After the storm, we were one of only three hospitals in the entire area to remain open- several hospitals, including Charity Hospital, still remain closed. West Jefferson Medical Center was in good financial standings before Hurricane Katrina with a projected profit of $8 million in 2005. When I testified before you in March, West Jefferson had incurred $48 million in Katrina-related operating losses. That number has since increased to $54 million- an additional loss of more than $6 million in only 4 months.

I want to assure you that I am here today to offer the facts regarding the operations at West Jefferson Medical Center. Our numbers have nothing to hide, our books are open and we are confident that we have done everything in our power to run our hospital in an efficient manner. We continue to pursue that cause intensively. Currently, West Jefferson is operating at 2 percent under its 2007 budget and loosing money daily.

In fighting to provide the best possible care for our patients while spending our money in an efficient manner, we have implemented several business improvement plans and negotiated with doctors to create cost-saving programs. This month, West Jefferson Medical Center became the first hospital in Louisiana's history to receive the Energy Star award for energy efficiency awarded by the Environmental Protection Agency. We continue to make great strides in this direction.

Fortunately, The West Bank of Jefferson Parish was not flooded by Hurricane Katrina and West Jefferson Medical Center was spared from extensive physical damage. However, West Jefferson experienced a large increase in patient volume as more than 1000 patient beds were closed in the New Orleans area. To compound the problem with an increase in overall patient volume, our hospital has also seen a 50 percent increase in patients that are uninsured. So even as we struggle to accommodate the increased patient load, fewer of these are paying patients leaving us with much higher costs and more losses.

The healthcare situation in Louisiana has an uncertain future. However, these five hospitals testifying before you today will continue to provide high quality services as long as our doors remain open.

The other four CEOs and I, and all of the patients we serve, are extremely grateful for Congress's response on behalf of all America to Hurricane Katrina. However not enough of this support has reached our hospitals, our doctors, our nurses, and our patients to remedy our ongoing needs. We urge the congress to review these existing allocations made to Katrina Disaster Funds with the current healthcare crisis uppermost in mind.

I'd like to explain to you five of the issues that count for some major financial issues faced by these five hospitals from Orleans and Jefferson Parish.

We continue to suffer losses due to higher labor costs. Immediately after the storm, we were forced to hire contact laborers because so many of our healthcare workers evacuated. At one time, we employed almost 100 agency or temporary, out-of-region nurses to replace employees who left the area. In 2006 alone, these increased labor costs amounted to $12 million—double our costs in 2005. In summary, our nurses are twice as expensive while the patients that we treat pay half the cost. This is exactly why we continue to lose money.

In order to keep nurses and doctors from leaving a region still struggling to reopen its schools, its stores and restore its quality of life, we have had to boost recruitment and retention packages by 25 percent. West Jefferson is also opening a new nurse training program on our campus as a long-term solution to the nursing shortage. While we have received a one time grant to cover some of this additional labor cost, we need an ongoing fix for this ongoing problem. As requested before, we once again recognize the need for a Wage Index Adjustment to help us manage the greatly increased cost of labor.

Non-labor costs present unique issues for West Jefferson Medical Center, but similar issues are shared by all five hospitals. Because West Jefferson, as a public hospital, remained open through the storm and immediately incurred millions of dollars in losses, we received a Community Disaster Loan. I'd like to take this opportunity to thank Congress for the CDL that we received in February 2006 as it enabled us to continue to provide services to the area. We'd also like to say thank you for recent Congressional action allowing this loan to be forgiven. We now find that FEMA regulations require us to wait until 2009, three full years after the storm, to apply for forgiveness. We hope Congress will urge the Administration to grant forgiveness immediately to relieve the burden of interest costs over the next three years.

We have incurred further financial strains as West Jefferson Medical Center was recently declared in default of its bond insurance requirements. As we predicted, the operational losses since Hurricane Katrina, coupled with our unpaid business interruption insurance claim, have placed us in default with our bond insurers. This has resulted in the insurers placing a mortgage on our hospital and implementing other fees and restrictions on our operations. The impact of continuing to carry the CDL interest and the default of our bond insurance has added more than $2 million a year to our costs. In addition, with other businesses in the area we share increases in insurance rates, utilities, supplies and more. The accumulation of these costs continues to contribute to our millions in losses.

My hospital has also seen a significant increase in non-paying Emergency Room patients. With overall patient volume increases, Emergency Room wait time has peaked at around 14 hours. In addition, the average length of stay for patients has increased from 6 to 7 days in just one year which further increased costs. Primary Care Clinics in our region received an additional $100 million grant recently, which we support. You need to be aware that this assistance should greatly increase the number of clinic patients. You need to also realize that this will increase demand for inpatient and outpatient specialist care services in our 5 hospital, further adding to our financial losses from the uninsured.

Another shared concern is reimbursement associated with Graduate Medical Education. West Jefferson Medical Center became a teaching hospital after the hurricane in response to the needs of displaced medical students in the region. We have been supportive and understand the importance of our teaching program but, like others, are being penalized by the current GME reimbursement rules. Again, we lose money on every resident, but think it is vital to keep training medical personnel in our region as we depend on the vast majority remaining here after they complete their studies. We ask that the current reimbursement rules be reconsidered.

In line with strains felt nationwide concerning workforce issues, we also face a similar but more severe problem. Although we have felt these strains from physician shortages for many years, currently, physicians are leaving our area at a rapid rate. Our hospitals have to offer large recruitment and retention packages to keep doctors and staff from leaving, and even still, keeping those highly trained workers has proven to be a very difficult task.

As mentioned earlier, West Jefferson is currently treating more than twice as many uninsured patients than before the hurricane, while only being reimbursed for 45 percent of our costs. Every time an uninsured patient is admitted into our hospital, we lose money as West Jefferson Medical Center is only partially reimbursed for the treatment of these patients. However, we have chosen to pay our doctors in full for their services. This causes a deep and direct cut to our bottom line, but our patients and community would suffer more without an adequate number of doctors. As a public hospital it is our charge to serve all those who come in our doors—but

unlike many public district hospitals that you may be familiar with, we receive no dedicated revenue from our Parish government.

As chief executive officer of West Jefferson Medical Center, I am faced with these and other financial issues everyday. While we continue to offer vital services to the community, I struggle with meeting the financial demands that pull my hospital in multiple directions. Roughly two years ago, Hurricane Katrina forced the closure of more than 1,000 beds in New Orleans. We are now facing a Category Five financial storm which could result in the same. Even if ground were broken today on a new Charity hospital, our hospital would still have to wait three to five years for the completion of this hospital until some of these costs are alleviated.

Since the 4 months since I came before you in March, West Jefferson has lost an additional $6 million. If I were allowed to make a presentation before you again in 4 months, unless changes are made, my story would be the same- more losses. Our hospitals can only serve the community so long while facing such mounting debt. I will leave it up to you to consider what actions will need to be taken if this continues.

Once again, I offer many thanks to you, Mr. Chairman and members of the subcommittee for your attentiveness and understanding.

Mr. MELANCON. Thank you, Mr. Muller. Mr. Lagarde, if you would.

TESTIMONY OF MEL LAGARDE, III, PRESIDENT/CEO, HOSPITAL CORPORATION OF AMERICA, DELTA DIVISION, NEW ORLEANS, LA

Mr. LAGARDE. Mr. Chairman, members of the committee and staff, good afternoon. My name is Mel Lagarde. I am vice chairman of the Partnership Board and managing partner for Tulane University and Clinic, which is a two-hospital system with clinics and facilities in both Jefferson and Orleans Parish. Tulane University Hospital and Clinic is a joint venture between Tulane University and HCA. For over 160 years Tulane University Medical School has provided innovative medical education, cutting edge research, and quality clinical services to New Orleans. I was at the Tulane downtown campus during Hurricane Katrina. I was directly involved in the complete evacuation of all patients and employees from the facility.

After being closed almost 6 months due to damage from Hurricane Katrina, Tulane reopened our main campus in February 2006 and is providing services in the area most directly impacted by the hurricane. As someone involved in the overseeing the rebuild, I appreciate the opportunity to come before you to discuss Tulane's experience in providing health care to New Orleans after Katrina. Despite significant progress during the last 2 years, the New Orleans health care system has not recovered from Hurricane Katrina. Since then, these coalition hospitals have provided approximately 95 percent of the health care services in the New Orleans metropolitan area providing patients with essential health care services despite significant challenges including constrained resources, damaged infrastructure, and significantly increasing cost.

After reopening one-quarter of our former size, we now maintain 306 of our 335 pre-Katrina beds that are downtown in Jefferson Parish campus. To date we have spent more than $250 million repairing and restoring Tulane. This represents an important investment in the health of current and future New Orleans residents and the recovery of the greater New Orleans area. Tulane is the primary teaching hospital of the Tulane University Medical School.

Tulane Hospital and its patients are essential to the education of medical students, residents, and fellows who serve the New Orleans area. As the result of significant work, we are currently providing training for 100 percent of our pre-Katrina resident positions. The success of the medical school is closely linked to the success of Tulane Hospital, and we are committed to maintaining that connection into the future.

The reopening of Tulane has also provided access to health care services for area veterans. After the Department of Veterans Affairs medical center closed due to flooding from Katrina, Tulane has granted staff privileges to VA physicians and permits them to treat VA patients at Tulane. We hope our support will permit the VA to rebuild in downtown New Orleans. The coalition hospitals play a vital role in the recovery of patient care needs in New Orleans and in the greater New Orleans area. Although the Federal and State government have provided recovery funds they are not adequate to address the challenges faced by hospitals serving post-Katrina New Orleans. The coalition hospitals' labor costs have skyrocketed as a result of city wide shortages of doctors, nurses, and other health care professionals.

On an adjusted basis, Tulane's salary expenses for the first 5 months of 2007 as compared to 2005 are up 57 percent and contract labor expenses are up 73 percent. Other expenses have also increased for us. Our utility expenses are up 34 percent. Insurance is up 33 percent. And interest expense as a result of borrowing in order to fund losses is up an extreme 1,000 percent. Since we resumed operation in February 2006, Tulane has experienced operating losses every single month of our operations. In 2007 Tulane experienced $24 million loss for the first 5 months. All financial reports of Tulane University Hospital and Clinic, we willingly support a GAO audit. We have simply nothing to hide.

All the coalition hospitals have experienced similar losses as a result of the critical shortage of help at providers and the higher insurance and utility expenses, increased bad debt, and sicker patients in post-Katrina New Orleans. Since reopening net of business interruption insurance and the $5 million we received in Federal funding, we have incurred a loss of $173 million. On behalf of Tulane and the other hospital systems on this panel, I respectfully request that this committee financially support this coalition for the next 3 to 5 years to permit the New Orleans health care sector to recover. Specifically, I request that the committee support funding by, one, redirecting existing Gulf Coast recovery funds to our needs, two, continue the current Louisiana uncompensated care cost formula of which approximately 70 percent is funded by the Federal Government, and, three, suspending the 3-year rolling average component for graduate medical education payments.

Thank you members of the committee and staff for your time and attention. I will be happy to respond to any questions. Thank you.

[The prepared statement of Mr. Lagarde follows:]

TESTIMONY OF M.L. LAGARDE, III

VICE CHAIRMAN OF THE PARTNERSHIP BOARD AND MANAGING PARTNER OF THE TULANE UNIVERSITY HOSPITAL AND CLINIC (TULANE)

BEFORE THE

OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

OF THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

AUGUST 1, 2007

Mr. Chairman, members of the Committee and staff – good morning. My name is M.L. Lagarde, III, and I am the Vice Chairman of the Partnership Board and Managing Partner of the Tulane University Hospital and Clinic ("Tulane"). The Partnership Board is the governing body of the Tulane joint venture. The partners are Tulane University and HCA. Through this partnership, Tulane works to continue our tradition of excellence and expertise in providing the best quality care, education and research through our combined resources. For over 160 years, the Tulane University Medical School has demonstrated its dedication and commitment to New Orleans by providing innovative medical education, cutting-edge research and quality clinical services.

As Vice-Chairman of the Partnership Board, I am actively involved in the operations of Tulane. Indeed, I was at the downtown hospital campus during Hurricane Katrina and directly involved in the complete evacuation of all of our patients and employees from the facility. I have also been actively involved in the substantial effort and commitment to rebuild and reopen Tulane in downtown New Orleans after it was closed for almost six months as a result of the

tremendous damage to the facility from Hurricane Katrina. As a result of this effort, Tulane has reopened, providing services in the area directly impacted by Hurricane Katrina.

At the end of August, two years will have passed since Hurricane Katrina pummeled the Louisiana and Mississippi coasts. Despite the significant progress in rebuilding hospitals and other critical elements of the healthcare infrastructure in New Orleans, the New Orleans healthcare system has not recovered from the damage inflicted by the Hurricane or the floods that followed in its wake. Of the nine adult acute care hospitals in Orleans Parish operating prior to Katrina, all remain closed except Tulane, Touro Infirmary and University Hospital. The three hospitals which remained open after Hurricane Katrina in Jefferson Parish are East Jefferson General Hospital, West Jefferson Medical Center, and Ochsner Health System (I refer to the five systems -- Tulane, Touro, East Jefferson, West Jefferson and Ochsner -- currently operating in Orleans and Jefferson Parish as the "Coalition"). Since Hurricane Katrina, the Coalition hospitals have provided approximately 95% of the healthcare services in the immediate New Orleans metropolitan area. Tulane, along with the State-operated University Hospital, are the only two hospitals operating in the downtown area most heavily damaged by the flooding in the aftermath of Katrina.

The hospitals in the Coalition have continued to provide patients with essential healthcare services despite significant challenges including strained resources, damaged infrastructure, and significantly increasing costs, all of which are directly attributed to operating in post-Katrina New Orleans. In particular, the Coalition hospitals are confronted with a critical shortage of doctors, nurses and other healthcare professionals, higher insurance and utility expenses, increased bad debt, and sicker patients. These factors have substantially increased the costs of operating a hospital in post-Katrina New Orleans. Importantly, these increased costs are

projected to continue to increase for the foreseeable future. As a result of the increased expenses, the hospitals in the Coalition are expected to lose a combined $135 million in 2007. These staggering losses threaten the current and continuing operation of all of the Coalition hospitals.

A vibrant healthcare system is a critical component of New Orleans' short and long term recovery from the devastating impact of Hurricane Katrina. Numerous reports and analyses have all concluded that, in order to address the area's long term healthcare needs by redesigning and building new healthcare infrastructure, the hospitals that are currently operating in New Orleans must remain financially viable and able to address the current healthcare needs of patients in the area. The recovery funds that have been provided by federal and state governments to date are not adequate to address the unique prospective challenges faced by hospitals serving post-Katrina New Orleans. Specifically, of the approximately $300 million in federal funds that have been distributed for healthcare services, only 13% of these funds have been paid to New Orleans hospitals. In order to address the exceptional cost pressures threatening the New Orleans hospitals, we request additional financial support for the next three to five years, including: (i) provision of additional funding either by redirecting existing appropriation dollars for 2007 – 2009 to New Orleans or identifying other revenue sources, to offset losses attributable to post-Katrina expenses; (ii) continuation, for at least three years, of the current State of Louisiana Department of Health and Hospitals' uncompensated care costs ("UCC") formula; and (iii) elimination, for the next three years, of the three year rolling average component of the payment formula for graduate medical education costs.

Each Coalition hospital serves an essential role in addressing the current and continuing healthcare needs of the area. Tulane's downtown campus had to completely evacuate during the

flooding following the Hurricane because of damages it sustained. Tulane remained closed for six months after Hurricane Katrina in order to rebuild and repair the significant water and mold damage from the flooding. By pursuing an aggressive rebuilding schedule, Tulane was the first hospital to reopen in downtown New Orleans in an area that, prior to Hurricane Katrina, was recognized as the medical district of New Orleans. Tulane's reopening provided patients in the area with access to essential healthcare services. It also provided critical services and support to the Tulane University Medical School and the United States Department of Veterans Affairs, which rely on and partner with Tulane. Tulane plays a vital role to the recovery of the New Orleans healthcare system, and as a result the New Orleans area, by providing access to critical healthcare services for patients, ensuring access to medical education for future healthcare professionals, enabling physicians, nurses and other healthcare professionals to maintain their proficiency, and stabilizing the New Orleans medical district to facilitate its rebuilding and recovery. However, without additional financial support to adequately address the unique operating challenges facing Tulane in post-Katrina New Orleans, Tulane's ability to maintain these vital contributions is threatened. I appreciate the opportunity to come before you this morning to discuss Tulane's experiences, both in terms of the significant services that Tulane is currently providing the New Orleans community as well as the significant financial constraints that are challenging our continued ability to provide these services.

I. TULANE PROVIDES CRITICAL ACCESS TO HEALTHCARE IN DOWNTOWN NEW ORLEANS

Tulane has two facilities in the New Orleans metropolitan area, including our main campus in downtown New Orleans and our secondary campus at Tulane-Lakeside Hospital in Metairie, LA. Between these two campuses, Tulane aims to provide a full range of medical

services to the greater New Orleans area. We were forced to evacuate these two facilities during and following Hurricane Katrina. After local officials ordered a mandatory evacuation, we closed Tulane-Lakeside Hospital and transported patients, employees, and family members to a safe location by bus convoy. Our main campus in downtown New Orleans also sustained heavy damage and had to be evacuated, primarily by helicopter. Hurricane Katrina inflicted heavy damage on Tulane's main campus, and caused damage to the Lakeside campus sufficient to close the facility for thirty days.

Despite the substantial damage to the downtown buildings, Tulane has remained fully committed to providing for its patients in the New Orleans area. Indeed, in the fall of 2005 and early 2006, we undertook an aggressive and costly rebuilding schedule that would permit the downtown campus to reopen as quickly as possible. The goal of our aggressive schedule was to open prior to the Mardi Gras celebration of 2006, which represented an important symbolic and cultural milestone for New Orleans. Because damage sustained from Hurricane Katrina had forced every hospital in the downtown area to close, Mardi Gras presented a pressing need for emergency medical services in the downtown area as revelers in need of emergency medical attention, where time is of the essence, would have had to travel to one of the other hospitals in the greater New Orleans area. We therefore expended significant resources, investing over $90 million prior to February 2006 alone, to ensure that the hospital was able to at least partially reopen prior to Mardi Gras.

On February 15, 2006, after being closed for almost six months, Tulane reopened its emergency room, several operating rooms, sixty-three of its 235 beds, an adult and pediatric intensive care unit, a pharmacy and several cardiology labs. Tulane reopened in February at about one-fourth of its pre-Katrina size and with about half of its pre-storm staffing. Tulane's

reopening answered one of the city's most urgent needs by making hospital services available again in downtown New Orleans. Since that time we have continued to aggressively repair and reopen the remainder of the Tulane facility in stages.

To date, we have spent more than $250 million to repair and restore Tulane. We have relied on funds from business interruption and property insurance and our own indebtedness to reestablish Tulane in downtown New Orleans. Although we have requested funds from the Federal Emergency Management Agency ("FEMA"), at this point, we have not received any payments. Currently, Tulane has completely reopened and is operational. Prior to Hurricane Katrina, Tulane's downtown campus was a 235-bed facility. We currently have reopened 206 of these beds. We believe that the money that we have spent to repair and restore Tulane in downtown New Orleans is an important investment in the health of current and future New Orleans residents as well an investment in the recovery of the greater New Orleans area.

The reopening of Tulane is also critical to ensure the long term availability of healthcare services in the New Orleans areas. Due to the closure of Charity Hospital, Tulane has become the primary teaching hospital of the Tulane University Medical School. The availability of this hospital and access to patients is essential to the medical education of medical students, residents and other healthcare professionals who will continue to serve patients in the New Orleans area for years to come. The success of the Tulane University Medical School is closely linked to the success of the Tulane Hospital and we are committed to rebuilding the hospital and continuing its close connection with the medical school.

The reopening of Tulane has also provided access to healthcare services in the downtown area for patients of the Department of Veterans Affairs ("VA"). The inpatient services at the VA Medical Center in downtown New Orleans closed due to flooding from Hurricane Katrina.

Tulane has provided extensive support and assistance to the VA by granting VA physicians with staff privileges and permitting them to treat VA patients at Tulane. Tulane's relationship with the VA has enabled the VA to maintain its presence in downtown New Orleans and enabled VA physicians to continue their practice of medicine. As a result, many veterans requiring inpatient care can receive VA-sponsored care in New Orleans and can avoid traveling to other VA hospitals. We hope that this support will permit the VA to eventually build a new VA hospital in the downtown New Orleans area. This access to medical services in downtown New Orleans is vitally important to the numerous veterans who live in the region that was served by the now-closed VA Medical Center in New Orleans.

II. TULANE IS VITAL TO THE ECONOMIC RECOVERY OF NEW ORLEANS

The continued and increasing presence of hospitals and healthcare services is essential to the ongoing recovery of New Orleans. As the Government Accountability Offices ("GAO") reported in March 2006, "rebuilding the healthcare system will be vital to attract people back to New Orleans to ensure its recovery." Local leaders also have publicly acknowledged the importance of ensuring adequate healthcare services both in the greater New Orleans region, as well as in the downtown medical district in particular. For example, a May 2, 2007, Times-Picayune article quoted Mayor Ray Nagin as saying that "the growth of downtown New Orleans and the stability of the entire region relies on the continued clustered development of medical care and bioscience investment." Even more recently, an article on the state of healthcare in New Orleans that appeared in the New York Times quoted Andy Kopplin, Executive Director of the Louisiana Recovery Authority, as explaining that

> the city's healthcare system 'is critical both for the short and long term . . . Short term, having confidence that the healthcare residents need will be

> available and accessible is vital for folks who are returning . . . Long term, it's important for employers – and healthcare is a huge business in New Orleans.'

Tulane was the first hospital to reopen in the downtown hospital district, it remains only one of two operational hospitals in downtown New Orleans, and it is the hospital closest to the areas directly impacted by Hurricane Katrina and the flooding in New Orleans. The Tulane University Medical School and our hospital depend upon each other for their ongoing continued success. Together, we provide medical services, education, and employment in the medical district which are essential to bringing people back into the downtown area and to the overall security and recovery of the New Orleans community.

III. HOSPITALS OPERATING IN NEW ORLEANS FACE ESCALATING COSTS ATTRIBUTABLE TO HURRICANE KATRINA

The Coalition hospitals face unique challenges that are directly attributable to the effects of Hurricane Katrina. More than 30% of the City of New Orleans population has not returned since Hurricane Katrina, including an overwhelming number of physicians, nurses and other healthcare professionals. As a result, hospitals operating in New Orleans face a city-wide shortage of doctors, nurses, and other licensed healthcare professionals. This shortage is severely limiting each of the hospitals' capacity to provide care, both in terms of the types of care, since there are fewer specialists available, and the volume of care, since there are fewer physicians and nurses available to perform the specialized services that are required. This shortage has resulted in increased labor costs for contracting with or employing healthcare professionals that have remained, or in attracting professionals back to the area.

According to data collected by the Coalition, salary and contract labor costs have increased nearly $60 million for the first five months of 2007 when compared to the same five

months of 2005, pre-Katrina. The increase since 2005 in wage rates alone exceeds 21%. The Coalition hospitals are also experiencing a 37% increase in utility costs, which are projected to continue to increase, increased insurance costs of 40%, with less coverage being provided and higher deductibles, and a 35% increase in bad debt.[1] Financing costs, as measured by Interest Expense, have increased 24%. Further, all of the hospitals are reporting difficulty in obtaining sufficient revenue to remain in operation. Because costs continue to escalate, the combined financial statement for the Coalition for the first five months of 2007 reflects a $70 million difference between income and catastrophic losses when compared to the same time period for 2005. This annualizes to a deterioration in financial results of $168 million.

Tulane has, individually, experienced increased costs that track those experienced by the Coalition hospitals collectively. Tulane's total operating revenue for the first five months of this year has decreased by 6.2%, primarily as a result of diminished volumes, when compared with the same time period for 2005. This loss of revenue is compounded by the increase in costs that Tulane has experienced during the same time periods. The most significant of these expenses has been labor costs resulting from the shortage of physicians and other medical professionals.

Many healthcare professionals never returned to New Orleans after Hurricane Katrina and the area continues to experience a migration of providers out of the area. Indeed, the Orleans Parish Medical Society has reported that more than 200 of its 650 members have left New Orleans. As a result, Tulane must employ more physicians than it did prior to Hurricane Katrina. Specifically, in May 2005, Tulane only employed twenty physicians. Currently, fifty-two physicians are directly employed by Tulane. In order to retain physicians in the area and assure critical healthcare services are available to the community, we have found it essential to

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1 Increases are measured based on the respective "cost per adjusted patient day," which is a standard metric in the hospital industry.

employ physicians in order to ensure them a stable income. Because we have more than doubled the number of our employed physicians, our labor expenses have similarly escalated. Our salary expenses for the first five months of 2007 have increased by 15.7% compared to the same time period for 2005 despite having significantly fewer employees on our payroll. Adjusted for the decline in volume, wage costs have increased by 57%.

We are also having problems attracting other healthcare professional staff and support staff to the New Orleans area. Affordable and available housing is a critical issue with which we have to deal. We are incurring additional expenses to recruit employees to the area, including providing registered nurses and allied health professionals with the option of either three months of free rent or paying their relocation expenses. Prior to Hurricane Katrina, this was not an expense that we had to bear. Despite our increased recruiting benefits, we are still facing a staffing shortage while incurring significantly more expenses for the contract staff. For example, our labor costs for contract nurses for the first five months of 2007 have increased more than 73% compared to 2005. Adjusted for volume, the increase is 136%.

In our experience, the patient care we currently provide is more expensive than the average cost of care pre-Katrina. Many who remained in New Orleans are uninsured, unemployed and have no means for paying for care. In addition, the shortage of available physicians and nurses has resulted in longer waiting times for appointments, and in many cases patients have been unable to obtain an appointment. As a result, more patients, even those with insurance, are relying on the emergency room for their primary care treatment.

Tulane's other expenses have also increased. Since pre-Katrina operations in 2005, Tulane's utility expenses have increased 34%, insurance expenses have increased 33% and interest expenses have increased by over one thousand percent. In total, Tulane experienced a

$24 million net loss[2] from total operations from the first five months of 2007. Hospital operations with these kinds of losses are simply not sustainable.

IV. CONGRESSIONAL ACTION IS REQUIRED TO ENSURE THE AVAILABILITY OF HEALTHCARE SERVICES IN NEW ORLEANS

A vibrant healthcare community is a critical component for the short and long term success of New Orleans' recovery from the devastating impact of Hurricane Katrina. However, the healthcare community is simply not able to sustain its operation when it is experiencing such staggering losses. The problems that the Coalition hospitals are facing are likely to be compounded if, or when, any individual hospital is no longer able to continue to operate in New Orleans. The challenges facing the Coalition hospitals are unique, and dwarf those faced by any other hospital in any other area of the country. As a result, the federal government should take steps that directly address the challenges faced by the Coalition hospitals. On behalf of Tulane and the other four systems that are represented on this panel, I respectfully request that this Committee consider options to support vital health services for the next three to five years in order to afford the New Orleans healthcare sector an opportunity to recover sufficiently to support a revitalization of this city. Specifically, I request that the Committee: (i) provide additional funding either by redirecting existing appropriation dollars for 2007 – 2009 to New Orleans or identifying other revenue sources, to offset losses attributable to post-Katrina expenses; (ii) continue the current Louisiana Medicaid uncompensated care costs ("UCC") formula, of which approximately 70% is funded by the federal government; and (iii) eliminate,

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2 This excludes an estimated business interruption recovery of $2.5 million, and a one-time CMS wage index adjustment payment of $3.4 million.

for three years, the three year rolling average component for graduate Medical education payments.

Thank you, Mr. Chairman and members of the Committee for your time and attention. I will be happy to respond to any questions.

Mr. MELANCON. Thank you, Mr. Lagarde, I appreciate those comments. Chancellor Hollier from LSU, if you would, for 5 minutes.

TESTIMONY OF LARRY H. HOLLIER, M.D., CHANCELLOR, LSU HEALTH SCIENCES CENTER AND DEAN OF THE SCHOOL OF MEDICINE

Dr. HOLLIER. Chairman Melancon, Ranking Member Whitfield, I am Dr. Larry Hollier, chancellor of the LSU Health Sciences Center and Dean of the School of Medicine. I represent the LSU's Schools of Medicine, Nursing, Dentistry, Allied Health, Public Health, and Graduate Studies. I also represent the LSU graduate medical education programs, the 10 LSU public hospitals, and 36 health care clinics spread across our state. When LSU representatives testified before this committee in March they expressed apprehension over the future of graduate medical education and health care delivery. Now while obstacles remain and we look at what needs to be done, my message is that solutions are evident, but we need your help to implement them.

Nonetheless, we are finally moving forward. Two years after the storm, emergency rooms are still overwhelmed by patients who believe they have no choice but to use the emergency room for primary care. In an effort to relieve this demand, LSU is deploying satellite health clinics throughout the New Orleans area. These clinics are expected to be operational by October. We also continue to experience in New Orleans a severe shortage of mental health beds. While LSU is adding 33 psychiatric beds in leased space the lack of mental health facilities will not be substantially relieved until a new academic medical center with a 68-bed behavioral health unit can open.

Private medical education is also a continuing concern. In the floods following Katrina, LSU lost seven of its nine teaching hospitals in New Orleans.

We had a desperate scramble then to find new places to train our residents. We convinced very busy private hospitals to take in our residents and become part of our academic teaching network. They consented to do so in order to save our medical education system in Louisiana even though they realized that they were undertaking a financial burden for which they had not been able to plan. For that year following the hurricane, CMS granted a waiver that gave them full reimbursement for their GME cost. However, that was only for 1 year. Since then they have been subjected to the 3-year rolling average wherein only a portion of their GME costs are reimbursed. This adversely impacts our ability to secure adequate training slots for our residents.

We have repeatedly offered suggestions and requests to CMS regarding ways to fix this problem but to no avail. Perhaps this committee could urge CMS to give us a proposal to fix this problem by some mechanism that is acceptable to them.

On another front LSU is participating in a medical home demonstration project in New Orleans that will provide coordinated patient care in satellite health clinics. We also continue to forge partnerships with faith based clinics and private hospitals to deliver primary care in the spirit of a redesigned health care system. This initiative will utilize health information technology to monitor

quality, enhance patient charting, and track prescriptions. Our faculty practice has already purchased and started implementing an ambulatory electronic health record, and we are making that available to the various primary care clinics in the region to implement the integration of the medical homes with the delivery of tertiary care.

However, we need the ability to use DSH dollars to help pay for physicians and clinic services. Without this flexibility the medical home model of coordinated care through community clinics will not become a reality in Louisiana.

We believe that the key to our ability to move beyond recovery to revolutionizing Louisiana's health care system is construction of a new LSU academic teaching hospital. As you know, LSU and the State of Louisiana, in February 2006, signed a Memorandum of Understanding with the Department of Veterans Affairs to build a joint medical center in downtown New Orleans. Land acquisition has been accelerated, architects have been selected, and we are identifying the types of service that will be provided by LSU, Tulane, and the VA and those that will be shared.

Governor Blanco and the legislature meanwhile recently substituted $300 million in State money for the Federal Community Block Grants to insure that the State can meet VA's construction time table. In short, Louisiana and LSU are ready to go. So, while we are making steady progress mostly on our own, we still need Federal help to complete our recovery and reform. We need a firm and immediate commitment from the administration, particularly the U.S. Department of Veterans Affairs, for the construction of a new academic teaching hospital. This new facility is critical to the future of medical training programs at both LSU and Tulane. I believe that is the only way to insure that we have an adequate supply of skilled medical professionals in the future.

Contrary to assertions by some skeptics, this project is the avenue of escape from what has been described by our critics as a two-tiered health care system. It is the lynch pin of a reformed health care system. Moreover, this project represents the largest urban renewal project in the history of New Orleans, a facility that will serve as a beacon of hope and security for individuals and business seeking to return and to rebuild. Thank you for your time, your interest, and your assistance.

[The prepared statement of Dr. Hollier follows:]

STATEMENT OF LARRY HOLLIER, M.D.

Chairman Stupak and distinguished members of the Subcommittee, thank you for this opportunity to update you on the painstaking progress being made as we continue to recover from the impact of Hurricane Katrina on Louisiana State University's professional medical education programs its ten public hospitals, and 36 health care clinics spread around our state.

When LSU representatives testified before this committee in March, they expressed considerable apprehension over the future of graduate medical education and health care delivery.

Today, on behalf of my colleagues, as Chancellor of the LSU Health Sciences Center in New Orleans, my message is one of hope that we are finally moving forward.

With the support of Louisiana's political leadership, including Governor Blanco and the Legislature, we are deploying satellite medical clinics in New Orleans and the first stage of what will be a comprehensive, statewide electronic medical records system.

In addition, LSU's Health Care Service Division has been working closely with representatives of the U.S. Department of Veterans Affairs to plan construction of a joint academic medical center in downtown New Orleans.

Collectively, we have much work left to do and our medical training programs are still threatened, but the picture I will paint today is significantly more optimistic than it was four months ago.

I will also briefly address a number of continuing myths about the joint hospital project, falsehoods that have caused a great deal of concern among indigent patients and our veteran population.

Overall, although wait times for uninsured and underinsured patients at our hospitals and clinics are improved, they're still too long.

We also need more bed space for mental health patients. In a few weeks, LSU will open 33 mental health beds in leased space at a former mental hospital in uptown New Orleans.

We are adding diagnostics beds for mental patients at the Interim LSU Public Hospital, but there is an overwhelming need to do more, and this need will not be met until a new, 68-bed crisis intervention unit at the planned LSU hospital is opened.

LSU and the state are planning early next year to deploy a "medical home" demonstration project in the New Orleans area funded by the State of Louisiana.

The project will provide coordinated, patient-centered care that utilizes partnerships and health information technology to improve health outcomes at reasonable costs while providing increased training opportunities for our medical students.

Key to the effectiveness of this project will be new, satellite health clinics operated by LSU doctors, nurses and allied health personnel in areas where our patients live. Those clinics will be operational by the end of October, and will be in addition to the other community and faith-based clinics currently in operation.

We believe this approach when eventually deployed statewide will relieve overcrowding not only at the Interim LSU Public Hospital in downtown New Orleans, but also at private hospitals throughout the state that have seen their emergency rooms overwhelmed by uncompensated care patients.

When the New Orleans demonstration project is fully online, it will include an electronic health record, which our faculty physicians have already begun implementing. It will provide quality guidance and monitoring of the quality of care delivered. It will also include an innovative software program to enhance patient charting and prescription tracking, a service not limited to LSU-run facilities.

We have already forged partnerships with faith-based clinics and private hospitals to deliver care in the spirit of health care redesign without depending on a massive infusion of Federal taxpayer dollars.Our graduate medical education programs, meanwhile, are another issue. Dr. Alan Miller from Tulane Health Sciences Center is testifying regarding suggestions of temporarily changing how GME is funded following major disasters. LSU is strongly supportive of the suggestions outlined in his testimony on GME and believe it would be very helpful in stabilizing GME in the New Orleans area.

Prior to Hurricane Katrina, LSU annually trained approximately 627 residents and fellows in 95 programs. Today 475 LSU residents are being taught in 76 programs, a 24 percent decline.

Because nearly three out of four physicians, dentists, nurses, and other allied health professionals are trained by LSU and remain to practice in Louisiana, I believe we are facing a long-term shortage of doctors and other medical professionals that will be worse than forecast physician shortages in other areas of the United States.

This view is based on the fact that LSU's GME slots are increasingly going to international medical graduates, especially in internal medicine and family practice. These young doctors will likely return to their home countries once they complete their training whereas in the past, the majority of our graduates stayed to practice in our state.

Following Katrina, the New Orleans area lost an estimated 50 percent of its medical professionals. At LSU, we lost more than 165 faculty. However, we have been aggressively recruiting and our efforts have yielded almost 200 new faculty members during the last fiscal year. We also expect to add more than 100 new residency slots by next summer.

We are encountering a pioneering spirit among new faculty members who are committed to helping us revolutionize Louisiana's health care delivery system.

The key to that revolution is the construction of the new LSU/VA academic teaching hospitals.

Over the past four months, LSU and the State Office of Facility Planning and Control have accelerated land acquisition and design team selection, and are mobi-

lizing teams that will complete historical preservation and environmental evaluation and construction of these facilities.

Of particular note in this effort is the governor and state legislature's decision to substitute state funds for $300 million in Federal hurricane relief funds to eliminate any possible delay in the state meeting the Department of Veteran's Affairs timeline for beginning the joint project. Among those state funds is $74.5 million for the purchase of 37 acres of land along with design work for the project. Legal teams are identifying and expediting property acquisition, environmental assessments, and relocation matters. Architects for both facilities have been selected.

The city of New Orleans and the State Division of Administration, meanwhile, have executed a Cooperative Endeavor Agreement to purchase an additional 29 acres of property adjacent to the LSU site for the exclusive use of the VA.

The LSU/VA cooperative planning group, which includes the VA, LSU and Tulane University, has identified dozens of services that will be provided by each hospital. Many of those services, such as lab work and radiology, will be shared.

Still other services will be purchased from each hospital. For instance, LSU will purchase EEG, Pulmonary and Audiology services from the VA, while the VA will buy Radiation Oncology, Dental, and Dietary services from LSU.

LSU alone estimates it will realize more than $4.2 million per year in operational savings. Our business consultants estimate combined operational savings to LSU and the VA will exceed $400 million over 25 years.

This facility makes economic sense. Cash flow will be sufficient to operate the facility, service debt, and finance the continued maintenance of the new facility thereby reducing reliance on state funds.

Moreover, the joint hospitals project, which will create 20-thousand jobs, will spur growth in biomedical and research sectors and serve as the single largest post-storm urban renewal project in New Orleans history.

A recent letter from Governor Blanco to Secretary Nicholson urging the VA's continued collaboration with LSU to rebuild the VA facility in Downtown New Orleans was cosigned by Louisiana's legislative leadership, the presidents of LSU and Tulane Universities and the chancellors of their medical schools, the mayor of New Orleans, the director of the downtown development district, and a number of individuals representing veterans organizations.

My testimony would not be complete without addressing to those who contend such a project should not be built in a flood zone. It is important that they keep in mind breaches of Federal levees by Hurricane Katrina's monster surge inundated 80 percent of the city of New Orleans.

Flood maps indicate both proposed sites for the new VA hospital were covered or threatened by up to two feet of water.

Plans for the new LSU/VA medical center, however, include armoring both hospitals against hurricanes and terrorism. First floors of both facilities will be built at least 25 feet above ground and the two hospitals will be capable of sustaining operations for 30 days following any potential disaster

Finally, let me direct your attention to opponents of the joint LSU/VA project who contend that the population of the New Orleans area will not be large enough to support the new hospital.

Population estimates indicate people are slowly coming back to New Orleans. Since Katrina, an estimated 90 percent of the veteran's population in New Orleans has returned along with a like percentage of residents in Jefferson Parish which is part of the regional catchment area for the new academic medical center. The average age of the population in the catchment parishes for the new hospitals will be older than their pre-Katrina population and will hence require more medical services.

This project will stop the so-called "Brain Drain" of skilled, well-compensated medical workers while attracting a new generation of health care professionals. It will also meet the medical needs of veterans for generations to come.

After nearly two years, New Orleans remains a shattered city on the mend, but the outlook for health care and medical education is steadily improving.

Since the last time LSU representatives appeared before this committee, our institutions have begun aggressively working out and implementing solutions on their own, but we still need Congressional help.

The message from New Orleans today is that we are making major progress in building a "medical home" based health care delivery model using an electronic medical records system that we believe will serve as a model for the nation.

Mr. Chairman and members, thank you for this opportunity to discuss these issues. I will be happy to answer any questions you may have.

Mr. MELANCON. Thank you, Chancellor Hollier. I appreciate those comments. Dr. Miller, if you would, with the Tulane Health Sciences, 5 minutes, please.

TESTIMONY OF ALAN MILLER, PH.D., M.D., INTERIM SENIOR VICE PRESIDENT, HEALTH SCIENCES, TULANE UNIVERSITY HEALTH SCIENCES CENTER, NEW ORLEANS, LA

Dr. MILLER. Thank you, Mr. Melancon, Mr. Whitfield, staff, and members. Since the March hearing, and through your efforts a number of actions have been taken that will have an immediate impact on health care. We must turn our attention to long-term stabilization, specifically the supply of future doctors and graduate medical education or GME. Discussion must include keeping our training programs vibrant. I will focus my comments on the role of GME in providing the region's health care and future workforce, the role of the VA in patient care and physician training, and financial stability for the region's providers. The tragedy of Katrina has energized our young adults. Students flock to New Orleans to assist in rebuilding.

This fall, our medical school will admit its largest class ever with no compromise in quality. As a result of damage to the medical infrastructure, we have voluntarily downsized our GME programs. Each year, the Tulane and LSU train fewer residents, Louisiana faces long-term problems in physician supply. Prior to Katrina, Louisiana ranked second in the percentage of physicians practicing in the State in which they trained, yet Louisiana was still well below the national average for physicians per 100,000. Our experience revealed flaws in the system for reimbursing GME that still impacts us and will be repeated in other cities if a disaster results in the total or partial closure of a major teaching hospital.

Pre-Katrina both schools had their largest concentration of residents at the Medical Center of Louisiana at New Orleans, MCLNO, which was closed for 15 months post-Katrina. Although partially reopened, it can accommodate only a portion of the previous total residents. The financing of GME is a complicated maze. We have provided diagrams demonstrating the process before and after Katrina. We train residents at several hospitals and rotate those residents among them. The medical schools act as pay masters so the residents have consistency in salary and benefits. During the period of total and partial closure the medical schools remain responsible for education of the residents and pay their salaries despite being unable to receive reimbursement from the closed hospital.

As a result, Tulane lost $6 million in fiscal year 2005–06 and anticipates $1.5 million this year. This process has been a bureaucratic nightmare. This diagram that you see on the screen shows you the situation before on top and since Katrina in how the medical schools operated with hospitals and CMS to receive reimbursement and train the residents. CMS provided initial waivers that helped but fell far short of solving the problem. Currently, we must find teaching environments that meet accreditation standards but cannot get agency approval until after the training is in progress. Closed or partially closed hospitals must enter into affiliation

agreements with host hospitals which then enter into agreements with medical schools.

Our proposed remedy is pictured in the third diagram in the written testimony. When a teaching hospital that functions in partnership with a medical school for GME will be totally or partially closed the slots that cannot be supported should be put in the stewardship of the medical school giving the school greater flexibility in assuring training and continued financial support. GME payments would go the host hospitals who would reimburse the schools. This would continue as long as the originating hospital could not support its total approved slots and be adjusted annually. The process would be far simpler and assure the stability of the GME programs.

Another challenge has been the 3-year rolling average by which CMS funds GME slots based on the average number of residents over the preceding 3 years rather than the actual count. This was waived for affected hospitals through June 2006, despite the fact that the programs never totally closed as was stated earlier. Hospitals accepting additional residents report significant negative financial impact and have been unable to fully reimburse the medical schools. The difficulty in finding temporary hospital placements for residents was in part a function of Medicare's cap on the number of reimbursable training slots assigned to hospitals. Hospitals were reluctant to accept residents because of the negative financial implications of exceeding the cap.

The process of resident placement is dynamic in a recovery period. Adjustments must be made as the original training hospitals reopen beds and as feedback from accreditation agencies mandate change. We request that Congress instruct CMS or if necessary pass legislation to provide further exemption from the 3-year rolling average for hospitals that take in displaced residents until a replacement MCLNO is completed. Prior to Katrina, Tulane provided approximately 70 percent of the care at the VA medical center in New Orleans which also provided training for 120 residents. The VA closed as a result of Katrina and today provides outpatient services in VA clinics and admits some patients to Tulane University Hospital.

The VA's integration with the Health Sciences Centers at Tulane and LSU provided a critical synergy. The missions of these 3 institutions in patient care, education, and research are integrally intertwined. The quality of the health care provided to our veterans is enhanced by the association with the schools and the highly skilled clinical faculty. It is critical that construction of a new VA hospital in downtown New Orleans proximal to the two medical schools begin without further delay. Finally, I ask you not to forget the doctors who are providing uncompensated care. If hospitals are compensated and doctors are not who will admit, diagnose and treat. Once again, I thank you for your continued attention and support for the challenges that we face.

[The prepared statement of Dr. Miller follows:]

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMITTEE ON OVERSIGHT AND INVESTIGATIONS

TESTIMONY OF DR. ALAN M. MILLER, Ph.D, M.D.
INTERIM SENIOR VICE PRESIDENT FOR HEALTH SCIENCES

August 1, 2007

Mr. Chairman and members of the Committee: Thank you for the opportunity to again testify about the state of health care in the New Orleans region and specifically the future of our physician workforce.

I also want to thank members of the Committee for their continuing support for the region's rebuilding efforts. Since the March hearings and through your efforts a number of actions have been taken that will have an immediate impact on healthcare for the most vulnerable of our citizens. It is now time to turn our attention to the long-term stabilization of health care. Central to that goal is the the impact of Graduate Medical Education (GME) on the region's supply of future doctors. GME is a key component in the growth and stability of healthcare in Louisiana. Prior to Katrina, according to the Association of American Medical Colleges, the number of medical students and residents for 100,000 persons trained through Louisiana's GME programs was well above the national average. Louisiana retained close to 50% of its trainees, ranking second among states in the percentage of physicians practicing in the same state as they were trained. The training of a qualified and committed physician workforce will assure the future of care in New Orleans and Louisiana, but unless the region's medical schools and teaching hospitals receive support, the survival of these programs will be in jeopardy.

I represent Tulane University, an institution of higher education whose mission includes both the provision of healthcare and the training of our next generation of doctors. Critical to any discussion of healthcare in New Orleans must be how to ensure that our training programs remain vibrant so that Tulane and LSU can continue to attract the best and brightest. Therefore today, I'd like to focus my comments on four key areas.

1. The role of Graduate Medical Education in providing the region's health care;
2. Short and long term needs associated with maintaining and growing an adequate physician workforce to meet patient needs.
    a. Ability to negotiate directly with hospitals to place residents in appropriate training programs;
    b. Exemption of the 3 year rolling average for host hospitals
3. The role of the VA in physician training
4. Financial stability for the region's healthcare providers

Role of Tulane and Graduate Medical Education

To date, Tulane University's cumulative financial losses from Hurricane Katrina are nearing $600 million. As of August, 2007 we have recovered approximately $300 million from insurance, FEMA, Federal recovery and foundation grants. As I said in my previous visit to the Committee, the past two years have been extremely challenging for everyone in New Orleans, but especially for those of us attempting to assess healthcare needs, rebuild broken systems, continue to provide care for all New Orleanians who need it, and effectively train our young physicians. Despite these challenges, Tulane University as the largest employer in Orleans Parish has continued to do exactly what it has done since its creation in 1834: provide health care, educate physicians, and advance medical knowledge through research and discovery in New Orleans and Louisiana.

The tragedy of Katrina has energized our nation's young adults like no event in our history. Thousands of high school and college students continue to flock to New Orleans to assist their fellow Americans in rebuilding their lives. Likewise we have seen an increased interest from future health care professionals who feel compelled to be a part of the rebuilding process. As one of the nation's leading research intensive medical schools, Tulane has always drawn some of the most talented students from around the country and resident training in New Orleans has always been of the highest quality. Now, students and residents are also offered an unparalleled opportunity to learn first hand about community based care and disaster recovery. But to be effective we must have quality training sites or some of our programs could be forced be closed. Before Katrina, Tulane University had 620 medical students, with a first year class of 155, and 521 residents and fellows trained in 44 programs. Post-Katrina, we received 7,000 applications for admission and increased the class size last year to 165. It will increase this year to 175. After losing the Medical Center of Louisiana at New Orleans (MCLNO), we voluntarily downsized our resident training programs to maintain their quality. We now have 331 residents training in 36 programs. LSU has faced a similar downsizing of its residency programs. It's important to note that each year that Tulane and LSU train a reduced number of residents the state faces long-term problems in terms of the supply of physicians in Louisiana.

Short and long term needs associated with maintaining and growing an adequate physician workforce to meet patient needs

The experience of the New Orleans healthcare institutions revealed flaws in the current system for reimbursing GME that are still impacting Tulane, LSU and our host hospitals,

and will undoubtedly be repeated in other cities if a disaster results in the total or partial closure of a major teaching hospital for an extended period of time. That is unacceptable. Prior to Katrina, both Tulane and LSU trained medical residents at several area hospitals, but the one site where both schools had their largest concentration of residents was the MCLNO. As a result of Katrina the hospitals comprising MCLNO were closed for 15 months. Although they have since partially reopened, they are only able to accommodate a portion of the total residents trained before the storm.

The financing of GME is, even under ordinary circumstances, a complicated and complex maze of agreements and reimbursement procedures that can often be navigated only with the assistance of attorneys. Simply put, before Katrina, CMS provided payments to MCLNO for the costs of training and in turn MCLNO reimbursed the medical schools so that they could provide for the salaries and benefits of residents and fellows. While there are other models around the country, because our residents train in multiple hospitals, they are paid directly by the medical schools in order to maintain consistency in payment and benefits. It's important to keep in mind that during the period of total and partial closure, the medical schools remained responsible for the education of the residents, and for paying the salaries and benefits despite being unable to receive reimbursement from the closed hospitals. As a result, Tulane lost $6 million in FY 05-06 and anticipates a loss of $1.5 million for FY 06-07.

The issue of finding temporary hospital placements for residents during the Katrina disaster was, in part, a function of Medicare's cap on the number of reimbursable training

slots that a hospital may have. Tulane was able to identify hospitals that were willing to accept displaced residents. Given the moratorium on any increase in training slots at existing programs, however, these hospitals were reluctant to agree to reimburse Tulane for displaced resident salary and benefits because the receiving hospitals were, in many cases, at or above their Medicare resident cap.

The regulatory solution to the Medicare cap dilemma has become a bureaucratic nightmare, so much so that Tulane had to engage outside counsel to navigate the unwieldy process. Unlike the relatively simple pre-Katrina experience, in order to place residents in alternative training locations Tulane and LSU must now identify hospitals capable and willing to take in additional residents. These host hospitals must provide appropriate supervision, adequate libraries, call rooms and laboratories to meet accreditation criteria. Tulane and LSU are the responsible accrediting parties, not the host hospitals. After identifying the sites, MCLNO as the "owner" of the Medicare-reimbursable resident slots must then, at the prompting of the medical schools, enter into emergency Medicare GME affiliation agreements with each of the hospitals for the specified number of slots. These agreements allow MCLNO to transfer some of its unused slots to the host hospitals, thus allowing the host hospitals to seek reimbursement from CMS for the displaced residents. As previously noted, without these agreements, most host hospitals would be unable to seek reimbursement from CMS because most hospitals are already training residents at or over their resident "caps." At the same time the medical schools must enter into separate Affiliation and Reimbursement Agreements with the host hospitals to provide the training and reimburse the medical schools for the

salaries and benefits of the residents. Once this laborious process is completed, the agreements must be renegotiated and renewed annually until the residents return to their home hospital, in this case MCLNO. It is worth repeating that in Louisiana, Tulane and LSU, NOT the host hospitals, are responsible to the accrediting agencies of residency programs, to assure the quality of the training programs at each hospital and payment of salaries and benefits to the residents.

Undoubtedly the most critical flaw that remains is that Medicare does not in all cases reimburse the institution that bears the direct responsibility for training the residents and paying their salaries and benefits. This then exacerbates the financial stress placed on responsible institutions during the disaster and recovery period. However we are not here today to ask for direct reimbursement. Instead we asking only for help in reducing our administrative burden by giving administrative stewardship of the slots allocated to closed or partially closed hospitals such as MCLNO to the medical schools so that we may directly negotiate with the host hospitals to place our residents.

We propose the following:

When it is clear that a teaching hospital that functions in partnership with a medical school(s) for GME will be totally or partially closed for an extended period of time (greater than 30 days), the "slots" that cannot be supported educationally and financially by the hospital should be placed in the "stewardship" of the medical school(s) by CMS such that the medical schools assume the financial responsibility for supporting the displaced residents.

- If multiple medical schools are involved, the slots would be divided according to the usual proportion of distribution under full operations.
- The medical school(s) would enter into an agreement with the originating hospital specifying the number of slots and period of time for which they would have stewardship. This would be tailored to coincide with the originating hospitals plans for wholly or partially reopening.
- The medical school(s) would then be able to enter into agreements with receiving hospitals to provide training for a specified number of residents, and reimbursement of the school(s) for their costs.
- The medical school would continue to pay residents and faculty and steward the well-being of the program, while the receiving hospital would receive GME payments.

Stewardship would continue as long as the originating or home hospital could not support its total approved slots, and would be adjusted annually based on the originating hospitals ability to educationally and financially support the slots. The overall process would be far simpler than the current one, while assuring the integrity of the GME programs and its financial support during the recovery period.

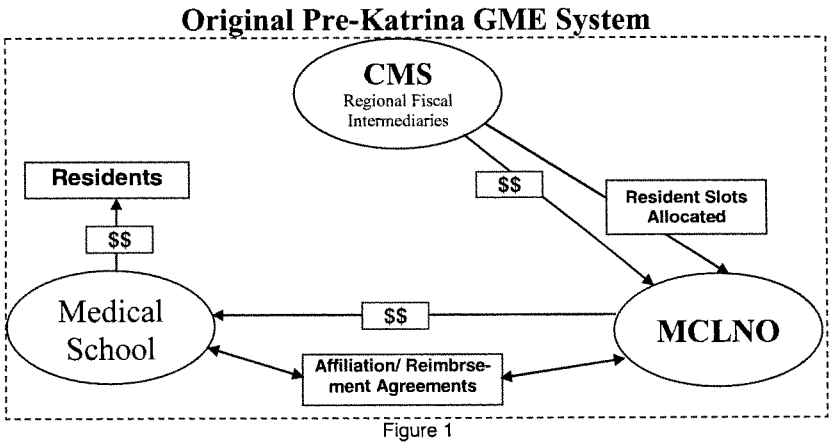

Figure 1

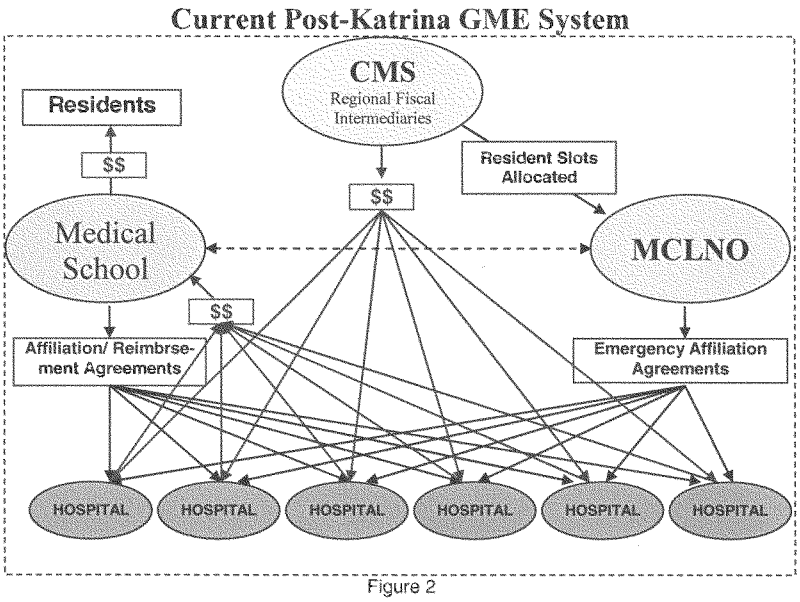
Current Post-Katrina GME System
CMS
Regional Fiscal Intermediaries
Residents
$$
Resident Slots Allocated
$$
Medical School
MCLNO
$$
Affiliation/ Reimbrse-ment Agreements
Emergency Affiliation Agreements
HOSPITAL
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Figure 2

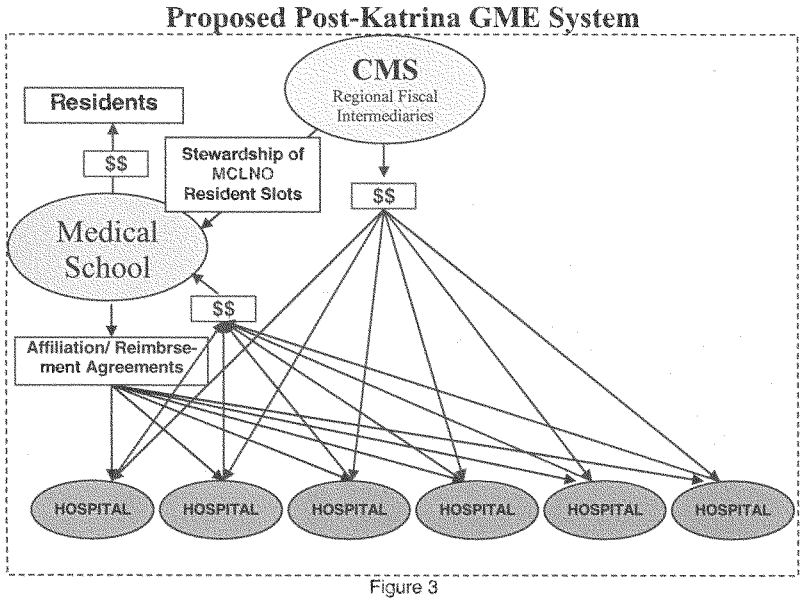

Figure 3

Exemption from 3 Year Rolling Average

Following Katrina, CMS waived the application of the 3 year rolling average for affected hospitals from August 29, 2005 to June 30, 2006, to allow host hospitals to include all of the displaced residents in their FTE count, and hence full GME payments for those slots, immediately. This was important to the financial well being of the hospitals but also to medical schools which needed to continue to collect money from those host hospitals for resident and faculty salaries.

Unfortunately as time has passed there remains a need for shifts in training locations. In the first year post-Katrina many of our residents were placed at training sites outside of

the region and state. As the region recovered and the Medical Schools returned to their downtown locations, residents were relocated to other host hospitals in the New Orleans region. Tulane and LSU are finding it necessary to continually adjust the location of residents and programs as original training hospitals gradually re-open beds, and as feedback from accreditation surveys require adjustments.

In July, 2006, the 3 year rolling average was reinstated. Since that time, host hospitals that have accepted additional residents are reporting significant financial impact due to the rule and in many cases they have been unable to fully reimburse the medical schools, creating an additional burden for Tulane and LSU. This is especially troublesome in the current financial environment of substantial increases in un-reimbursed care. This could result in some hospitals being unable to accept residents.

We request that Congress instruct CMS to provide an exemption of the 3 year rolling average for host hospitals taking in displaced residents. The exemption is requested for 5 years with a re-evaluation on an annual basis until a replacement MCLNO is completed.

The Role of the VA in Resident Training

Prior to Katrina, Tulane University provided approximately 70 percent of the patient care at the VA, with more than 75 Tulane faculty physicians serving joint appointments with the VA in many medical, surgical, and psychiatric sub-specialties and advanced clinical services. The VA Medical Center and Hospital in New Orleans provided training for approximately 140 residents, 120 of whom were from Tulane.

The VA's integration with the health sciences centers at Tulane and LSU provided a critical synergy that was a key strength both for the New Orleans VA and the region's overall health care standing. The quality of the healthcare provided to our veterans was enhanced by the association with the medical schools, and their highly skilled clinical faculty. The VA continues to play a crucial role in graduate medical education and medical research in New Orleans.

Today, the VA's outpatient clinics have reopened and visits are up to 75% of the pre-storm numbers. In addition, through its partnership with Tulane, the VA is now providing much-needed inpatient care at Tulane University Hospital and Clinic as it strives to keep up with the rapidly expanding population. Currently, the VA is supporting an average of 26 Tulane residents per month who are involved in outpatient care. If more VA beds were available, Tulane would increase the number of residents there to 70.

In addition to our residents, more than 40 Tulane physicians are currently providing services and training at various VA locations in the area, representing more than $2.2 million in physician compensation. In addition, numerous other Tulane faculty physicians are frequently available for service at VA locations as needed. The Tulane Health Sciences Center is now actively recruiting new physicians to accommodate the increasing need in the area and has open searches for five faculty positions specifically to support the clinical mission at the VA.

As we look down the road five, 10, 20 years and longer, it's clear that the VA will continue to be a cornerstone in the future of health care and the biosciences industry in the region. These industries already represent a significant share of New Orleans' regional economy. More than 8,000 people are employed in the bioscience and health related fields, with the metro area ranking 67th in the country. Prior to Katrina, the New Orleans Bioscience District was actively building a framework for entrepreneurial success. As a crucial component of that framework, the LSUHSC, Tulane University and the State of Louisiana formed both the Louisiana Gene Therapy Research Consortium and the Louisiana Cancer Research Consortium (LCRC). These partnerships are focused on leveraging the universities' research and education strengths to position the region as a leading center for clinical, biomedical and translational research, and to increase the area's competitiveness for large-scale research projects funded by the National Institutes of Health. In support of the region's efforts to expand its bioscience and biomedical infrastructure, the State of Louisiana also provided support for the creation of a 60,000-square-foot New Orleans BioInnovation Center (NOBIC). This center is designed to support the area's growing bioscience community, to attract additional biotechnology investment, and to foster the commercialization of new technologies and pharmaceuticals developed in the vibrant New Orleans Bioscience District. With additional funding provided this year by the state legislature, construction will begin this fall in the downtown bioscience district on an $86 million cancer research facility, and the $60 million BioInnovation Center.

The synergy generated by Tulane, LSU, the construction of the BioInnovation Center and the LCRC building, each within a few city blocks of the other, will create a rich, dynamic teaching and research environment that will rival any in the country. A strong VA Medical Center is a crucial component of this burgeoning bioscience hub that will maximize the potential of both the district and of the VA. It is hard to imagine the district without the VA, and the VA being built anywhere but the district.

Although it may have taken longer than many of us would have hoped, the state has done its part in providing funding for a public hospital to be built in tandem with the VA. This leverages the federal government investment, providing substantial cost savings and demonstrating good stewardship of taxpayer dollars. In addition, the investments by the state, city, and our own institutions in the emerging bioscience district provide a unique opportunity to create a vibrant inter-reliant collaboration among key healthcare, education and research entities, all of which are crucial to the VA's mission. It is the hope of Tulane University, as well as that of the many local and regional stakeholders (see attached letter) in the biosciences, that the VA and the City of New Orleans move quickly to begin the process of land acquisition, planning and construction so that we may re-establish the full spectrum of care for our rapidly growing veteran population.

Financial stability for the region's healthcare providers

According to the Louisiana Department of Health and Hospitals there were 617 primary-care physicians in New Orleans prior to Katrina. By April 2006 that number had dropped to 140, a decrease of 77%. In July 2006, Blue Cross Blue Shield of Louisiana reported a 51% reduction in the total number of physicians filing claims in Region 1. Nearly all of

this reduction—96%—was from Orleans Parish. The loss of additional clinical faculty at Tulane as well as LSU will not only decrease the available current physician workforce, but will reduce the clinical teaching faculty needed to teach the next generation of physicians for the region and the state. Our region's hospitals are here today to request funds to keep them financially viable, I would ask that you not forget the doctors in the area who are providing care and remain uncompensated for that care. Providing funds for uncompensated care provided at the hospitals will not directly assist our physicians, therefore we request a separate Federal allocation specifically for physicians so that we can stem the tide of physicians leaving the area.

Once again, I thank you for your continued attention and support in overcoming the challenges that we face.

Mr. MELANCON. Thank you, Dr. Miller. I appreciate your comments. Dr. Peck, if you would, please, 5 minutes.

TESTIMONY OF GARY Q. PECK, M.D., AMERICAN ACADEMY OF PEDIATRICS

Dr. PECK. Good afternoon. I appreciate this opportunity to testify today. My name is Gary Peck, and I am proud and pleased to represent the American Academy of Pediatrics. I chair the Academy's Disaster Preparedness Advisory Committee and I sit on the Board of Directors. I also am a former medical director and assistant State health officer for the Louisiana Office of Public Health as well as a former pediatrician who practiced in New Orleans.

An effective health care system has two primary components: strong hospitals and related institutions, but an equally robust cadre of private practitioners in the community. We have heard a great deal about hospitals today and institutions. We have heard virtually nothing about the vitally important physicians in private practice, so allow me to share with you this afternoon the litany of issues faced by my colleagues in the New Orleans area.

Many physicians faced the total destruction of their homes and office space, including medical records, equipment, and supplies. Physicians lost revenue during the weeks or months they were unable to practice. Many physicians who stayed in the region are only now—2 years later—seeing an adequate volume of patients to sustain their practice.

Under the Stafford Act, physicians in private practice are considered for-profit entities like dry cleaners or liquor stores. As such, they are unable to access most forms of Government aid like the programs that assist hospitals and community health centers. The Louisiana Department of Hospitals and Health Program retains and recruits new providers, but has been the subject of a good deal of confusion, and its impact on retention, especially in pediatrics, is very unclear. While the greater New Orleans Health Service Corps will distribute $50 million, 70 percent of that is earmarked for recruitment of new providers and only 30 percent for retention of existing health care workers in the New Orleans area.

In the immediate wake of the storm, the entire Gulf Coast region experienced an influx of volunteer organizations providing free or low cost care to our residents. Local, private practitioners found their patients going to temporary facilities that were more visible, better advertised, and easier to access than their own practices. While certainly well meant, these efforts had the unintended consequences of diverting patients to temporary providers that fail to provide a medical home and deny needed revenue to local health care providers.

With the loss of jobs after the hurricane, the number of patients covered by Medicaid or having no coverage at all has increased dramatically. Louisiana Medicaid now covers approximately 20 percent of all people in the New Orleans area. At the same time almost 65,000 fewer children are covered by Medicaid in the SCHIP program. We are faced with a paradoxical situation of having far fewer residents but a higher proportion of uncompensated Medicaid care.

Physicians in private practice do not have the ability to charge more for their services. Pediatricians are locked into contracts with

private insurances or Medicaid that prevent them from altering their rates. In fact, one private insurer, United, is currently decreasing reimbursement to New Orleans primary care pediatricians.

The recruiting challenges faced by hospitals and health systems are as bad if not worse in physician practices.

As caregivers for children, pediatricians do not treat Medicare patients and were therefore unable to benefit from the modest health provider shortage area increases disbursed through Medicare to Gulf Coast providers. Medicaid rates, in Louisiana average 60 to 70 percent of Medicare rates although recently the legislature has passed a measure that will raise our Medicaid payments to 90 percent of Medicare rates effective October 1.

Pediatricians face very high overhead costs, particularly in the forms of vaccines, which must be purchased and paid in full up front with no guarantee that all of the doses will be administered or reimbursed. Pediatricians struggle to provide medical help, particularly for children with chronic or complex health needs. Usually they find the extra time and work involved does not get compensated. Children's mental health in New Orleans are woefully unmet; a recent study estimated that 45 percent of children returning to New Orleans need mental health services.

If we hope to rebuild a robust health care system in New Orleans that can provide quality, high health care to all patients. policymakers must recognize the crucial role that private physicians in private medical practices play in that. In pediatrics in particular, 85 percent of all patient encounters occur in privately owned and operated practice settings.

In conclusion, I have two recommendations for the State of Louisiana. The American Academy of Pediatrics commends the State of Louisiana for its recent decision to increase Medicaid payments. Unfortunately, this increase is still insufficient to assure access to care for all children. Policymakers should re-examine the emphasis of the greater New Orleans Health Services Corps on retention versus recruitment. The State's effort to establish additional community health centers and federally qualified health care centers should be reviewed to insure that it represents a long-term strategy that will best serve the needs of my area residents.

The Louisiana Department of Health and Hospitals should affirm the vital role of private practitioners in the health care system by exploring creative incentives for supporting these practices and their efforts to serve their patients and recruit staff in their practices.

The Federal Government must transform its goal in disaster medical care from providing short-term, temporary care to supporting the local health care system and its providers. After the immediate recovery phase, Federal efforts should focus on the reinstatement of local health care institutions and providers, rather than the provision of care through volunteers and short-term facilities. Health care providers, including for-profit private practices must be provided with aid to re-establish their operations. Patients must be encouraged and be assisted in returning to their prior health care providers to improve the continuity of care. The Stafford Act should be examined to identify avenues for providing aid for profit health

care entities such as private practices, recognizing the vital role they play in a health care system.

The American Academy of Pediatrics commends you, Mr. Chairman, for holding this hearing today to examine the ongoing challenges facing the health care system in my home, New Orleans. I appreciate this opportunity to testify, and will be pleased to answer any questions you may have. Thank you.

[The prepared statement of Dr. Peck follows:]

TESTIMONY OF GARY Q. PECK, MD, FAAP
ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

ENERGY AND COMMERCE SUBCOMMITTEE
ON OVERSIGHT AND INVESTIGATIONS

"Post-Katrina Health Care in the New Orleans Region:
Progress and Continuing Concerns"

August 1, 2007

Good morning. I appreciate this opportunity to testify today before the Energy and Commerce Subcommittee on Oversight and Investigations at this hearing, "Post-Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns." My name is Gary Q. Peck, MD, FAAP, and I am proud to represent the American Academy of Pediatrics (AAP), a non-profit professional organization of more than 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. I chair the Academy's Disaster Preparedness Advisory Council and serve on its Board of Directors as the representative of the region encompassing Louisiana, Mississippi, Texas, Arkansas and Oklahoma. I am a former Medical Director, Deputy Assistant Secretary, and Assistant State Health Officer for Louisiana's Office of Public Health and a former practicing pediatrician specializing in the field of adolescent medicine.

The American Academy of Pediatrics (AAP) has grave concerns regarding the current and future health of children in New Orleans and along the Gulf Coast who continue to recover from Hurricane Katrina. From the dangers and hardship associated with evacuation and relocation, to respiratory problems and injuries immediately after the hurricane, to the ongoing concerns related to mental health effects, the children of the Gulf Coast have borne an enormous amount of suffering associated with that disaster.

Challenges Facing Private Practice Physicians in the New Orleans Region

Today, perhaps one of the greatest challenges facing the entire health care system in New Orleans is the retention of existing health care providers and recruitment of sufficient new providers to ensure timely access to quality care. Health care does not happen without qualified, committed practitioners. Among the physicians displaced after the storms, almost 4,500 had worked in the New Orleans region.[1] In summer 2006, the number of board-licensed primary care physicians in New Orleans compared to the month before Katrina dropped from 2,645 to 1,913, a decrease of 28 percent.[2]

Those of us who live in New Orleans have seen a pattern to the loss of physicians. Immediately after the storm, the first wave of doctors who departed tended to have high medical school debt and not be established firmly in their practices. A year or more later, another round of departures occurred among long-time area physicians whose families were simply exhausted by the high crime rates, poor school performance, and the routine stress of negotiating daily life in a community where it can be difficult just to run normal errands. Institutions outside our region have begun recruiting heavily among our ranks, offering hefty bonuses and perks to those willing to move. At the same time, the New Orleans hospitals struggle with staff shortages at all levels, our emergency departments are chronically stressed, and the dearth of mental health providers presents both short- and long-term challenges.

Physicians in private practice have faced enormous hurdles over the past 22 months in re-establishing and maintaining viable practices. As a pediatrician, I can attest that many of

these difficulties are common to all health care providers, while some are specific to pediatric care providers. Allow me to share with you the litany of issues faced by my colleagues in the New Orleans area.

Personal and Professional Losses. It is difficult to convey adequately the devastation inflicted upon the New Orleans area community and health care infrastructure. Many physicians faced the total destruction of their homes and office space, including medical records, equipment, and supplies. Office staff may have been unwilling or unable to return to the area. In addition to the physical losses, physicians lost revenue during the weeks or months they were unable to practice. Many physicians who stayed in the region are only now -- two years later -- seeing an adequate volume of patients to sustain a practice. I am personally familiar with many physicians who were denied insurance coverage for their losses, or whose insurance payouts did not begin to cover their actual costs. These doctors are now carrying the double burden of pre-existing debts and obligations and the new expenses associated with re-establishing their practice.

Lack of Access to Aid. Under the Stafford Act, physicians in private practice are considered "for-profit" entities, much like dry cleaners or liquor stores. As such, they are unable to access most forms of government aid like the programs that assist hospitals and community health centers. Physicians are eligible only for Small Business Administration (SBA) loans up to a certain level. The delays and other problems in SBA loan processing have been well-documented by the Government Accountability Office.[3]

The Louisiana Department of Health and Hospitals program to retain and recruit new providers has been the subject of a good deal of confusion, and its impact on retention, especially in pediatrics, is unclear. While the Greater New Orleans Health Service Corps will distribute $50 million, fully 70 percent is earmarked for recruitment of new providers and only 30 percent for retention of existing health care workers.

Lack of Systemic Support for Local Health Care Providers. Particularly in the immediate wake of the storms, the entire Gulf Coast region experienced an influx of volunteer organizations providing free or low-cost care to residents. Local private practitioners found their patients going to temporary facilities that were more visible, better advertised, and easier to access than their home practices. While certainly well-meant, these efforts had the unintended consequence of diverting patients to temporary providers that failed to provide a medical home and denied needed revenue to local health care providers.

A Higher Proportion of Uninsured and Medicaid Patients. With the loss of jobs after the hurricanes, the numbers of patients covered by Medicaid or having no coverage at all has increased from about 15 percent of the population to about 20 percent. Louisiana Medicaid now covers approximately 20 percent of all people in the New Orleans area.[4] At the same time, almost 65,000 fewer children are covered by the Medicaid and the State Child Health Insurance Program, which is a Medicaid expansion, in the New Orleans region. We are faced with a paradoxical situation of having far fewer residents but a higher proportion of uncompensated and Medicaid care.

Poor Payment for Services. Unlike most other service providers, physicians in private practice do not have the ability to charge more for care. Doctors are locked into contracts with private insurers or Medicaid that prevent them from altering their rates. In fact, one private insurer, United, is currently decreasing reimbursement to New Orleans primary care pediatricians. Even under the best of circumstances, private practitioners find it difficult to negotiate for better rates with large insurance companies. After the hurricanes, most physicians were in no position to take the time and effort necessary to renegotiate their contracts with insurers. Programs like Medicare and Medicaid largely failed to respond with higher rates.

Difficulties in Recruiting. The recruiting challenges faced by hospitals and health systems are as bad, if not worse, in physician practices. Physicians are facing tremendous obstacles in recruiting new physician partners as well as nurses and office staff. The availability of specialists and subspecialists to care for patients with special needs is extremely low. The cost of living in the New Orleans area is requiring physicians in private practice to offer prohibitively high salaries to their staff – some of whom can earn better salaries in low-skill private sector jobs than they can in health care.

Challenges Specific to Pediatrics. Many of the issues mentioned above are exacerbated in the pediatric setting. As caregivers for children, pediatricians treat no Medicare patients and were therefore unable to benefit from the modest Health Provider Shortage Area increases disbursed through Medicare to Gulf Coast providers. Medicaid rates in

Louisiana average 60 to 70 percent of Medicare rates, although the Legislature passed a measure recently that will raise our Medicaid payments to 90 percent of Medicare's rates as of October 1. Pediatricians face high overhead costs, particular in the form of vaccines, which must be purchased and paid in full up front with no guarantee that all of the doses will be administered and reimbursed. Pediatricians struggling to provide a "medical home" for their patients, particularly for children with chronic or complex health needs, usually find the extra time and work involved goes uncompensated. Children's mental health needs are woefully unmet; according to one study, an estimated 45% of children returning to New Orleans need mental health services.[5]

Private Practices are the Foundation of the Health Care System

If we hope to rebuild a robust health care system in New Orleans that can provide high quality care to all patients, policymakers must recognize the crucial role of private medical practices. In pediatrics, 85 percent of all patient encounters occur in privately owned and operated practice settings.[6] Without the work of private practitioners, hospitals and community health centers would experience an untenable influx of patients, many of whom would not be receiving care in the most appropriate or cost-effective setting.

In order to be able to provide care, private practitioners must receive appropriate payment for their services. For the past two years, many New Orleans-area physicians have been expected to treat large numbers of patients whose care is uncompensated or paid at rates that do not cover costs. This is not a sustainable business model. Policymakers must

recognize the value of these services and finance them at levels that allow for practitioners to operate a viable enterprise.

Recommendations for Louisiana. The American Academy of Pediatrics commends the State of Louisiana for its recent decision to increase Medicaid payments. This increase will have an immediate impact on the ability of physicians, including pediatricians, to accept Medicaid patients. Unfortunately, this increase is still insufficient to assure access to care for all children.

Policymakers should re-examine the emphasis of the Greater New Orleans Health Service Corps on retention versus recruitment to determine whether that focus is appropriate. The state's effort to establish additional community health centers and federally-qualified health centers should be reviewed to ensure that it represents a long-term strategy that will best serve the needs of area residents. The Louisiana Department of Health and Hospitals should affirm the vital role of private practitioners in the health care system by exploring creative incentives for supporting these practices in their efforts to serve patients and recruit staff.

Recommendations for the Federal Government. The federal government must transform its goal in disaster medical care from providing short-term, temporary care to supporting the local health care system and providers. After the immediate recovery phase, federal efforts should focus on the reinstatement of local health care institutions and providers, rather than the provision of care through volunteers and short-term

facilities. Health care providers – including for-profit private practices – must be provided with aid to re-establish their operations. Patients must be encouraged and assisted in returning to their prior health care providers to improve continuity of care. The Stafford Act should be examined to identify avenues for providing aid to for-profit health care entities such as private practices, recognizing the vital role they play in a health care system. Finally, the AAP supports efforts to replace the Medicare Sustained Growth Rate with a more appropriate medical inflation adjustor. Given that Louisiana has indexed its Medicaid payment increases to Medicare, any cut in Medicare rates will cause an associated decrease in Medicaid payments.

The American Academy of Pediatrics commends you, Mr. Chairman, for holding this hearing today to examine the ongoing challenges facing the health care system in the New Orleans region. I appreciate this opportunity to testify, and I will be pleased to answer any questions you may have.

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[1] Madamala K, Campbell C, Edbert H, Hsieh Y, James J. *Characteristics of Physician Relocation Following Hurricane Katrina.* Disaster Medicine and Public Health Preparedness, Vol 1, No. 1, July 2007.
[2] Ibid.
[3] Small Business Administration: Additional Steps Needed to Enhance Agency Preparedness for Future Disasters. (GAO-07-114). Government Accountability Office, Washington, DC: Feb 2007. Available at http://www.gao.gov/new.items/d07114.pdf.
[4] Louisiana Department of Health and Hospitals, available at http://www.dhh.louisiana.gov/offices/page.asp?id=88&detail=7589
[5] Rebuilding Louisiana's Health Care System. Alliance for Health Reform, July 2007. Available at http://www.allhealth.org/publications/State_health_issues/Rebuilding_Louisianas_Health_Care_System_66.pdf.
[6] Tank S. *Profile of Pediatric Visits.* American Academy of Pediatrics, Elk Grove Village, IL, 2007.

Mr. STUPAK. Thank you, Dr. Peck, and thank you to the full panel for being here today and your testimony and your help and support in what we are trying to do in New Orleans. I apologize for being in and out but we have been on the floor with SCHIP. For questions, Mr. Melancon, please, do you want to start?

Mr. MELANCON. Thank you, sir. First, and a positive statement, Dr. Quinlan, don't feel bad for trying to take an opportunity and make it work for your hospital. No one faults you for that. The people that should be faulted for that happening in the sense of where the VA didn't go yet, where Charity didn't go yet or the people up here that have played politics with it and left it out there. I truly understand. Now our goal is, and I think what I heard from every one of you gentlemen and Dr. Rowland, is that we have got a lot of immediate problems that we need to address, and I think you have delineated those very well today. And if I can, I would like to rather than ask questions just kind of make sure I hit them and then let us talk about what we do from this point forward.

I have been in office with every one of you, I believe, at some point in time in the last 2 years, and we have had these discussions. As Dr. Hollier, I believe, expressed it never went anywhere after you had the discussions with the bureaucracy. They listened, and then as I heard today, and I said where is the action switch, we haven't seen that. One is we have to remedy the situation with the bleeding, with the red ink, and address those issues in whatever way that we can try and get those things, take a direct attack at them through the legislation.

Now the second one is the GME, the third is the DSH dollars to compensate physicians at the hospitals. I think I have got them all. They are not all inclusive, but what I would like to ask of the chairman and the ranking member is that at this juncture, the end of this meeting, that the staff of this committee become the mediator between the Louisiana medical community or the New Orleans regional medical community and the agencies we are dealing with and start trying to put something down that they can do with either the rules and regulations or that we can do through legislation here because it is entirely too long the process that has been ongoing. But is there anything that anybody other than your prepared statement, Mr. Chairman, if I am allowed with my extra 2 minutes that if anybody has any other comments or suggestions of things that we need to make sure to include.

Dr. HOLLIER. I will just make one comment for emphasis. We keep hearing multiple comments being made in Washington that they would prefer that we not build a replacement University Hospital in New Orleans in order to help drive health care reform. We have been trying to change the system since before Katrina, and we are still committed to doing that, but what is often missed is that how one funds health care and how one provides graduate education and care for patients are related but different. It is important to recognize that the University Hospital, Charity Hospital, that we had before the storm not only trained residents but it had over 2,200 students that it trained.

LSU and Tulane trained over 70 percent of the physicians in the State of Louisiana. All the health care professionals are dependent upon this training system. It has been very destructive to have so

much opposition to building a hospital. I think all of my colleagues here that we worked with and the hospital CEOs have had concerns on their own about not being able to replace the workforce that they need, so this is an important thing we recognize. We need a place not only for the residents but to also train all these students that we have to train.

Mr. MELANCON. Let me ask one. When you have had the conversations after either our meetings or the last hearing and we thought maybe things would move, what kind of response did you get from CMS or VA or any of the agencies? Was it just they read to you what the programs provided and then left it or did they try and give you any suggestions?

Dr. MILLER. Particularly on the GME issues, I think what we have tried to do is educate on what the problems were and how we saw that they might be ameliorated, and what we got in return was education on what their regulations were and how they wouldn't allow what we wanted.

Mr. MELANCON. And when you presented to them the problems, what was their response? What did they do?

Dr. MILLER. It was similar to what you had this morning in the earlier panel.

Mr. MELANCON. A renumeration of the program.

Dr. MILLER. Yes.

Mr. MELANCON. Mr. Chairman, thank you.

Mr. STUPAK. Mr. Whitfield for questions, please.

Mr. WHITFIELD. Thank you, Chairman Stupak, and I would thank you all once again. I know how frustrating it is to be sitting here so many hours when you have so many issues facing you. Chairman Stupak, I would follow up on the suggestion made by Mr. Melancon that it maybe would be helpful to have our committee staff be intermediaries to deal with this because every time we have a hearing and the people from the Federal Government, CMS, and other agencies may have the very best intentions but it appears that there is always an explanation of a regulation or a rule or a law or why you can't do something, why you can't address the issue, why it is an obstacle. And so all of us seem to be tied up in knots and not getting anywhere. And when Dr. Peters presents the combined financial statements of the five hospitals that he talked about for the first 5 or 6 months of this year and the combined losses in excess of $53 million, it makes you wonder—and, by the way, in March when you all were here we were talking about those losses as well.

And so we have discussed the depleting of these cash reserves and the deficits and how long can you all really continue to operate? Where does this money come from? If you all would address that, you executives of those five, how long can you operate?

Mr. MULLER. Maybe I should start because I think I am a little different at West Jefferson because of the bond insurance requirements. We have to have an operating income quick. They are talking about September, another review by December, so if we don't have operating income, which would include grants and things that are immediate then we become in default. They take the mortgage. They can come in and operate West Jefferson. That would not serve the community.

Mr. WHITFIELD. And what about you, Dr. Quinlan? What about Ochsner?

Dr. QUINLAN. Well, we made a commitment from the beginning that we are not going to put patients in the middle, and to date we have been reasonably successful at preserving services and we have committed the company to risk its existence to promote economic growth in addition to care. We keep scrambling to find new ways to stretch dollars and make them work but the losses make that progressively more difficult.

Mr. WHITFIELD. Mr. Hirsch.

Mr. HIRSCH. We are in a similar position. I brought a deficit budget to our board in the beginning of this year. I have never in my career—I can't say that I have never operated at a loss before but I have never planned on doing it before the year started. And that budget called for going through about two-thirds of a board designated fund of cash to support our operations to the tune of about $20 million. And so we can't do that for another year or two. It is a spiral. To Mr. Muller's point, we had the same kind of issues. We are not in a technical default right now but I don't know how far away we might be from that. We had that last year as well so it is—the question gets asked what do you cut and when. I am not certain about that, but I know that it looms as a possibility. I am not prepared today to say exactly what but again in almost 30 years, I have never seen a picture like this.

Mr. WHITFIELD. Dr. Peck.

Dr. PECK. This is a great question. I can comment on a couple of pediatricians. I know of two practices in New Orleans who are just getting ready to go under. They can't practice for much longer. And it wasn't just New Orleans. It is the Gulf Coast. There was a pediatrician who practiced in Bay St. Louis. He was very young. He went back to Bay St. Louis after Katrina and tried for 2 years to get things going and just ran out of money. I have two practices in New Orleans I know of that if it doesn't turn around they are having to leave the city just because of reimbursement costs. It is incredible.

Mr. WHITFIELD. Well, thank you very much for that, and I know this next question is not related to the physician which is an important component of this obviously, but after our last hearing Dr. Quinlan and Dr. Miller and Dr. Hirsch signed a letter which they outlined certain solutions to this problem or at least helpful steps that could be taken. And one was relating to critical access designation so the reimbursed costs plus, and I remember at that hearing there was a lot of discussion about that but whatever happened to that suggestion and is that not possible or what is the deal?

Dr. QUINLAN. Actually we have looked into that further and we have different effects with the different hospitals based on the size of their graduate medical education program. Because of our size we have 350 residents and fellows that would actually lose revenue by that mechanism. Don't ask me how but we would. It is kind of an archaic accounting system. Others I think would benefit so the effects would not be the same.

Mr. WHITFIELD. So some would benefit and some would not?

Dr. QUINLAN. That is correct.

Dr. PETERS. I would make the comment probably very general in nature. I think what it really takes at this point is to try to come up with some creative solutions. I think first acceptance of the data and maybe making sure that it is accurate, which we are convinced that it is, I think that that has always been a question mark with some of the agencies, is it really as bad as what maybe individuals anecdotally portray. So and not to be repetitive, but I think there have been a lot of dead ends with regulatory roadblocks, and I think I will speak for East Jefferson, we would welcome staffers being helpful to be intermediaries to whether it is thinking out of the box or really determine a type of cost-based reimbursement that would address this unique issue that exists.

Mr. WHITFIELD. Thank you very much. Do you want to say something, Mr. Hirsch?

Mr. HIRSCH. I was just going to say that we would be supportive of cost-based reimbursement. It would help us. We have hit these same kinds of dead ends that we heard earlier with some of the questions that the Chair was asking, and we just hit dead ends on these kinds of solutions.

Mr. LAGARDE. For Tulane we would—critical access designation would negatively impact us with the same reason it would negatively impact Ochsner. The hospitals with the large teaching programs, I agree with Dr. Quinlan on this, it is impossible to understand but it would not benefit. It would have millions of dollars worth of impact to us to move to a critical access designation at this point in time.

Mr. STUPAK. But if the purpose is to give you critical access designation so you can be paid a premium for your services, not asking you to move or do other things, just that the reimbursement rate was at a critical access hospital rate wouldn't that be beneficial?

Mr. LAGARDE. In theory it would but the way the critical—if critical access designation is amended from the way it is currently paid it potentially could be beneficial for all five hospitals represented here but the way it currently reimburses hospitals it would have an impact upon——

Mr. STUPAK. Because of your GME?

Mr. LAGARDE. Because of not only GME but also our indirect medical education costs as well.

Mr. STUPAK. We sort of see that from this side of dais, and we see it in sort of a separate situation like you would think you would be reimbursed your critical access for services provided, the emergency room, your GME, but one offsets the other, right?

Mr. LAGARDE. That is correct. Dr. Hollier was reminding me, it is a formulation, it is a formula driven reimbursement that doesn't fully account for the cost associated with large graduate medical education or direct or indirect medical education.

Mr. STUPAK. You want to waive those requirements so you can get reimbursed for services.

Mr. LAGARDE. I think as Mark Peters has mentioned this is something that we would probably like to have a good conversation about.

Mr. STUPAK. Dr. Peters, on the financial statements that you provided us, do you have any objection if this committee bipartisanly asks GAO to go through those numbers so we can get some quick

verification? We will ask them to do it expeditiously because we need some verification and get back to HHS and others to move this process along.

Dr. PETERS. No, absolutely. We all welcome that and we welcome the rapid approach to that.

Mr. STUPAK. We talked today, and there has been discussion about like $195 million coming in to the area and another $100 million is supposed to be available around September 1, and $26 million for GME. You hear these numbers, and my folks back home are saying, man, you are pouring a lot of money in there, but then I look at your financials and it is not there, the money is not there, so how did we get to this point? Can you give us a little bit more? Has Secretary Leavitt or representatives from HHS engaged you in a dialog about these issues, the financial parts? Mr. Peters, do you want to start? How did we get here?

Dr. PETERS. I think it is probably a multi-factorial reason. One is I think the efforts have been diluted as we have talked about. I think that Medicare wage index money is a good example that went to 31 parishes, 60 some hospitals. That diluted its impact on the hospitals in our area. I think that——

Mr. STUPAK. The wage index—let me stop you there. So because people were not in your hospitals, what happened to the wage index? Did they take it down on you? Did you get less money?

Dr. PETERS. Well, first off the dollars came as a grant. It was not stepping——

Mr. STUPAK. I see what you are saying. It was spread out too.

Dr. PETERS. Change in the dial, the new setting that would pay us at a different level for every Medicare patient that is admitted to the hospital which is again one thing that is an immediate partial solution to the problem because there is a process already in place. There is a way to audit it. We do Medicare cost report, et cetera. So I think that that is a huge area of opportunity. I think second maybe stepping aside from dollars, I think that there has been maybe too much emphasis looking at long-term reform and not the immediate needs. And I think what the testimony of my colleagues has expressed today health care providers continue to want to do the right thing and keep taking care of patients in spite of all this bad stuff. None of us are businessmen at heart and if we were we probably would have about half the beds in place. So I think not enough attention to address the short-term needs which honestly would help us have more ability to look at reform as we move forward.

Mr. STUPAK. Define your short-term needs. From listening to the last panel with HHS it seemed like the short-term needs was, OK, the hurricane was over, things calmed down, we are out of here. But I see your short-term is a little bit longer than what——

Dr. PETERS. To fill a gap that exists to get us back to break even because the other thing we have not talked about——

Mr. STUPAK. Was that short-term going to be 2 years, 3 years?

Dr. PETERS. I think we would say 3 years, 3 years to fill that hole because the other thing that has happened is that we have all cut back on expenditures. We have all not bought some of the things we would have normally and there is going to be a huge price to pay at a later date. The other thing that I wanted to mention to

Congressman Whitfield's question is how long can we all go. The other thing that has happened that we all appreciate now is how intertwined our fates are and whether it is East Jefferson, West Jefferson, Ochsner, Touro or Tulane if somebody cuts services tomorrow it is going to make my situation worse because this is all that is there. And with all due respect to the new facility, the VA, where it should be located, this is that immediate issue that if as Gary talked about he is forced out of his own control to do something we are all going to pay the price and it starts back that downward spiral. And that is not even talking about how much that impact will be on whether somebody is going to come back to New Orleans.

Mr. STUPAK. Well, you must have had these conversations with HHS. What is their response? We certainly understand it up here but what is their response? What are they doing to help?

Dr. PETERS. They listen. They will say we will try to evaluate and look at some of these solutions, and again there have been partial solutions. East Jefferson got $5 million for the Medicare wage index. That is a lot of money but relative to where it should be if current data was being used it to a degree it is like me saying here is a quarter, go have a great lunch. It is nice you got a quarter but I don't think it is going to buy you much of a lunch. We appreciate that effort but it just hasn't taken care of it, and we are frustrated too. We are very frustrated. But also why we are here is we are still trying to come up with solutions.

Mr. STUPAK. Dr. Miller and Dr. Hollier, I mentioned earlier to HHS that the Utah demonstration project for reimbursement of your GMEs, could that work in your situations or am I just off base?

Dr. MILLER. After that, I talked a little bit with Secretary Cerise and with Dr. Hollier regarding that. Something of the modification of that plan could possibly work for us. I think the plan itself is too broad to apply because you don't really need to apply it to the hospitals that are open and taking care of their own GME slots. It really only needs to be applied or something like it applied to the handling of GME slots from a closed or partially closed facility. So if there were 600 some odd slots at MCLNO prior to the storm, if you could put those 600 slots into some type of stewardship, whether the stewardship was administered by the medical schools in proportion to what proportion of those slots they handled before or by some type of oversight, that would go a long way to solving the problems. We would be able to place those residents in hospitals that could handle them with the proper teaching environment.

The funds would flow so that the medical schools and the hospital supporting the GME were reimbursed, and it should take away any of the 3-year rolling average problems.

Mr. STUPAK. I don't mean to interrupt you, but could the two of you put together a proposal of the modified Utah, get it to us, and we will try to coordinate that with Secretary Cerise, and maybe we can start pushing HHS. So what I have been hearing again today is DSH payments, we have to get that fixed. We could do a waiver there. The GME, we need to fix this one. The wage index, we have to get back and take a look at it now. Any other areas I am missing? I know we still got the BA issue.

Dr. QUINLAN. I think the other issues would be don't forget immigration to increase the labor pool. Those are caught up in the visa problem bottleneck. And remember the wage index refers just to that. It is a workforce issue but there are other expenses around insurance and utilities that are significant contributors, and there are other smaller ones but this problem is not one thing. It is hard for people to understand. It is a lot of things that go against us and a little bit that doesn't go for us. In aggregate, that is how small companies develop large deficits.

Mr. STUPAK. I am looking at this financial and I see utilities are up 32 percent, your employee contract labor is 162 percent increase. This is pre and post-Katrina. Then I am looking at insurance, business interruption, that is up 35 percent. Bad debts up over 30 percent, so I can certainly understand how these numbers multiply and if there are five hospitals it multiplies in a hurry. Dr. Rowland, if I can ask you just a couple quick questions on some financial things. You have heard the hospitals stating their financial situation and it sounds pretty stark. What would you recommend to the committee and some of the HHS areas they could address?

Ms. ROWLAND. Well, I think that one of the issues that has clearly come out today is that our health policies and health reimbursement policies are based on a health system that is continuing and continuous and so you can go back to 3-year old data and move forward. I think there clearly needs to be for future disasters like this and to even help here to have some mechanism by which these rules can be flexible and suspended. Then if a crisis occurs you can have a demonstration program or an initiative that lets you weave together all these pieces that everyone has talked about today whether it is for special incentives for workforce or other componets.

And I recall many years ago, when I worked at the Department of Health and Human Services, we had an initiative we called financially troubled hospitals. And it happened in New York, it wasn't Louisiana at the time, but we were looking at ways to use grant funds combined with waivers of Medicare and waivers of Medicaid and put together a demonstration project that could really move in and provide the funding. And the other piece that I have heard today is that it not 1 year or 2 months. It is over a long period of time and that instead of focusing on what the health system will look like in 2020, we need to focus on how to get enough of the resources there to get them over the hump, and the hump I think is a lot higher than what we had said before. But clearly looking at one of the lessons out of this I think is to really put together some kind of a disaster-related assistance so when a health system is disrupted as that in Louisiana you have some ability to go in whether it is an earthquake in San Francisco or whatever.

And we clearly just see a patchwork approach, and I think that is why there are so many stumbling blocks about trying to put one piece together and another piece doesn't work.

Mr. STUPAK. I am sorry. I am way over my time. Mr. Burgess, do you have questions? I am sorry. I didn't see you down there.

Mr. BURGESS. That is all right, Mr. Chairman. Cheerful persistence is my motto today. Let me just ask a question I had. I prob-

ably ought to ask this of Mr. Miller because I remember we talked about this in October 2005 when I was there. Community development loans were monies that you all needed to keep your operations going. Actually I think you wanted those to come in the form of Federal grants and they actually came in the form of loans. But my understanding from information I received is there was $100 million left on the table at the end of September 2006 that was not subscribed. What was the reason that you couldn't utilize that money, that the hospitals couldn't utilize the money? Was it because they had to be paid back? Was that a problem with your bond holders from East Jefferson and West Jefferson's perspective?

Mr. MULLER. Actually a couple things. The formula again for receiving any amount of money comes from your revenues lost and the CDL. We had actually applied for almost $50 million and ended up getting $30 million, so that $20 million was left on the table East Jefferson, Jefferson Parish, Orleans Parish, whoever got the CDLs. The formula drove a lower number. The second thing——

Mr. BURGESS. So then let me just interrupt you for a second, then that money left on the table could not be accessed? You didn't get another bite at it?

Mr. MULLER. No.

Mr. BURGESS. Does anyone know what has happened with those dollars since then? When the time limit expired did those dollars come back to the Federal Treasury or maybe that is something we need to find out, Mr. Chairman. I don't know what happened to those dollars.

Mr. STUPAK. That is a good point. That is a good point. What happened to them? If it was designated for you and you couldn't use it because of the formula based upon past old information if that money has been designated why can't we get it back?

Mr. BURGESS. And let me just, reclaiming my time, let me just ask have we done anything legislatively to alleviate some of the burden as far as the repayment of this? Has anything happened to your understanding in either the House or Senate where they made a legislative fix that these loans would convert to perhaps grants where repayment would not be requested?

Mr. MULLER. Well, it was approved in the Iraq war bill, part of the Iraq war bill, to have them forgiven. Again, we said that is wonderful. What we have found is that the process of forgiveness is going to take several years, and that is the problem.

Mr. BURGESS. Again, reclaiming my time, this was in the supplemental that we just passed in June, is that correct?

Mr. MULLER. In June, that is correct. It was in the bill. It was forgiven. We said wonderful. I believe the rules came out like end of July or something and we found that it would take several years to do it. I am not going to get into how they decided this but it is a legislative way of doing it.

Mr. BURGESS. Mr. Chairman, I know we are not a legislative committee but maybe we could put our staff to work on this if there is language that we can write that would make this money available and make those loan forgivenesses accelerated so that you guys aren't in hot water with the New York bond holders and can continue——

Mr. STUPAK. That was not the intent of Congress, that is for sure. Maybe HHS wrote the rules that way but that is not——

Mr. BURGESS. We actually wrote part of the rules that way.

Dr. QUINLAN. Can I make a point?

Mr. BURGESS. Please. I wish you would.

Dr. QUINLAN. Not all institutions are eligible because we are not governmental agencies.

Mr. BURGESS. And that is a very good point. Had these been handled as grants rather than loans perhaps Ochsner would have had the availability of some of those funds. And again, Mr. Chairman, I would just suggest that if we are looking for legislative fixes that may be something that we ought to investigate.

Dr. Peters, I do need to ask you, and I thank you for outlining the five issues, the target issues, that you brought to our attention. And based on your understanding of what is available, what do you see—I know my time is brief. Maybe the chairman will indulge me a similar amount of time that he had. What do you see as the fixes that are amenable that could be done from the Federal agency, from HHS, from the standpoint of State government, and the standpoint of congressional activity? Are there things that come to mind that leap off the page looking at those five targeted areas where if HHS would do this, if the State would do that, and if Congress would do the other things that your lives would be improved.

Dr. PETERS. At the State level, I think that what we would really like to see is a consistent, more than a 1-year response of how we could plan from compensated care dollars. Our State goes through a legislative process every year. It is always unclear how that will settle out so we are really interested in consistency, again, over the next 2 to 3 years to let us effectively plan.

Mr. BURGESS. Let me just interrupt you for a second. Have you found a sympathetic ear at your State legislature for that concept?

Dr. PETERS. I think that the State legislature has been very engaged in this process. I think they have wanted to come up with some solutions.

Mr. BURGESS. I hope they have.

Dr. PETERS. I think one of the challenges that remains is, how much should be directed to New Orleans as it relates to the other part of the State, so that is a recurrent issue both at a State and Federal level of everyone has problems these days and health care is not wonderful anywhere, so we face that challenge. At the Federal level——

Mr. BURGESS. Let me just interrupt you there for a second. I just have to ask this, and it may be inappropriate and I apologize in advance if it is, but other States were affected by this disaster. Are they having the same types of difficulties vis-a-vis their State legislatures with the distributional issues that have been brought to our attention this morning? Is it unique to where you are living or is it in fact all of the States that have been so affected have found the same problems?

Mr. MELANCON. If I could, if you would yield for a second, I think I can explain something. What happened in Orleans Parish is that the entire——

Mr. BURGESS. We have experts that we asked—you and I can talk any time.

Mr. MELANCON. The difference of what happened is on the budgetary problems the State constitutional amendment says they have to balance the budget every year, and they don't do 2 years of projections. That is——

Mr. BURGESS. You and I can have that discussion.

Mr. MELANCON. I yield back. Thank you.

Mr. BURGESS. Is there anyone on the panel who has a feeling about that? Is there something that is unique to Louisiana or is in fact Alabama and Mississippi having similar sort of difficulties?

Mr. LAGARDE. Wearing my HCA hat, we operate hospitals in Lafayette, Louisiana and also Gulfport, Mississippi. Neither of their total of four hospitals that we operate in these other communities, as well as we operate a hospital on the north shore of—none of our hospitals anywhere else other than in Orleans and Jefferson Parish do we have this fact pattern. As far as the metrics, the normal operating metrics of hospitals and hospital expense management issues, revenue issues, totally out of whack, and Orleans and Jefferson Parish in relation to anywhere else that we do business.

Mr. BURGESS. OK. I think, Mr. Chairman, that is something at some point this committee does need to follow up on. Let me go back to Mr. Peters, and then again from the standpoint of the Federal agency and from legislative action, are there fixes you see that aren't over the horizon that are within your grasp or within the capabilities of the Federal agency or this committee?

Dr. PETERS. I think a very rapid meeting of the minds that says, OK, we have this gap, how can we best accomplish fixing that, or something that comes close to that that is acceptable. We in this conversation talked about cost-based reimbursement, critical access designation, adjustment of the Medicare wage index. I think the numbers need to be plugged in and think about how can we come up with the solution and then create whether it is waivers or legislative changes to make that be accomplished and not have the perspective of we can't do this because of this rule or that rule.

As you have heard, we all have some different structures and different needs, and so I think thoughtful analysis of all of those potential solutions so that we don't create a solution that partially solves the problem or helps two out of the five of us which then doesn't really solve the New Orleans situation.

Mr. BURGESS. Very good. And, Mr. Chairman, again, I would ask that perhaps that is something we can task our committee with trying to draft whatever language would be necessary. And then finally, Dr. Peck, in the time I don't have remaining, let me just ask you because it did come up earlier about preparedness for the current hurricane season that is ahead of us, how do you feel—obviously a hurricane planted square at New Orleans again would be—strike the community with an additional disaster do you have a feeling as to the level of preparedness?

Dr. PECK. I certainly have concern. Something you could do is certainly look at the Stafford Act again. I think the Stafford Act needs to be reexamined at and potentially have some rewriting of the Stafford Act so it can help for-profit health care providers for the immediate recovery of a situation. Should it happen next weekend, private practitioners could be of benefit from that, and I think

you would go a long way to help that region and that part of America.

Mr. BURGESS. Very good. I just want to thank everyone for being here and for your indulgence today. We have had things happen on and off the floor that have kept us away, and I apologize for the time I wasn't here. It wasn't because your issue is not important to us, and some of the most venerable names in American medicine, Charity Hospital, Ochsner Clinic, these are words I heard all my life growing up because my dad was a physician too. These are cherished medical institutions in our country and we are really privileged on this committee, Mr. Chairman, to be able to be participating in saving these institutions. With that, I will yield back.

Mr. STUPAK. I thank the gentleman.

Mr. MELANCON. If I may, Dr. Peck, in your testimony you mentioned the monies from the DRA are going to bolster the greater New Orleans Health Service Corps in the fact that the bulk of the money will be going to attract or recruit new providers.

Dr. PECK. Yes, sir. Of the $50 million that is going through, 70 percent of that is going to be for the recruitment of physicians to the area versus 30 percent that is going to be for retaining of physicians.

Mr. MELANCON. So very little that is going to help you or other physicians like yourself?

Dr. PECK. That is correct.

Mr. MELANCON. Another question, the monies that they are talking about to attract physicians back in, will that also be available to the physicians that have hung in there if they are not back up to that level of income?

Dr. PECK. Talking to the pediatrician in the city of New Orleans it is available but the restrictions and the confusion about the applications and all the restrictions within—three big practices that I know in pediatrics, and one of those had about a 99 percent Medicaid practice. The other one had a dual practice in Metairie and in New Orleans. It was not worth the effort, the issue or the detail, so of all the private practitioners that I know of in my region 1 of them ended up applying for it and receiving that care. It is certainly available for those that come out and if you did receive it you were pretty much insured—unless you really had a substantial practice—of insuring yourself at $33,000 annual salary.

Dr. MILLER. I do want to say that it is a good thing. I think it can be simplified and it can be made better but certainly this $50 million that is available, and it came in one pot of $15 million that was very heavily for primary care and recruitment, and then the second pot which more recently came to the State of $35 million, which does have more for retention and also more for specialties and allows more use by the teaching institutions is a good thing. It can be improved in the way that physicians who are currently in practice and have needs can access it, but I think it is a positive that came out of previous hearings.

Ms. ROWLAND. Mr. Chairman, if I could interject. I think one of the ways to really help the existing physicians who are there is through some of these changes like we talked about with the DSH allocation to allow that to go to non-institutional providers and to help physicians because currently there is no way to really provide

for the uncompensated care cost that they may be incurring. I think you need a dual strategy, one that helps recruit people back but also helps to provide a reasonable income to those who are there practicing and seeking to re-establish——

Mr. STUPAK. Well, Dr. Peck or Dr. Miller, have you talked about the DSH payment concept to help you out? Have you looked at that if all if we can get a waiver here?

Ms. ROWLAND. I think the State has already asked for such a waiver but it hasn't been granted.

Mr. STUPAK. Was it turned down or granted? The State asked for it, did they not?

Ms. ROWLAND. They just asked for it but——

Mr. STUPAK. Or HHS.

Ms. ROWLAND. But it has not been granted.

Dr. PECK. I certainly don't know the immediate answer but I certainly can get that for you from one of the——

Mr. STUPAK. OK. I think it was turned down anyway or not ruled upon. That is one I think we should take a look at for those providers who tried to hang in there. Anyone else? Mr. Burgess.

Mr. BURGESS. To clarify, are you talking about the disproportionate share funds that were allocated for the fall of the last quarter of 2005 or have there been ongoing allocations for DSH funds for hospitals that are no longer in existence?

Mr. STUPAK. I am talking about 2005.

Mr. BURGESS. Then going forward, and I don't know if anyone can answer this, what has happened to that stream of disproportionate share funds for say all of the quarters of 2006? If Charity was not able to see patients then what has happened to those funds?

Dr. HOLLIER. Dr. Cerise could probably answer that but I believe that some of those funds were moved to where the patients were now being cared for in the other Hospitals. Lafayette got a large influx of patients. Baton Rouge got another large number of patients; so some of those budgetary funds were moved there where the patients were cared for.

Mr. BURGESS. Were any of those funds moved to East Jefferson, West Jefferson, Touro, Ochsner?

Dr. HOLLIER. I think that is the problem we are talking about. They haven't been able to have that.

Mr. MELANCON. Mr. Chairman.

Mr. STUPAK. Mr. Melancon.

Mr. MELANCON. If I could, and I think we have a good pretty good handle on the issues that are here in front of us, and I would like to request, if I could, when you think about it we got what, a five-person staff for this subcommittee, the Department has about 5,000 people, and they can't seem to solve the problems, if we could ask for a meeting with the Secretary and Mr. Madison and sit down and go through the list and find out what their intentions are. We have talked about just trying to move this forward. We have tried to do it nicely. I had the same problems with FEMA. You bring it to public attention. They get a little bit of responsiveness and then all of a sudden they go back to wherever they came from and disappear, so, Mr. Chairman, I would make that request if I could.

Mr. STUPAK. We tried that a few times, but we will continue. Any other questions?

Mr. BURGESS. I will just say obviously the flooding we have had in Texas this spring nowhere near on the order of magnitude of what you have endured but I will just have to say the Federal agencies I have found were responsive when those requests were made, and I am still having a hard time understanding what is going on that makes this so difficult to solve. I know it was a big storm. I know it is going to be difficult to recover from it, but it just seems like we have more than our share of difficulty dealing with this. And, again, I just frankly don't understand what the problem is.

Dr. QUINLAN. It is a simple issue of scale. This scale is of such magnitude it simply cannot be dealt with by conventional means. It is that simple. The tools that are designed to address these kind of problems were designed to address exactly what you experienced in Texas and absolutely has nothing to do with what we have experienced in New Orleans.

Mr. BURGESS. But still after 2 years time and $100 billion from the Federal Government, it seems like we should be doing a better job. They had the same—and again I don't know really—I haven't traveled to Mississippi. I don't know the difficulties that they have encountered or where they are in their recovery but we don't have Mississippi at the table and they had the same storm. And I realize that New Orleans had three crises happen one right on top of the other with the wind, the water, and then the levees breaking. But still it seems like we should be in a better place now with all of the effort that has been extended. And I don't understand why it is so difficult to overcome that inertia and make some things happen.

Mr. MELANCON. If I could——

Mr. BURGESS. And again we have plenty of time to talk——

Mr. MELANCON. And I would like to but I wanted to invite you to come on a CODEL on the 12th through the 14th to New Orleans where we will sit down with all of the aspects of the community including health care, and you will get an opportunity to go to Gulfport and Biloxi and get a first-hand view and an opportunity to visit with those folks.

Mr. BURGESS. And I will tell the gentleman I wish he had disclosed that to me earlier. Obviously, my August schedule is pretty much set as is yours. It would be very difficult for me to get out of obligations, but I do think this committee ought to have a follow-up hearing on site, a field hearing like we did in January 2006. It is high time we did that, and maybe we can include some of the other sites as well.

Mr. MELANCON. If the gentleman would yield back, I agree, and of course getting a CODEL authorized when it happens, it happens, and then you move as quickly as you can and it happened at the end of last week so now we are trying to get people to go. And we understand that, and I understand your schedule and everyone else's, but it is difficult to explain without actually—and you can see it on TV, you can hear about it when people talk about it including you and I having conversations about it, but until you

physically ride the mile after mile after mile after mile of devastation and vacancy, and it is——

Mr. BURGESS. Well, if the gentleman will yield, I have—I haven't spent a lot of time but I have made two trips to New Orleans, one with this committee and one as a guest to the private hospitals who invited me down there in October, and very kind to fly me in a helicopter around the Plaquemines Parish and saw the mile after mile after mile and saw the car dealerships that were inundated. And, yes, it is devastation on a scale that I have never seen before. But, again, I don't understand why we can't move this process forward. If it is inertia at the Federal level, let us get past it. If it is inertia at the State level, let us get past it. Again, I get criticized at home for the amount of money that the Congress has spent and yet it doesn't feel like we have done a darn thing. That leads to an internal conflict that I find very, very difficult to reconcile. We kept these gentlemen long enough, and I am going to yield back.

Mr. STUPAK. I think today and especially this last panel has pointed out a number of areas we can work on, and I think it is the Federal rules, regulations, and laws that are passed are not designed for a hurricane or disaster like this, and we have to find a way to get waivers and other creative ways to help these folks out in a bipartisan manner. We have asked for the Secretary to come. We have asked for Ms. Madison to come who seems to be holding the keys to many of these programs. They have refused us. So maybe we have one last weapon in our arsenal here we can use and maybe we ought to ask the Secretary once more to come and set a time and date at his convenience, and if he can't then we subpoena him or something. We have to get this thing rolling. I think we are all frustrated. Their financial ruin is sitting right there, and we have to move this thing along. If you have some good suggestions, we will work on it. Stay in touch. Chris Knauer and his staff will be working on this for the Energy and Commerce Committee, and both sides of the aisle have been great and they have been down there a couple of times and spoke with most of you. We will continue to work this. This is our third hearing. I am looking forward to a fourth hearing in New Orleans. I hope we have good news. It seems like we get a little impetus every time we have one of these hearing. Things start moving and then after about a month or two it falls apart again.

And I am not casting any shadows at anyone at this table. We are here in Washington. I find it ironic that we have this hearing today. We asked the Secretary to be here. He couldn't be here, 600 feet away, but yet he is down in New Orleans. It sounds like the Federal Government just can't get coordinated, can we? But I will dismiss this panel, and thank you again for all that you do, and thanks for services you do for the people in New Orleans and this country. That concludes our questioning. I want to thank all of the witnesses for coming today and for their testimony. I ask unanimous consent that the hearing record will remain open for 30 days for additional questions for the record. Without objection, the record will remain open. I ask unanimous consent that the contents of our document binder be entered into the record. Without objection, the documents will be entered in the record. This concludes

our hearing. Without objection this meeting of the subcommittee is adjourned.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 1 2007

The Honorable Bart Stupak
The Honorable Edward Whitfield
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

Dear Chairman Stupak and Ranking Member Whitfield:

I appreciate your interest in the efforts the Department of Health and Human Services has made in response to Hurricanes Katrina and Rita. Specifically, I would like to take this opportunity to clarify the Department's position on rebuilding the health system in Louisiana and New Orleans. Further, I would like to provide you with a general outline of some work we still have ahead of us in the coming weeks and months.

As you know, I have been working extensively - including going to Louisiana eleven times in the year and a half since Hurricane Katrina hit - to encourage and assist local, regional, and state officials in developing a plan to rebuild the health care system that was devastated by the hurricanes that hit the Gulf Coast. During Acting CMS Administrator Leslie Norwalk's testimony before the Committee, it was noted that Louisiana, as one of the poorest states, provides health coverage through Medicaid and the State Children's Health Insurance Program to approximately 20% of the State's population while still ranking the highest in the nation for infant mortality rates, HIV/AIDS caseload and mortality due to diabetes. The destruction caused by the hurricanes worsened this circumstance by devastating the health care safety net system in New Orleans and contributed to increased physical and mental health problems. To address these significant problems, my goal has been to encourage the establishment of a health system that emphasizes expanding access for the uninsured, and particularly low-income people, to insurance coverage and high quality health care. This goal, which I shared with the Louisiana Healthcare Redesign Collaborative (the "Collaborative"), requires rethinking and reworking the flawed and inefficient system that was in place prior to the storm.

In October of last year, the Collaborative submitted a concept paper which served as the basis for subsequent discussions and interactions with the State and many stakeholders in Louisiana. I supported the reform concepts in their proposal. Following this submission, the Centers for Medicare and Medicaid Services (CMS) worked with the State to develop a financial model to facilitate the State's submission of a Medicaid demonstration application that accomplishes the goals of the Collaborative. The model used data provided by the State. To apply these reforms on a statewide basis, CMS made available its analysis - together with a financial modeling tool - that demonstrates how Louisiana could adopt the reforms laid out in the concept paper on a statewide basis. This tool is intended to be flexible, and can also be used to analyze local or regional proposals. CMS staff members also hold regular weekly calls with representatives from the State to provide assistance.

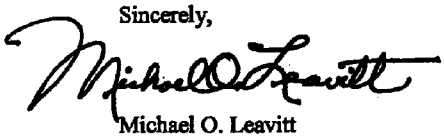
As Acting CMS Administrator Leslie Norwalk stated in response to your committee's questions last week, the Department of Health and Human Services is open to a demonstration application from the State of Louisiana that begins with plans for improving the health care system in the New Orleans region only. We support this Region I approach as an initial step that can more easily be achieved in a relatively short period of time. We would expect that such a submission would also indicate how it could be expanded on a state-wide basis in the future. Obviously, such a submission should address the special issues that could be presented by a "local or regional first" approach, such as variations in coverage in New Orleans and other parts of the State, differences in eligibility in New Orleans and the rest of the State, and the potential of fraudulent residency claims. Further, some concepts endorsed by the Collaborative could be implemented without a waiver or demonstration submission and the State has the option of submitting a State Plan Amendment immediately to provide additional coverage.

In addition to the Department's continued work with state and local officials on the development of a waiver submission, we continue our efforts to help the State to rebuild the health system in other ways in the short term. In February, we authorized use of $160 million of the remaining funds under the Deficit Reduction Act for state payments to hospitals and skilled nursing facilities in Louisiana, Mississippi and Alabama because those facilities face increases in wage rates not reflected in current Medicare payment methodologies. We also authorized $15 million of the remaining funds for state payments to recruit and retain professional healthcare workers in the Greater New Orleans area. We are in the process of reviewing how additional DRA fund distributions could be accomplished, and will keep the Committee informed as we proceed.

We are also reviewing Medicare Graduate Medical Education (GME) payments in light of the suggestion that more funding would assist in retaining sufficient numbers of interns and residents. Hospitals expressed concerns that existing regulations limiting Medicare GME affiliation agreements to hospitals in the same or a contiguous MSA, prohibited placement of residents who had been displaced by the hurricane. In response to those concerns CMS issued an Interim Final Notice (IFC) in April 2006 allowing hospitals affected by Hurricane Katrina to enter into an "emergency affiliation agreement" with hospitals located anywhere in the country, allowing the "host" hospitals to be paid GME payments for the affected residents for up to three years. The slots could return to the affected Louisiana hospital and those hospitals could be then be paid for GME based on those residents as soon as they were able to resume training. We continue to monitor whether the IFC has provided the intended relief to the affected hospitals.

I hope this provides additional insight into the response of the Department of Health and Human Services to the storms that have so dramatically affected the lives of so many in the Gulf Coast region, and I look forward to continuing to work with you and your colleagues to ensure the rebuilding of the health care system in New Orleans.

Sincerely,



Michael O. Leavitt

HHS News

U.S. Department of Health and Human Services www.hhs.gov/news

FOR IMMEDIATE RELEASE
Thursday, May 24, 2007

Contact: HHS Press Office
(202) 690-6343

HHS ANNOUNCES ADDITIONAL $195 MILLION IN GRANTS FOR GULF COAST REGION

To provide direct patient care and attract good health care workers, HHS Secretary Mike Leavitt today announced that additional grant funds have been made available to improve health care in areas affected by Hurricane Katrina. To date, HHS has provided the region with more than $2.5 billion in funding for social services, health care and efforts to rebuild the health care system in the Gulf Coast region.

Of the $195 million in grants, $100 million will be allocated to Louisiana for public and not-for-profit clinics that provide primary care to low-income and uninsured residents in the Greater New Orleans area. An additional $60 million will go to the states of Alabama, Louisiana and Mississippi to be directed to acute care hospitals, skilled nursing facilities, inpatient psychiatric facilities and community mental health centers. The remaining $35 million will go to Louisiana for further assisting the Greater New Orleans area in recruiting and retaining health care workers.

"The three states hit hardest by Katrina -- Alabama, Louisiana and Mississippi -- continue to face challenges in attracting health care workers and providing patient care. These grants will help alleviate the financial pressures faced by providers and allow the people of the Gulf Coast region broader access to care," Secretary Leavitt said. "This is emergency funding and these grants should be viewed as a bridge to a long-term solution. We continue to believe that Louisiana's best interests will be served if it submits a large-scale waiver request. For now, these grants address immediate needs."

In addition to the $195 million announced today, other awards this year have included $175 million in Deficit Reduction Act grants.

"I am pleased that Secretary Leavitt has responded to the region's pressing health care needs, including mental health challenges, with thoughtful, targeted, and effective federal support to local leaders and providers," said Donald E. Powell, federal coordinator for Gulf Coast Rebuilding. "This aid will not only address the immediate needs of patients, hospitals, and neighborhood caregivers, but will also advance the vision for a redesigned health system that offers greater access to high-quality preventive care for more citizens."

Secretary Leavitt has visited the Gulf Coast region regularly since Hurricane Katrina and most recently visited four clinics in Greater New Orleans on April 5.

- More -

"During my 13 visits to the region, I have seen health care providers doing all they can to provide people with care," Secretary Leavitt said. "I applaud their determination and good work. It's important that we support these neighborhood efforts in the short-term, so these organizations survive in the long-term."

As a result of those visits and based on input from providers, state health care officials and others, HHS is making $100 million available to Louisiana to assist not-for-profit clinics and public health entities that treat the area's neediest residents. The grants will be used by clinics to restore and expand access to outpatient primary care, including professionally delivered medical and mental health services, substance abuse treatment, oral health care, and optometric health care administered in a clinical setting. Of these monies, $4 million will be used to restore capability to the city of New Orleans Health Department to provide primary care in city neighborhoods that are not adequately served. Because of the unique impact on the low-income and uninsured populations of Greater New Orleans caused by the storm and its resulting floods, the Secretary is directing the resources to Jefferson, Orleans, St. Bernard and Plaquemines Parishes.

An additional $60 million will be divided among the three states to help certain providers that face financial pressures as a result of changing wage rates that have not yet been reflected or adjusted for in Medicare payment methodologies. Based on each eligible organization's share of total Medicare payments under a prospective payment system for inpatient care, the Centers for Medicare & Medicaid Services (CMS) will allocate funds in the following proportions and amounts: 44 percent, just over $26 million, for Louisiana; 39 percent, approximately $23 million for Mississippi; and 17 percent, $10.5 million for Alabama. Funding is available to care providers in counties/parishes designated by the Federal Emergency Management Agency to receive both individual and public assistance. As part of the grant process, the three states must submit applications to CMS.

In addition, the Secretary has made $35 million available for a supplemental grant for Louisiana to use for the Greater New Orleans area to help the region attract doctors and other health care providers. According to the Louisiana Health Care Redesign Collaborative, approximately 50 percent of the physicians who worked in the region before Katrina are no longer practicing there, leaving a shortage of doctors and other clinicians. The $35 million grant can be used to further recruit physicians, dentists, psychiatrists, registered nurses, clinical faculty, and licensed professional health care staff. Louisiana has flexibility in determining the type and scope of recruitment activities, but these efforts can include income guarantees, annual medical malpractice payment relief, loan repayments and incentive payments, such as relocation expenses and sign-on bonuses. In January, Louisiana received a $15 million grant for the same purpose.

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Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

The New York Times
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DIRECTED BY DANNY BOYLE

July 24, 2007

New Orleans Recovery Is Slowed by Closed Hospitals

By LESLIE EATON

NEW ORLEANS — At the tip of Bayou St. John in the Mid-City neighborhood here, the brown and white bulk of Lindy Boggs Medical Center looms behind a chain-link fence. Nineteen people died at the medical center after Hurricane Katrina, and now the hospital itself is dead, sold to developers who plan to replace it with a shopping mall.

On the surrounding streets — Bienville and Canal and Jefferson Davis — lies the wreckage of a once-bustling medical corridor. Doctors' offices sit empty behind five-foot-high water marks, and nearby clinics wait to be demolished. In back of one medical building, a gaping refrigerator still holds jars of mayonnaise and Mt. Olive Dill Relish.

Harder to see, but just as tangible, people here say, are the other ripple effects of the flood and the closed hospital: workers displaced, houses for sale and, of course, patients forced to seek health care many miles away. If they have returned to New Orleans at all, that is, given the grave wounds to the health care system.

"I've been telling people, don't bring your parents back if they are sick," said Dr. David A. Myers, an internist who lived and worked in Mid-City before the flood and has moved his home and practice to the suburbs.

Of all the factors blocking the economic revival of New Orleans, the shattered health care system may be the most important — and perhaps the most intractable.

Except for tourism and retailing, health care was the city's biggest private employer, and it paid much higher wages than hotels or stores. But there are now 16,800 fewer medical jobs than before the storm, down 27 percent, in part because nurses and other workers are in short supply.

Only one of the city's seven general hospitals is operating at its pre-hurricane level; two more are partially open, and four remain closed. The number of hospital beds in New Orleans has dropped by two-thirds. In the suburbs, half a dozen hospitals in adjacent Jefferson Parish are open — but are packed.

Fixing the city's health care system "is critical both for the short and the long term," said Andy Kopplin, executive director of the Louisiana Recovery Authority. "Short-term, having confidence that the health care residents need will be available and accessible is vital for folks who are returning," Mr. Kopplin said. "Long-term, it's important for employers — and health care is a huge business in New Orleans."

Studies suggest that hundreds of doctors never returned. And some of those who did, especially specialists and young physicians, are leaving, said Dr. Ricardo Febry, president of the Orleans Parish Medical Society, which has lost more than 200 of its 650 members. The exodus has "been a steady trickle," Dr. Febry said.

The city's mortality rate appears to have risen sharply in 2006, although state and local officials disagree about the level and persistence of the increase.

With the stress of life in the flood-ravaged city, the limited health care and insurance, the lingering mold and the discomfort of living in trailers, doctors report that the patients they see are often far sicker than those they treated before the storm. And even residents with health insurance can have a difficult time finding someone to treat them.

Government officials and civic leaders are floating plans for the future of the city's medical system, for a state-of-the-art hospital, for a cutting-edge system to cover the uninsured, even for a "bio-innovation center" that would be an engine for economic growth. The question is what will happen in the meantime, which is likely to be many years long.

"We have to find a way to survive to that point, to provide care, or our city will collapse," said John J. Finn, president of the Metropolitan Hospital Council of New Orleans.

Waiting for Care

The problems with health care hit hardest on the poor and the newly uninsured, but they also affect doctors and patients, politicians and entrepreneurs, the displaced and the returned — and everyone at any level who has the misfortune to turn up in a jam-packed emergency room.

Consider the case of Bernadine R. Fields, 50, who learned firsthand how far people have to go for major medical care. A supervisor of city 911 dispatchers, Ms. Fields was among the many laid off after the storm.

The money she had saved for her retirement went for repairs to her house in New Orleans East. By last July, she could no longer afford the $367 a month it cost to continue her health insurance, or all the medicines she needed to treat her high blood pressure, or the $250 it would cost to see a doctor.

So she kept ending up in one of the few open emergency rooms, waiting for hours. After one of these episodes in April, she was told she needed transfusions to treat anemia — but there was not a bed available in New Orleans for an uninsured patient.

Ms. Fields finally got the treatment she needed — but only after an ambulance took her to the state-run hospital in Baton Rouge, 80 miles from her home and family. She stayed there four days.

"I devoted 15 years of my life to serving the public," she said, "and when I need to be served, there is no one to count on."

Ms. Fields's neighborhood in the eastern section of the city, like other stretches of town, cannot recover unless medical care becomes available there, officials say, and neither can large sections of the economy. Doctors and hospitals, though, are reluctant to return unless the population does.

"I'm just hoping and praying nobody dies," said Frederick C. Young Jr., president of the Methodist Health System Foundation, which is working with the city to try to reopen a hospital there.

The sharp contraction in the health care industry has economic effects, too, for coffee shops and florists and medical-supply companies. Marshall F. Gerson, whose family has owned the Ellgee Uniform Shop downtown for almost 70 years, said sales of scrubs and other medical uniforms had fallen to about half their pre-storm level.

"At this time of day when times were good, it was bustle-bustle here," said Mr. Gerson, 63, standing in his shop late one recent afternoon. Now, "the foot traffic is almost nil."

By working harder and selling more industrial and restaurant uniforms, Mr. Gerson has kept his business going but, he said, "I'm not a happy person when I get home."

An Era's End

The future of Mr. Gerson's shop — and in many ways the future of health care in New Orleans — is bound up in the thorny question of what if anything will replace the hospital known as Big Charity.

Since it opened in 1939, Charity Hospital's imposing building downtown has provided basically all the medical care — emergency, acute and basic — for the city's poor, and served as a training ground for generations of doctors.

Despite some community protests, Louisiana State University, which ran the hospital, closed it permanently after the storm, saying it was too damaged by basement flooding. The state plans to replace it with a $1.2 billion complex that officials believe will attract insured patients as well as the poor, will also care for veterans and will serve as an economic catalyst for the city. But the hospital's future is now the subject of a debate about the best use of federal health care dollars, even after the state agreed to pay $300 million to get the project off the ground.

The federal government would prefer that the state build a small hospital and use its federal dollars to buy private insurance for the poor. Dr. Frederick P. Cerise, the secretary of Louisiana's Department of Health and Hospitals, said that plan would help less than half of the uninsured.

On a positive note, the city's trauma center, which treats gunshot wounds and other serious emergencies, reopened in February at University Hospital downtown, which like Charity is part of the Medical Center of Louisiana at New Orleans. But the number of beds at University remains limited, and the building is so outdated that it will eventually have to be replaced, said Dr. Cathi Fontenot, the medical director.

In the meantime, the sick have to go somewhere. Often, that somewhere is Ochsner Medical Center, a huge private hospital complex in the western suburb of Metairie that looks like a mall, with a computerized grand piano that entertains patrons in a sunny atrium.

Before Hurricane Katrina, patients waited just 20 minutes to be seen, said Dr. Joseph Guarisco, chairman of emergency services at Ochsner, and surveys found that 99 percent were satisfied with their care.

After the storm, the number of people coming to the emergency room jumped, on some days reaching nearly twice the pre-hurricane volume. The number of psychiatric patients soared.

The uninsured, who had made up a small percentage of emergency patients at Ochsner, began accounting for more than a quarter of emergency room patients. Waiting times routinely topped an hour. The patient satisfaction rate fell to 34 percent.

This year, Dr. Guarisco reorganized the emergency room and cut the waiting time back to about 20 minutes.

But the other problems remain. "The hospital, post-Katrina, struggled financially," Dr. Guarisco said, "and it still struggles to this day."

Bad Time for a Fracture

No one thinks that emergency rooms are a good way to provide basic everyday health care, but government efforts to attract doctors and to open more neighborhood clinics have gotten off to a slow start.

Volunteers and nonprofit groups are trying to fill the breach, treating thousands of patients a month in more than a dozen low-cost clinics in the city. In many ways, the clinics have been a success for their patients, as they are elsewhere in the country, but they represent just a drop in the city's ocean of medical need, health officials say.

Some were open before the storm but have expanded; others are new, like the Common Ground Health Clinic, which provides free medical care four days a week in an old corner store in the Algiers neighborhood, across the Mississippi from the French Quarter. People wait outside in the heat for the clinic to open, and it is always jammed.

One recent Tuesday, the patients included a city employee with a neck problem, a college student with uncontrolled menstrual bleeding, a bartender with high blood pressure and glaucoma, and Nellie M. Lindsey, 54, a scrap hauler who was suffering from what she called "cancer stones."

Before the storm, Ms. Lindsey said, she would have sought treatment at Charity, but she is so happy with the Common Ground clinic — despite the long waits — that she took her adult sons and daughter there for checkups.

Most of the people who come to the clinic hold at least one job, and many are working two, said Anne Mulle, a family nurse practitioner who came from California after the storm to help and ended up staying.

In addition to longstanding problems like hypertension, diabetes and heart disease, most patients have anxiety, depression and stress, which are even harder to treat, the clinic staff says.

"We can take the health piece off your worry list," said Dr. Ravi Vadlamudi, a Tulane University doctor who serves as the clinic's volunteer medical director. "But we can't get you a better job market or housing market; we can't do anything about the schools; we can't do much with police problems. I can't do anything about most of what bothers you."

For patients who need more complicated care, including mammograms, stress tests and vision treatments, the clinic can make referrals to St. Thomas Community Health Center, which Dr. Donald T. Erwin founded in 1987. The fact that clinics are now collaborating — and recently qualified for federal financing — is a new and

welcome development in what can seem like a bleak medical landscape, Dr. Erwin said.

Another change he has seen, he said, is that even people with insurance are having a hard time finding doctors, getting tests and continuing prescriptions, so are turning up at his clinic, where they now make up about a quarter of the patients.

"Before the storm?" Dr. Erwin continued, and held a thumb and forefinger together to make a zero.

Counseling and mental health treatment are notoriously hard to find in New Orleans these days, and doctors say this is an especially bad time to break a leg, given the shortage of orthopedists.

Even patients with the means to pay and doctors who have returned can face long waits for treatment. Dr. Myers, the internist who used to practice in Mid-City, said recently that a new patient would probably have to wait two months for an appointment, though he would find a way to get existing patients in sooner. He estimates that 80 percent of those patients have returned.

Dr. Myers said he had been trying for months to lure another doctor to the area to join his practice.

"This is a great opportunity for people who have courage," he said.

So far, he has found no takers.

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ONE HUNDRED TENTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

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September 4, 2007

Ms. Elizabeth Richter
Acting Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Ms. Richter:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, August 1, 2007, at the hearing entitled "Post Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns – Part II." We appreciate the time and effort you gave as a witness before the Subcommittee.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from certain Members of the Subcommittee. In preparing your answers to these questions, please address your response to the Member who has submitted the questions and include the text of the Member's question along with your response. Please begin the responses to each Member on a new page. The responses should be returned to the Committee as detailed below.

In order to facilitate the printing of the hearing record, your responses to these questions should be received no later than the close of business **Monday, September 17, 2007**. Your written responses should be delivered to **316 Ford House Office Building** and faxed to **202-225-5288** to the attention of Kyle Chapman, Legislative Clerk. An electronic version of your response should also be sent by e-mail to Mr. Kyle Chapman at **kyle.chapman@mail.house.gov** in a single Word formatted document.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Kyle Chapman at (202) 226-2424.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Bart Stupak, Chairman
Subcommittee on Oversight and Investigations

The Honorable Ed Whitfield, Ranking Member
Subcommittee on Oversight and Investigations

The Honorable Gene Green, Member
Subcommittee on Oversight and Investigation

Additional Written Questions Submitted
After the 8/1/07 NOLA Hearing
Before the Energy & Commerce Subcommittee on Oversight & Investigations

The Honorable Bart Stupak

1. At the Subcommittee's August 1, 2007 hearing, representatives from West Jefferson Medical Center, East Jefferson General Hospital, Touro Infirmary, Ochsner Health Systems, and Tulane University Hospital testified that due to extraordinary Katrina-related increases in operating costs, they expect combined operating losses of $135 million in 2007 and anticipate their collective losses may grow to $405 million by 2009.

> These 5 hospitals report that they provide approximately 95 percent of hospital services in Region 1 of Louisiana and that they may not be able to continue operating at current levels. Their potential solutions included: ***(a) applying wage index values for Medicare reimbursement rates that approximate actual, real-time labor costs in the region; (b) increased funding to meet increased non-labor costs; (c) suspension of the 3-year rolling average for hospitals hosting displaced medical residents and interns; (d) assistance with other workforce issues such as recruitment and retention of nurses and physicians; and, (e) reliable and adequate funding for uncompensated care until a replacement public hospital is built***

What is the Department of Health and Human Service's (HHS) plan to address these issues and requests for relief? What is the timeframe for HHS' plan?

Answer to 1(a): Since Hurricane Katrina, HHS and CMS have taken great strides to help address the needs of general acute care hospitals, inpatient psychiatric facilities (IPFs), skilled nursing facilities (SNFs) and community mental health centers (CMHCs) that have faced considerable financial pressures due to changing wage rates among employers competing for health care workers. These wage costs are not yet reflected in Medicare's payment methodologies because the national uniform process to update the wage index precludes Medicare's payment system from being able to immediately recognize wage costs currently being incurred in communities affected by Hurricane Katrina. To ensure the accuracy of wage index calculations, wage data must undergo a rigorous collection, review and correction process before being used to calculate the wage index. This process precludes Medicare's payment system from being able to immediately recognize wage costs currently being incurred.

Consequently, to be able to respond to the critical challenges faced by the Gulf Coast States in hiring and retaining staff, the Secretary used his authority under Section 6201 of the Deficit Reduction Act (DRA) to make funding available towards this end. In February 2007 HHS awarded $160 million in Provider Stabilization Grants to Louisiana, Mississippi and Alabama for payments to hospitals and skilled nursing facilities facing financial pressure because of changing wage rates not reflected in Medicare payment methodologies. Of the $160 million, 45 percent, or roughly $71 million, went to Louisiana.

The Secretary subsequently authorized an additional $60 million in supplementary Provider Stabilization Grants, of which 44 percent was allocated to Louisiana. Between the two provider stabilization grants, Louisiana providers received approximately $98 million. The original $71 million was awarded on February 12, 2007. The State of Louisiana issued checks to providers in one lump sum amount on April 18 and 19 – roughly 2 months (60 days) after the announcement of the award. The supplementary $26 million grant was awarded on June 18, 2007. The State of Louisiana issued checks to providers on June 25 and 26 – approximately one week after the announcement of the award.

Notwithstanding these grant awards, HHS heard testimony as late as August 1 that the five major private hospitals in New Orleans were still incurring significant financial losses and they expected this to continue.

CMS has requested the Office of the Inspector General (OIG) to conduct a cost allocation audit sufficiently broad in scope to allow it to analyze and trend cost report data for all New Orleans hospitals for 2004 through 2006. This analysis will allow the OIG to ascertain an approximate estimate for the costs incurred, and their relative distribution across the payors involved. The study has just recently gotten underway and the OIG believes that they may have some initial findings to report as early as March 2008. With this information, all of the parties involved can determine the extent to which CMS can further assist West Jefferson Medical Center, East Jefferson General Hospital, Touro Infirmary, Ochsner Health Systems, Tulane University Hospital, and any other impacted hospitals on this wage payment issue.

Answer to 1(b): HHS has limited authority, other than through the DRA section 6201(a)(4) authority that is the basis for the Provider Stabilization Grants it has been awarding, to assist hospitals that have incurred non-labor related operating costs as a result of Hurricane Katrina and its subsequent floods. Once the Office of the Inspector General (OIG) has conducted its audit as described in Question 1(A) that includes analysis and trending of cost report data for all New Orleans hospitals for 2004 through 2006, including a breakout of how all these costs compare across payors, we hope to be able to determine the actual non-labor operating costs associated with the hurricane. With this information, all of the parties involved can then determine the extent to which CMS can further assist West Jefferson Medical Center, East Jefferson General Hospital, Touro Infirmary, Ochsner Health Systems, Tulane University Hospital, and any other impacted hospitals on this non-labor cost payment issue.

Answer to 1(c): Immediately following the hurricanes, CMS provided for a time-limited exception to the 3-year rolling average for host hospitals that accepted displaced residents for training. We do not believe CMS has further flexibility within the terms of the current statute to either suspend or eliminate the GME 3-year rolling average requirement for hospitals in the greater New Orleans region.

However, CMS has held numerous discussions with different stakeholders from the hospital and medical school community on the possibility of conducting a Medicare GME demonstration. As a result of there having been little agreement from the relevant Louisiana parties on what the specifics of such a demonstration might entail, Dr. Mark Peters, CEO East Jefferson General Hospital and former LA-DHH Secretary, Dr. Fred Cerise, convened a meeting with the five hospitals and the medical schools affected by the GME issue. The purpose of the meeting was to put together a unified position on what they would like to accomplish with a GME demonstration. To date, we have not received a proposal or any other information on the specifics of a request for granting a demonstration from the LA parties, though we have requested this information several times. CMS continues to stand prepared to meet with, and assist, this group as soon as they are ready to move forward.

Answer to 1(d): HHS has played a very active role in helping the State of Louisiana help the communities of New Orleans that were most impacted by Katrina (LA-DHH Region I) to address professional healthcare workforce retention and recruitment needs. In response to the region's shortages, HHS provided Louisiana with $50 million in DRA workforce supply grant funds, (1st award of $15 M on March 1, and a supplementary award of $35 M on June 18) to encourage and enhance the recruitment and retention of physicians (including pediatricians, internists, family practitioners, general practitioners, obstetricians/gynecologists and psychiatrists), dentists, pharmacists, registered nurses, nurse practitioners, physicians assistants, clinical faculty for medical, dental, nursing and other post-secondary health professional training programs, and other licensed professional health care staff. As of July 31, the State reported that HHS' grant made incentive payments to 301 physicians and other licensed healthcare professionals in exchange for their commitment to practice in New Orleans for the next 3 years.

During the August 1 Energy and Commerce Hearing, HHS heard testimony from former LA-DHH Secretary, Dr. Fred Cerise, that the need for immediate health practitioner support and assistance was still urgent. In response, on Friday, August 17, 2007, Sonia Madison organized a meeting between former Acting Surgeon General Rear Admiral Moritsugu and Drs. Fred Cerise and Kevin Stephens, to pursue the feasibility of deploying Commissioned Corps Officers to Greater New Orleans to give immediate relief for the provider shortage problem in Region 1, particularly in the area of mental health. All parties agreed that Drs. Cerise and Stephens would quantify more specifically their short- and long-term needs and the amount of financial assistance that Louisiana could supply. On September 5, Dr. David Rutstein, Director Office of Force Readiness and Deployment in the Surgeon's General office, received a draft deployment request from Louisiana to supply 157 Commissioned Corps officers with expertise in providing behavioral health services over a period of 18 months and for HHS and LA to share the estimated costs, namely LA would pay $15.7 M and HHS would pay $7.85M. HHS does not currently have enough active duty officers with the skills identified as necessary to fulfill LA's request. HHS and the State have met by conference call several times to further analyze local need in relation to available resources and are considering various options for feasibility.

Answer to 1(e): CMS provides to Louisiana over a billion dollars annually in Medicaid Disproportionate Share Hospital (DSH) funding for this purpose. Nothing has changed in this regard as a result of the hurricane. Under Federal law it is up to the State, not CMS, to determine which hospitals will be funded using the DSH funds.

Section 1923 of the Social Security Act spells out the two formulas that states must use to determine which hospitals *at a minimum* will receive payments under the DSH program. Currently, the State of Louisiana has designated the State-operated 'Charity' or Louisiana State University (LSU) hospital system to be the recipient of the vast majority of its DSH funding so that it can subsidize the cost of inpatient hospital and associated outpatient care to the uninsured, as well as through rural hospitals.

When Charity hospital had to close its doors during and following Hurricane Katrina, several of the private hospitals were able to keep their doors open to continue to provide care despite the adverse conditions and no promise of payment. Since the hurricane, these same hospitals have shouldered the task of providing the care that Charity Hospital would have provided had it not been destroyed. These hospitals have received a share of Louisiana Medicaid DSH funding that would otherwise have gone to Charity hospital.

The Medicaid program is a joint Federal-State program under which states have considerable flexibility to develop their Medicaid payment systems, including DSH payments. Under Federal law, states determine methodologies to distribute DSH payments to qualifying hospitals through their Medicaid State Plan. States may make DSH payments up to the total uncompensated care costs incurred by the hospitals for providing inpatient and outpatient hospital services to Medicaid and uninsured individuals (i.e., the hospital-specific DSH limit). Therefore, within the individual hospital-specific limitation and DSH qualifying criteria, the State has the discretion to allocate the available DSH funding among qualifying hospitals. The Federal government monitors the administration of these payment systems but does not have authority to determine them.

2. Will HHS approve the use of Medicaid disproportionate share funds for physician reimbursement in Region 1?

Answer: Although HHS has made considerable strides in addressing the continued health system recovery problems in the greater New Orleans area, the Department is currently not in favor of approving the use of Medicaid disproportionate share funds for physician reimbursement in Region 1 because such funding is not consistent with the Medicaid statute.

Section 1923(g)(1)(A) of the Social Security Act imposes a cap or hospital-specific limit on the amount of DSH payments that may be made to a hospital during a fiscal year. This annual payment limit is equal to a hospital's uncompensated costs of furnishing hospital services to persons eligible for Medicaid or who have no source of third party coverage. The components of the hospital-specific DSH limits were further clarified in a 1994 all-State Medicaid Director letter to include the unreimbursed costs of allowable

inpatient and outpatient hospital services. A recent decision from the Departmental Appeals Board (Docket #A-06-05, Decision # 2084, May 18, 2007) upheld this definition of allowable hospital costs under the hospital specific limit. This decision upheld a disallowance taken against a State that included physician costs in their calculation of DSH eligible costs.

Generally, physician services are not recognized as inpatient or outpatient hospital services. They are usually separately billed and reimbursed under a fee schedule for physician professional services. Moreover, under Medicare cost and payment principles, physician services are recognized as professional costs, not hospital costs. Because of these statutory limitations, Louisiana may not use DSH funding to pay for uncompensated physician costs or other uncompensated costs that do not meet the definition of inpatient or outpatient uncompensated costs eligible under the hospital-specific DSH cost limit.

3. What is the response by HHS to the requests of Tulane University and Louisiana State University for waiver of the 3-year rolling average and stewardship of medical resident positions?

Answer: Under usual GME payment rules, the Medicare statute requires that a hospital is paid in the current year based on a 3-year "rolling average" count of residents; that is, the average of the number of residents in the current year and the two most recent prior years. As previously stated in response to question (1)(c), HHS has considered all requests to exempt displaced residents from the 3-year rolling average for hospitals in the greater New Orleans region and elsewhere. We provided for a time-limited exemption from the 3-year rolling average, thereby providing a financial incentive for hospitals to train the displaced residents. CMS does not believe it has further flexibility within the terms of the current statute to "waive" or otherwise provide for exemptions from the 3-year rolling average requirement for hospitals in the greater New Orleans region.

However, with that being said, CMS has held numerous discussions with different stakeholders from the hospital and medical school community on the possibility of conducting a GME demonstration. Previously, there had been little agreement on specifics from the Louisiana parties. Dr. Mark Peters, CEO East Jefferson General Hospital and Dr. Fred Cerise have agreed to convene a meeting with the five hospitals and the medical schools affected by the GME issue. The purpose of the meeting is to put together a unified position on what they would like to accomplish with a GME demonstration. CMS is prepared to meet with, and assist, this group as soon as they are ready.

4. What are Sonia Madison's official responsibilities with respect to health care in the Gulf Coast region?

Answer: Sonia Madison's role as Senior Advisor to Secretary Michael Leavitt is that of an "on-the-ground" representative of his commitment to provide assistance and support to healthcare recovery in Louisiana. In this role she communicates to local officials and

stakeholders the Secretary's vision for healthcare reform and makes sure the agreed upon principles of recovery are followed. She also communicates to the Secretary issues of relevance and importance from those groups. Ms. Madison has made over twenty-five trips to Louisiana fulfilling the Secretary's commitment to provide an on-site presence.

Early on her role was directed toward assisting the Louisiana Health Care Redesign Collaborative in the development of a blueprint for healthcare reform for the State of Louisiana. This included creating and managing a special team of nine Federal staff, four of whom were deployed to work full-time in Baton Rouge to assist the Collaborative in completing its task. She continues to work with State officials, stakeholder groups, professional associations, New Orleans city officials and the community at large to coordinate the technical assistance and support needed from HHS for healthcare recovery on both short-term and long-term issues. Ms. Madison maintains close contact with HHS leadership to facilitate resolution of critical issues related to healthcare in Louisiana.

5. What recommendations has Ms. Madison made to HHS with respect to recovery and stabilization of the healthcare delivery systems in Region 1? Please attach all written recommendations.

Answer: As described in Question 4, Ms. Madison has served as the Secretary's spokesperson to help facilitate healthcare reform and rebuilding in Louisiana of a character that can be evidence-based and quality-driven. To this end, HHS officials have made considerable efforts to ensure that healthcare reform activities occur under the provision of locally led and community–based stakeholders that support the use of ambulatory and community-based services rather than emergency rooms and institutionally-based care in delivering efficient and effective care for all residents. In addition, HHS officials have been supportive of efforts to make healthcare more prevention oriented, advance the quality and value of health care, cultivate promising, evidence-based patient care improvements, and reward quality outcomes.

During the past year and a half, behind the scenes, Ms. Madison and her staff have used these guiding principles to spearhead and coordinate Secretary Leavitt's direct Federal staff support, guidance, technical assistance and other resources for Gulf Coast health care rebuilding activities including: formation of the Louisiana Healthcare Redesign Collaborative and its development of the overarching concept proposal for comprehensive, system-wide health care reform via a Medicaid Waiver and Medicare Demonstration (October 2006); and, development, implementation and monitoring of the nine Federal grants totaling $370 million awarded by the Secretary under section 6201(a)(4) of the Deficit Reduction Act (DRA) to help jumpstart short and intermediate term healthcare infrastructure rebuilding. These grants were: $220 million in Provider Stabilization Grants for Alabama, Louisiana, and Mississippi (February 2007, and June 2007); $50 million in Professional Workforce Recruitment and Retention Grants for Louisiana to help assist New Orleans (March 2007, and June 2007); and $100 million for the Primary Care Access and Stabilization Grant to Louisiana to assist New Orleans (July 2007).

Since the last Energy and Commerce hearing, Ms. Madison has continued to meet with local stakeholders on behalf of the Secretary to gain more insight on new and continuing issues surrounding post-Katrina healthcare infrastructure needs for Greater New Orleans, including continued shortages of mental health care professionals, GME concerns of hospitals and medical schools, and local healthcare reform efforts. To help address these issues, Ms. Madison continues to meet and work together with the appropriate HHS operating and staff division officials to help in analyzing the problems for Federal remedies, if possible.

The Honorable Gene Green

1. Earlier this year, the Administration made funds available to the Gulf Coast States for Hurricane Relief. These funds, totaling $195 million, were authorized under the Deficit Reduction Act.

While Mississippi, Alabama, and Louisiana were eligible for certain dollars, those dollars dedicated for primary care facilities and for recruitment of health professionals were targeted only to Louisiana.

Can you explain the Administration's policy rationale for limiting these funds to Louisiana providers?

Answer: Since January 2007, Secretary Leavitt awarded $220 million in the way of 6 Federal grants, with his authority under section 6201(a)(4) of the Deficit Reduction Act (DRA) to make payments to states in order to restore access to health care in communities impacted by Hurricane Katrina. These DRA-authorized grants, totaling $38,343,048 to Alabama, $83,800,420 to Mississippi, and $97,856, 532 to Louisiana, helped to jumpstart acute needs for hospital intervention for local populations impacted by Hurricane Katrina.

In addition to Hurricane Katrina, the subsequent flooding of New Orleans caused the mass exodus of over 4500 health care professionals from the region. To date, there remains significant continued displacement of these critical infrastructure resources, especially in the area of mental health and primary care, sufficient to meet the needs of the returning population, many of whom are uninsured. It is for these extenuating reasons that Secretary Leavitt further awarded to Louisiana $150 million in the way of 3 Federal sole source grants, to help the State assist Greater New Orleans to provide critical urgent access to basic care. These grants include: $50 million in Professional Workforce Recruitment and Retention Grants (March 2007, and June 2007); and, $100 million for the Primary Care Access and Stabilization Grant (July 2007).

COMMITTEE EXHIBIT BINDER

Exhibit No. 5: Department of Veterans Affairs report, "Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans"

Exhibit No. 6: Memorandum of understanding between U.S. Department of Veterans Affairs and Louisiana State University Health Care Services Division

Exhibit No. 8: Letter from Dr. Alan Miller, Tulane University to Mr. Barton

Exhibit No. 9: Letter from Karen DeSalvo, Tulane University, to Mr. Barton

Exhibit No. 10: Letter from Frederick Cerise to Secretary Leavitt regarding immediate health care needs in the New Orleans region

Exhibit No. 11: Letter from Thomas Koehl, et al., to Secretary Leavitt

Exhibit No. 12: Letter of Thomas Koehl, et a., to Messrs. Dingell, Barton, Stupak, and Whitfield

Exhibit No. 13: Letter from Norman Francis, et al., to Secretary Jackson and Secretary Nicholson

Exhibit No. 14: Letter from President Cowen and Senior Vice President Miller, Tulane University, to Secretary Nicholson

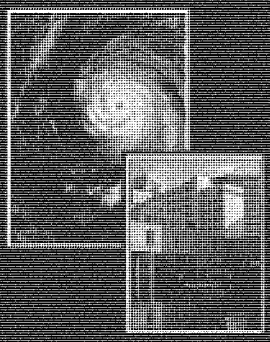
Exhibit No. 15: Letter from Greater New Orleans Healthcare Community Stakeholders to Mr. Stupak

Exhibit No. 16: Letter from Greater New Orleans Healthcare Community Stakeholders to Secretary Leavitt

Exhibit No. 5

DEPARTMENT OF
VETERANS AFFAIRS

Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans



R. James Nicholson
Secretary

February 28, 2006

DEPARTMENT OF VETERANS AFFAIRS

Plan for Re-establishing a VA Medical Center in New Orleans
28 FEBRUARY 2006

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ATTACHMENT B-1 ..... The Milliman Report

ATTACHMENT C ..... Memorandum of Understanding Between VA and LSU

This report was prepared by the Gulf Coast Planning Group (GCPG) of the U.S. Department of Veterans Affairs.
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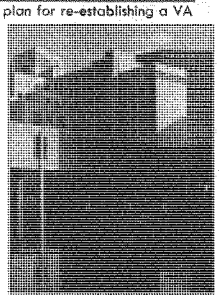
1. Introduction

This report presents an analysis of options and a summary level long-term plan for re-establishing a VA Medical Center in the City of New Orleans. It is submitted to Congress in compliance with P.L. 109-148 which includes the following directive: ***"The Department is directed to report to the Committees on Appropriations of both houses of Congress by February 28, 2006 on the long-term plans for the construction of a replacement hospital in New Orleans, Louisiana."*** Although the Congressional directive refers to a replacement "hospital" this report refers to "Medical Center" since it more accurately describes the current and future VA planned presence in New Orleans.



VA's plan is dependent upon a number of key assumptions. For example, expectations regarding the future veteran population and funding support and cooperation from state and local officials are all of particular importance - as is the restoration of the levy system. These assumptions, as well as others, are addressed in the discussion section for each proposed Option.

As acknowledged in numerous reports, VA's immediate response to hurricanes Katrina and Rita was highly commendable. However, a great amount of work remains throughout the affected region. While this particular report deals with infrastructure, VA continues to focus on the human element as well - assisting veterans and VA employees with a variety of support programs to hasten their return to a normal life. Their individual problems are indeed formidable.

The principal VA objectives regarding the New Orleans area are not only to restore complete service to veterans in the most cost effective manner, but also to assist in the City's restoration in the areas of health care and medical education. Prior to the hurricanes, VA's Medical Center provided primary, secondary and tertiary care to veterans throughout southeast Louisiana, eastern Texas and western Mississippi. It also supported an extensive program of on-going medical research and training in conjunction with LSU and the Tulane University School of Medicine. The VA facility was in fact the primary teaching hospital training over 450 residents and specialists as well as over 900 associate health trainees annually. As such VA had an important role in the medical community in and around New Orleans. This "teaching" aspect and the synergy of operating in close proximity to other medical facilities was a major consideration in VA's analysis of recovery options.

The report begins with a summary of VA capabilities in the affected region and the impact of hurricanes Katrina and Rita. This will provide the reader with an appreciation for VA related hurricane damage and recovery actions, as well as a frame of reference for the later discussion of the New Orleans Medical Center. Options for re-establishing the facility are presented in Section 3 and VA plan, which concludes that ***new construction of a facility shared with LSU*** is the preferred option, is discussed in Section 4. The report also has three Attachments: Attachment A is a summary of a contractor led assessment of damage sustained by the existing facility together with costing summaries of various re-establishment options; Attachment B is an analysis of demographics and the future workload the New Orleans Medical Center is expected to support; Attachment C is a Memorandum of Understanding (MOU) between VA and LSU Health Care Services Division wherein the Parties agree to jointly study state-of-the-art health care delivery options for New Orleans.

2. Background – VA in the Region and the Impact of Katrina and Rita

The Department of Veterans Affairs has an extensive network of facilities offering a wide variety of services and capabilities throughout the Gulf Coast area. Those within the area most affected by hurricanes Katrina and Rita are illustrated on Figure 1. The graphic provides a useful reference for the VA "footprint" in the affected region. Extending from Houston, Texas to Mobile, Alabama it covers the lower portion of Veterans Integrated Service Network (VISN) 16. As indicated, there are six existing Medical Centers (green stars) and twelve existing Community-Based Outpatient Clinics (CBOCs) (blue ovals) throughout this area. The red ovals indicate CBOCs that are planned for the future. The yellow ovals indicate CBOCs that are being established in an accelerated mode to temporarily alleviate the loss of VA Medical Center in New Orleans. Veterans Benefit Administration (VBA) Regional Offices and cemeteries of the National Cemetery Administration are also illustrated on the graphic.

In this coastal region the two Medical Center complexes that sustained hurricane damage are the Gulf Coast Veterans Health Care System (GCVHCS) in the Biloxi/Gulfport area and VA Medical Center in New Orleans. The most extensive damage occurred at Gulfport followed by severe flood damage at New Orleans. The following provides a short summary of hurricane damage to VA facilities in this area.

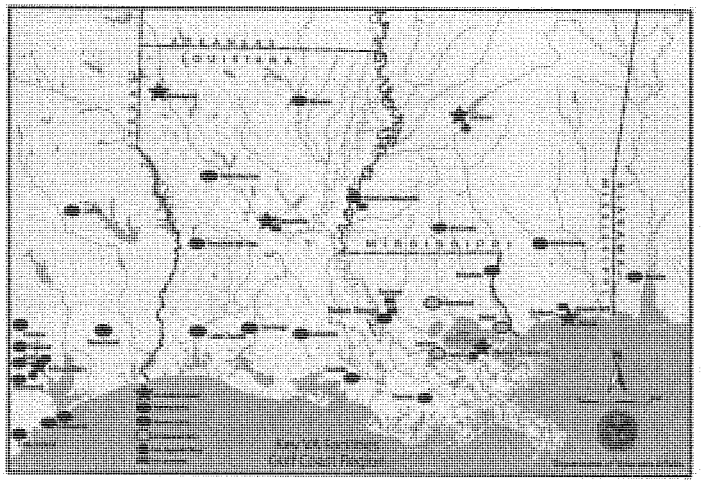


Figure 1: VA Facilities in the Affected Region of the Gulf Coast

2.1. Summary of Damage to VA Facilities in the Region

On Monday August 29, 2005 hurricane Katrina made landfall along the Gulf Coast with hurricane Rita following less than four weeks later on September 23. Damage to VA facilities in the Mississippi and Louisiana coastal areas was extensive and is summarized as follows:

- Biloxi – Although some damage did occur to the VA Medical Center at Biloxi this complex weathered the hurricane well and remained fully operational. All building systems, with the exception of emergency communications, continued to function normally during and after the hurricane. Damage at Biloxi included the asphalt shingle roofs on several buildings, window panes, seals and gaskets, doors and interior finishes, and some damage to electrical and mechanical systems. There was also significant site damage to the large number of live oaks and pines on the campus as well as to facility signage.
- Gulfport – Damage at the Gulfport VA Medical Complex, *only 8 miles from the Biloxi Medical Center*, was much more severe, to the point of catastrophic. The tidal surge from Katrina destroyed or made irreparable most buildings on the campus. Only the boiler plant and laundry survived, though both would need significant repair to resume operations. The Gulfport medical complex housed inpatient and outpatient mental health programs, substance abuse treatment programs, long-term care, primary care and specialty care and related support services. It also housed engineering and facilities management functions, billing and fee operations, long-term medical record storage and acquisition activities. Prior to the storm Gulfport employed 440 people. With respect to VA's capability to provide health care in the region the loss of the Gulfport complex was a significant disaster. Patients were relocated to other VA facilities in the region and throughout the country.
- New Orleans – At the City of New Orleans Katrina hit land at 6:10 AM as a Category 4 hurricane with recorded sustained winds as high as 175 mph. The previous evening, 28 August, the New Orleans Levee Authority lost power to most pump operations. At about mid day on 29 August, the New Orleans levee system, that normally holds back storm flow from Lake Pontchartrain, incurred multiple breaches of several sections as a result of rising storm surge levels. That evening, the 'eye' was directly over the VA Medical Center with reported 100 mph winds. The flood that followed crippled VA Medical Center, the entire City of New Orleans, and surrounding parishes. Severe flooding caused extensive damage to VA Medical Center – more detail on damage to this specific facility is presented in Section 3 below. The other key VA facility in New Orleans that sustained damage was the Veterans Benefits Regional Office. This office was located in GSA leased space in the New Orleans Postal Office Tower building. Severe flooding caused the office to be vacated.
- Cemeteries – Several VA Cemeteries along the coastal area also sustained damage to grave markers, trees and shrubbery and were also littered with debris.

2.2. Summary of Recovery Steps in the Region

Clearly many of the patients that had been using VA facilities in the region are now among the evacuees that have been relocated to other parts of the region and the country. In anticipation of their return, and to continue support for those who remained, VA has taken several actions to restore service in the area (refer to Figure 1 for specific locations):

- Biloxi – The construction of a new hospital (that was already planned as part of the CARES program) is being accelerated. This project also includes a potential partnership with the USAF at Keesler AFB - at least with respect to continuation of Graduate Medical Education (GME) - a key concern of the Air Force. From a medical education standpoint the University of Mississippi is also very interested in VA recovery activity in Biloxi.

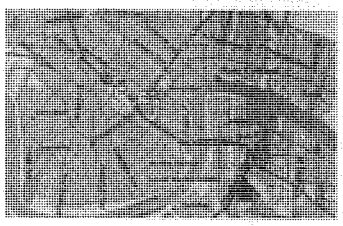
- Gulfport – Since the Gulfport facility was already scheduled for closure (as part of CARES), no extensive recovery is planned. Workload is being shifted to the Biloxi Medical Center. However, a temporary modular clinic is being established on the Gulfport campus. A trailer park for 200 trailers has already been established there – these trailers are currently being used to house VA employees and patients.
- Baton Rouge - Capacity has been increased at the CBOC in Baton Rouge with the lease of the former clinic space to accommodate administrative operations for New Orleans.
- North and west of Lake Ponchartrain CBOCs are being established at Laplace (in leased space temporarily pending donation of land for a modular building), Hammond (also a modular building), and Slidell (in leased space). The modular buildings VA will be using are pre-fabricated temporary structures that can be erected quickly. These structures come complete with electrical wiring, components, circuit breakers and heating and cooling outlets.
- Gretna, LA - A temporary Regional Benefits facility has been established in Gretna, Louisiana (60,000 Sq Ft and 125 parking spaces) about ten miles to the west of downtown New Orleans.
- In the existing New Orleans VA complex a primary care clinic has been opened in space available above the adjacent parking structure - limited specialty care will be available shortly.
- Clean-up work at VA cemeteries also continues.

From the standpoint of outpatient medical care, the above actions will accommodate the anticipated patient workload in the near term. However, inpatient care will not be available in the immediate vicinity of New Orleans until VA's Medical Center is re-established. ***This is the principal issue regarding full VA recovery in the New Orleans area.***

3. VA Medical Center, New Orleans

The New Orleans VA Medical Center (NOVAMC) is located in Orleans Parish about six miles South of Lake Ponchartrain and a mile west of the Mississippi River as indicated by the star in the upper section of Figure 2. Part of a four-hospital complex, as shown in the lower portion of the figure, it is the major VA medical facility in the "Central Southern" Market area of VISN 16.

This medical center has a critically important role in caring for patients throughout Southern Louisiana, Eastern Texas and Western Mississippi. Over 39,000 unique patients were treated in FY 2005. Pre-hurricane statistics included staffing of over 1,700 employees and 600+ volunteers, with an annual operating budget in excess of $130 Million.



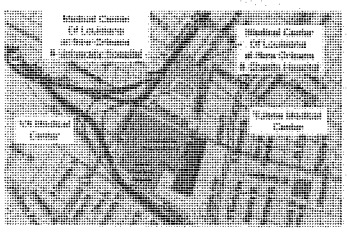


Figure 2: NOVAMC - Location

Currently about two thirds of the patients previously being cared for in this facility have been seen at other VA Medical Centers. Those remaining in the area are being served by the CBOCs illustrated in Figure 1 on page 2.

Pre-Katrina, the medical center had active medical affiliations with Louisiana State Health Sciences Center and Tulane University Health Sciences Center. In FY 05, 124 resident positions were allocated to the medical center. In total, over 500 University residents, interns, and other allied health students were trained at the medical center. There were also nursing and Department of Defense (DoD) affiliations with: Charity/Delgado, Dillard, Our Lady of Holy Cross College, LSUHSC, Loyola, University of South Alabama, University of Phoenix, University of Mobile, University of Louisiana at Lafayette, University of Southern Mississippi, Mississippi University for Women, the 926th Air Force, the 1010th Navy, Naval Ambulatory Care Center, and the 4010th US Army Reserve Hospital.

The medical center also had affiliations for physical therapy with Bishop State Community College, and Elon College; for pharmacy with Xavier University in New Orleans and University of Louisiana at Monroe; for psychology with SUNY at Stony Brook, SUNY at Buffalo, Emory University, Texas Tech University, and University of Georgia; for social work with Florida State University, LSU at Baton Rouge, and Southern University of New Orleans.

Affiliations with Tulane University were in place for audiology/speech pathology with LSU at Baton Rouge and New Orleans and University of Florida; for recreational therapy with Grambling State University; for ophthalmology, respiratory care, radiology, and nutrition/food with Delgado Community College; for dental hygiene, cardiopulmonary science, medical technology and physician assistant with LSU; for medical technology and respiratory care with Nicholls State University; and for nutrition/food with Southern University in Baton Rouge. Through sharing agreements there was collaboration in the areas of Radiation Therapy and Professional Radiology Services.

The medical center also had a well funded research and development program, including studies in such diverse areas as hypertension, heart disease, kidney disease, prostate cancer, schizophrenia, PTSD, Alzheimer's Disease, and more. All of which enhanced the ability to provide state-of-the-art medical techniques and treatments to veteran patients. The medical center was also the home of the Mental Illness Research, Education and Clinical Center (MIRECC) for VISN 16. A facility of significant importance to veterans, as well as to the extensive network of medical affiliates mentioned above, VA medical Center should be re-established without delay – this is supported by the demographic analysis presented later in this paper.

VA's campus in New Orleans (see block diagram at Figure 3) occupies approximately 10-acres which is bounded by Perdido Street on the south (the main visitor entrance), Gravier Street on the north, and Freret Street to the east. Across Gravier Street to the north is Charity Hospital, (illustrated on Figure 2). This was another facility severely damaged by flooding. The western campus property line is shared with a building site owned by Charity Hospital's Board of Administrators. Elevation of these facilities is very close to sea level (+/- 20 feet).

The NOVAMC medical center includes the following major structures:

- ***Building 1*** – This is the main hospital. It is originally of 1949 vintage construction consisting of 11-stories above grade, plus a basement level, a sub-basement level, and two above-roof equipment penthouse levels. This building originally included Quadrants A, B, C, and D (Figure 3), and has undergone numerous renovations to include the addition of Quadrant E - a 6-level plus basement infill connecting building 1 to Quadrant F (the Clinical/Research addition). The hospital is currently licensed (pre-Katrina) as a 450 bed acute care facility.
- ***Building 2*** – This is a 6-story plus partial basement facility, originally constructed in 1949 as a facility manager and staff nurses' quarters. It is detached from the main hospital and recently served as administrative space.
- ***Clinical Addition (Quadrant F)*** – This 9-story plus equipment penthouse facility was constructed in 1982, along with the connecting link to the original main hospital. This portion of the facility supports major research functions.

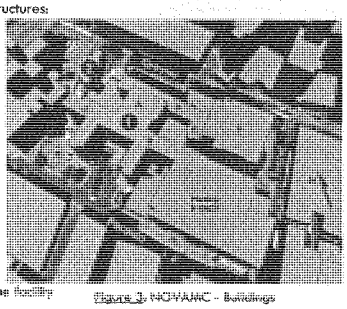


Figure 3: NOVAMC - Buildings

- ***NHCU and Parking Garage*** – This 11-story 1990-vintage facility includes a multi-story parking structure atop of which is a two-story 120 bed Nursing Home Care Unit (NHCU).
- ***Boiler Plant*** - A 1950-vintage two-story central boiler plant is located on the northeast portion of the campus along Frerer Street.

As stated earlier, severe flooding associated with hurricane Katrina began in this area late in the morning of August 29, 2005, when portions of the New Orleans levy system collapsed. Buildings in the complex sustained extensive damage which worsened over time when the flood waters failed to recede (VA's Medical Center complex is within several blocks of the Louisiana Superdome – the photo in the introduction illustrates the severity of the flooding).

Water from the breeched levees flooded the entire area around the medical center, including the basement and sub-basement of the main building - the areas that house the facility's major electrical, mechanical and dietetics equipment. The facility had no electrical power or air-conditioning for weeks following the hurricane. This condition caused extensive water/moisture damage both to the building and to equipment. Since there was no power to the complex for a long period of time the mildew and mold continued to spread creating unacceptable conditions for a medical facility. The excessive moisture damaged delicate medical instrumentation throughout the facility - similar conditions were experienced in the neighboring hospitals illustrated in Figure 2. VA's Medical Center remained empty until December of 2005 when a primary care clinic was established in the tenth floor of the former Nursing Home (NHCU) building where the parking garage also exists. In March of 2006 a specialty clinic will open in the 9th floor NHCU.

3.1. The Need for a VA Medical Center in the Vicinity of New Orleans

The demand from the initial CARES process culminating in the Secretary's CARES decision of May 2004 projected gaps in inpatient and outpatient care. These projections are still valid despite evacuations of the two Louisiana "parishes" most impacted by the hurricanes – Orleans and St Bernard. Attachment B of this report provides more detail on this very important issue and concludes that over the long term, a significant percentage of veteran evacuees will return to the catchment area resulting in very little change to demand projections – particularly with respect to utilization. This "rate of return" is already increasing - the data in the table below compares cumulative unique patients seen in New Orleans (and its associated clinics) this year and the last two years. While the numbers were down significantly in October the rate of increase has been accelerating such that by January the numbers were approaching 2/3rds of last year's workload. Considering that new clinics are just starting up, and housing is still limited, this is a clear indication that workload is gradually returning to previous levels.

New Orleans Unique Patients
FY 2005 Compared to FY 2006 by Month

Months	October	November	December	January
FY04	23,237	26,906	29,136	30,736
FY05 Pre Katrina	24,259	29,198	31,651	33,383
FY06 Post Katrina	6,378	10,602	17,521	21,326

Based on the demographic analysis in Attachment B, and observation of actual workload in the last few months, a basic assumption in this report is that there will be somewhat fewer but sufficient numbers of veterans with a reasonably high "utilization rate" to justify the re-establishment of a hospital either in, or close to, the City of New Orleans.

3.2. Options Considered

Four options for re-establishing a VA Medical Center in the vicinity of New Orleans were considered:

Option 1	Restore and Hurricane Harden the Existing Medical Center
Option 2	Renovate and Remodel the Existing Medical Center
Option 3	Construction of a New Medical Center as a "Shared Facility" in the same general area
Option 4	Construction of a New Medical Center as a "Stand Alone" facility on higher ground on a site yet to be determined

Common assumptions or considerations that will affect all of these options in varying ways are provided below. Additional assumptions specific to each option are included in the discussion below for each option.

- Veteran Population/Utilization Trends: Demand for Medical Center level care for the New Orleans catchment area (which goes beyond city limits) will return to sufficiently high levels (see Attachment B). Even with slow repopulation of the heavily affected parishes of Orleans and St. Bernard there will be little change to CARES assumptions of increased demand - to include some evacuees from the city resettling in surrounding areas as evidenced by the above table.
- Levy Infrastructure: The levy system will be repaired to pre-Katrina conditions by June 2006.
- Weather: The intense tropical storm and hurricane activity experienced the past two years will continue for the next five years (National Weather Service predication).
- Relationship with Affiliates: Affiliates are committed to VA (and vice versa); relationships will be established in the region with priority to a "shared service" model in the City.
- Availability of Qualified Workers: Although there has been some concern that the medical professional/service workforce may choose to permanently relocate outside the metropolitan area recent indications are more positive. Given the continued improvements, it is assumed that by the time a Medical Center is re-established, adequate numbers of qualified workers will be available. In addition, VA's compassionate actions on behalf of New Orleans employees during and after the hurricane as well as the commitment to return a full range of services to the city will solidify VA's position as an employer of choice.
- Revitalization: The continued presence of a VA Medical Center is important to the revitalization of the City of New Orleans.
- Other VA Activities: For all options, accommodations will be made for both the Veterans Benefit and the National Cemetery Administrations to share space as needed.

Estimated costs are included for each of the options but these continue to be refined. The most recent supplemental request submitted to Congress during the week of 13 February included $600M for a VA Medical Center in New Orleans. When added to the $75M previously approved, the initial estimate totals $675. The costs included for each of the options described below are the most recent reported by the firm of Leo A. Daly – more detail on these is provided in Attachment A.

3.2.1. Option 1: Restore and Hurricane-Harden the Existing Medical Center

General Description

In this option VA would re-establish the existing Medical Center by restoring it to a condition similar to that before the hurricanes. Steps would also be taken to better protect the facility from severe flooding. For example, all critical and sensitive equipment would be moved to higher floors and lower floors would be used for less critical activity (parking, non critical storage, etc.). All damage to equipment and interior finishes from the effects of very high humidity over a long period of time (mold, etc.) would be repaired to the extent possible. More detail regarding this option is included in Attachment A under Option A.

Critical Assumptions Specific to this Option

- Hazardous conditions for a medical facility (like mold and difficult to detect contamination) can be effectively removed.

VA Potential Cost

- Approximately $288M

Pros

- Option 1 has the lowest initial cost.
- No site selection required; potentially the quickest way to re-establish a VA Medical Center in New Orleans (24 months to 3 years)

Cons

- Although the facility would be better protected from flood damage, it would still be located in the flood plain where accessibility could be difficult if flooding occurred again.
- Money would be spent on repairing an older (1950's vintage) facility.
- Since the repair would not involve any extensive modernization, recurring operating costs would be similar to that prior to Katrina.

Issue

- Successful cleansing and disinfecting the hospital complex is the principal issue for this option.

3.2.2. Option 2: Renovate and Remodel the Existing Medical Center

General Description

VA would re-establish a medical center by renovating and remodeling the current facility. The complex would be restored as per Option 1, but in addition deficiencies to the 1950's era portions of the complex would also be addressed. All damage to equipment and interior finishes from the effects of very high humidity over a long period of time (mold, etc.) would be repaired to the highest degree possible. Sections of the building would be remodeled to accommodate a different modus operandi. For example as in Option 1 all critical and sensitive equipment would be moved to higher floors and lower floors would be used for less critical activity (parking, non critical storage, etc.). For example, the primary engineering and food service infrastructure would be placed above Katrina's precipitated "levee break" flood level. This would involve significant revamping/renovations to the first floor level as well as the construction of a new stand-alone Engineering Utility Plant tower building, probably on the site of (a razed) Building 2 in the northwest corner of VAMC campus. However Option 2 could also include the addition of two more floors - this would depend on a more detailed engineering assessment. More detail regarding this option is included in Attachment A under Option B.

Critical Assumptions Specific to this Option

- Hazardous conditions for a medical facility (like mold and difficult to detect contamination) can be effetely removed.

VA Potential Cost

- Approximately $622M

Pros

- Since the renovation would include extensive modernization, recurring operating costs would be lower than prior to Katrina.
- Although more time consuming than Option 1, no site selection is required; therefore, this option could also lead to re-establishing the Medical Center quicker than new construction (2 to 3 years).

Cons

- Although the facility would be better protected from flood damage it would still be located in the flood plain where accessibility could be difficult if flooding occurred again.
- Money would be spent on modernizing an older facility.

Issue

- Successful cleansing and disinfecting the hospital complex is the principal issue for this option.

3.2.3. Option 3: Construction of a New Medical Center as a "Shared" Facility – Same General Area

General Description

Under this option VA would build a new structure in the downtown area close to its partners, Louisiana State University (LSU) and Tulane Medical School. The State of Louisiana's safety-net health care system, Medical Center of Louisiana, is managed by LSU. The system in New Orleans includes Charity Hospital and University Hospital. The proposed concept is a hurricane hardened; single campus/shared support services model to be located at a new site and would include replacing Charity Hospital. This concept will enable VA to replace an aging, outdated 1950s facility with a state of the art medical center to provide quality health care for veterans.

A site in proximity to the current medical center (see Figure 4) would be acquired by the State of Louisiana and is expected to be donated for the shared campus. Each partner, VA and Medical Center of Louisiana/New Orleans (MCOL/NO), would assume ownership of their portion of the donated land. In addition, although the site would be located within the flood plain, there is sufficient land to ensure adequate hurricane hardening of the campus. The complex would need to be constructed so that operations could continue even under extreme circumstances.

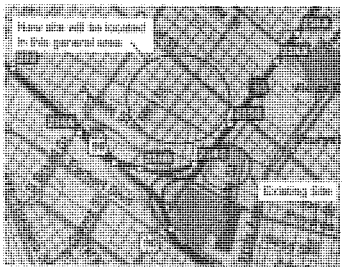


Figure 4: Building Site for Option 3

The single campus would include separate, autonomous bed towers and outpatient clinical space for VA and the Medical Center of Louisiana. All critical electrical, mechanical, and sensitive systems will be located in the upper floors to reduce the risk of flooding damage. Common areas would provide space for shared non-clinical support services such as parking, food services, laundry, energy and utility management, and helipad - these would be located in sections of the facility convenient to the bed towers. Separate, though contiguous, diagnostic, major therapeutic and interventional areas such as laboratory, radiology, catherization labs, and operating suites would be built for both VA and the MCOL/NO.

The facility would be smaller than the existing hospital (approximately 200 beds, about 60 of which would be for nursing home care). It would include sufficient parking spaces to meet the projected 2023 CARES program requirement. More detail regarding this option is included in Attachment A under Option C-2.

Critical Assumptions Specific to this Option

- Congressional support for a sufficiently large VA supplemental is obtained.
- The State of Louisiana obtains adequate funding to finance the MCOL/NO sections of the facility.
- The State of Louisiana provides land sufficient for the hospital complex.

VA Potential Cost

- Construction estimate for VA's share is approximately $636M.

Pros

- Since this option would result in a "state of the art" facility that would be shared by others, it would be the least expensive in terms of recurring operating costs.
- This option would be the most beneficial for rejuvenating the City of New Orleans since new facilities would be constructed in the heart of the City demonstrating a highly visible commitment.
- This option would leverage the mutual strengths of all medical affiliates in the region.

Cons

- Option 3 would be complex to implement in that a number of separate organizations would have to agree on the detailed plan (VA, the State, the City and the US Congress) and funding.
- Since this would involve new construction of a hardened, flood protected facility, initial costs would be high.
- A substantial amount of money would be spent on building a modern facility in an area susceptible to flooding.
- Time involved would be longer than repairing or modernizing the existing facility.

Issue

- Uncertain funding for the affiliate is the major issue associated with this option.

3.2.4. Option 4: Construction of a New "Stand Alone" Medical Center Hospital on Higher Ground

General Description

Under this option, VA would build a new complex in a location outside the flood plain. This VA Medical Center would provide all necessary services and would be a stand alone facility with no adjacent "partners". However, affiliation would be established with other medical centers in the region to the extent possible. More detail regarding this option is included in Attachment A under Option C-1.

Critical Assumptions Specific to this Option

- Congressional support for a sufficiently large VA supplemental is obtained.

Potential Cost

- Construction estimate is approximately $645M

Pros

- This facility would be secure and fully accessible regardless of flooding.
- Since it would be based on a modern design, operating costs would be lower than with the current building.

Cons

- Initial cost would be high.
- An exclusive site for VA would have to be purchased.
- Separation from affiliates would tend to complicate any "sharing/support" arrangements.
- Would send a mixed signal to those trying to re-vitalize the City of New Orleans.

Issues

- Adequate funding and "approval" to re-locate out of the City proper are the principal issues.

3.3. Evaluation of Options

Key consideration in evaluating the above options are the condition of the existing hospital, the initial investment and 20 year operating costs, and the synergy gained from affiliation with other medical facilities.

3.3.1.

Both ***Options 1 and 2*** focus on repairing, or completely renovating/modernizing, the existing facility. These courses of action rest heavily on the ability to completely remove all mold and contaminants in the hospital building. ***A key observation from the engineering assessment (summary at Attachment A) was that the greatest perceived enemy to complete recovery to full-functionality is the post-flood high humidity conditions and resultant spread of mold, mildew and other bacteria.*** The basement floor structure was submerged temporarily in a saturated condition for approximately 2-1/2 weeks before the water was pumped out. The sub-basement was submerged somewhat longer. Water contact by submersion for such a time period would not affect structural integrity. However, the pollutants within the floodwater could have an undesirable effect on the long-term durability, appearance and smell of the concrete surfaces. Concrete masonry walls and clay tile in these levels that were submerged would require complete removal due to the probability that contaminated sewage laden floodwater penetrated into the cores through mortar joints as a result of hydrostatic water pressure. This trapped polluted water would be nearly impossible to ever completely remove, and its retention and on-going leaching through the wall systems would be untenable. Another major area of concern lies with the air conditioning ductwork throughout the facility. All air-handling equipment and most ductwork located in the basement and sub-basement levels was completely submerged in the polluted floodwater. All such equipment and ductwork would have to be removed from the site. A related problem with the damaged air-handling equipment and ductwork is that several of these submerged systems were dedicated to serving first floor clinical and other functional areas. As such, not only are these first floor areas currently without air-conditioning, their associated ductwork, which traverse between these two levels, continue to be subjected to mold/mildew and other bacterial contamination. This is due to the fact that the contaminated ductwork originating from the basement below continues to provide open 'conduit' paths in which such contaminants may flourish. The extensive evidence of lingering mold and contamination is a major concern. VA officials do not have a high degree of confidence that complete elimination of this contamination is possible.

Reuse of the existing complex may be acceptable for a non medical facility but not for a hospital with patients susceptible to infection. ***The options addressing the existing facility are deemed too risky for future patient care and are unacceptable the Department.***

3.3.2.
Both ***Options 3 and 4*** require new construction that would result in modern, highly efficient facilities. The long term cost of each option (consisting of the initial investment and anticipated operations and maintenance costs over a 20 year period) would likely be more favorable. The table below provides a summary of data from the Engineering Assessment (Attachment A). This information continues to be refined but in general supports new construction Options (3 and 4) as being more economical over the long term.

($ M)	Construction	Utilities (20 Year)	Maintenance (20 Year)	Operations (20 Year)	Totals
Option 1	$288	$133	$443	$4,074	$4,938
Option 2	$622	$35	$130	$4,074	$4,861
Option 3	$636	$42*	$155*	$3,666*	$4,499*
Option 4	$645	$42	$156	$3,666	$4,509

*** Note: The estimates included in this table continue to be refined. For example the "sharing" arrangements for Option 3 (that will affect the 20 year utilities, maintenance, and operations costs) will be developed by a VA/Louisiana Medical Center Study Group soon to be formed. As described in paragraph 4.1.2, this Study Group will have a key role in outlining the specific details of a "shared facility".**

Option 4 calls for new construction on higher ground, but it does not appear likely the other hospitals will leave the current area. VA's solution for re-establishing a Medical Center in New Orleans hinges in a major way on recovery efforts taken by the State of Louisiana and the federal government. Recently there have been clear signals from state and federal authorities that New Orleans will be restored and that sizable amounts will be spent on levy restoration and repair of vital infrastructure. Given these conditions the major medical facilities (LSU, Tulane etc) are far more likely to remain in the City. The preference for VA is to remain in close proximity of these other hospitals so sharing arrangements can be coordinated and a more effective medical environment established. This "synergy of sharing" is a very important consideration. In this regard Option 3 is likely to be the most ***effective*** of the new construction options because it will be a ***shared*** facility providing the added benefit of co-location. The ***cost effectiveness*** of this course of action is attractive to VA (as well as to local and State officials).

VA is a leader in patient safety, disease management, health promotion, customer satisfaction, and the electronic health record. LSU and Tulane have well-established Centers of Excellence in research and clinical delivery of services in areas such as cancer care, cardiovascular diseases, epilepsy and seizures, neurosciences, and rehabilitation. The shared campus model will leverage these strengths, providing quality, cutting-edge health care for all beneficiaries, VA and non-VA. As an employer of choice, the joint operations will improve recruitment and retention of clinical staff.

VA believes that a new facility can, and should, be built within the City proper. This approach will provide added emphasis to the commitment of bringing New Orleans back to full functionality and it can be hurricane hardened to preclude a reoccurrence of flood damage. Given the considerable expense of both repair and renovation and the risk associated with removal of mold and other contaminants in the existing complex, new construction is believed necessary. The new construction option with the most attractive cost effectiveness is ***Option 3 – it is therefore VA's preferred Option.***

4. VA Approved Plan

Option 3, the construction of a new Medical Center as a shared facility, will re-invigorate the medical care environment in and around New Orleans. The general geographical area for this new facility was illustrated in Figure 4. A summary description of the planned complex is provided in the paragraphs below.

4.1. Key parameters of new facility

The single campus would include separate, autonomous bed towers and outpatient clinical space for both VA and the Medical Center of Louisiana/New Orleans (MCOL/NO). An illustration of the envisioned complex is provided in Figure 5. All critical electrical, mechanical, and sensitive systems will be located in the upper floors to reduce the risk of flooding damage.

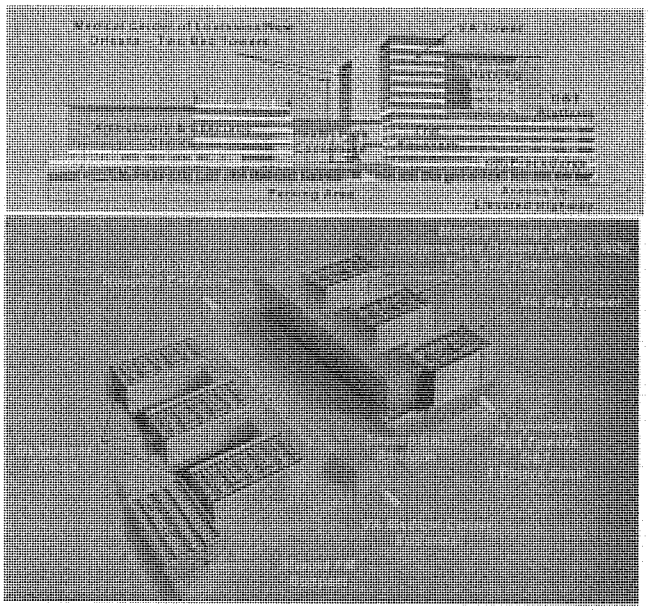


Figure 5: Notional Schematic of Option 3 – "Shared Facility"

Common areas would provide space for shared non-clinical support services such as parking, food services, laundry, energy and utility management, and helipad. Separate, though contiguous, diagnostic, major therapeutic and interventional areas such as laboratory, radiology, catherization labs, and operating suites, would be built for both VA and the MCOL/NO.

VA's facility would be smaller than the existing hospital (approximately 200 beds, about 60 of which would be for nursing home care). It would include sufficient parking spaces to meet the projected 2023 CARES program requirement. Ingress and egress from an elevated highway would also be part of the planned complex.

Additional key parameters/capabilities to be considered in the planning process:

- Square footage:
  - 870,573 SF of Acute Care for VA portion (2005 CARES)
  - 12,000 SF Central Plant Building
- Anticipated number of floors: 8 to 10
- Hurricane hardening:
  - Generator Concept: The generators shall be sized to serve both VA and MCOL/NO sections of the complex. For VA 30% of the total shared system cost is included in VA cost estimate for Option 3. VA section of the facility will require a 7 MW Diesel Powered Generator.
  - Pumps: Pumps will be sized to serve a 1.5 million gallon water tower. The water tower will be sized to accommodate the fire sprinkler system.
  - The entire area will be elevated a minimum of 2' above the recorded Katrina flood plain and the lowest floor level will be 6' above the Katrina flood plain.
  - Protection of Sensitive Equipment: The following components will be located at least 6' above the recorded Katrina flood plain:
    - Chillers
    - Air Handling Equipment
    - Boilers
    - Helipad
    - Elevated Roads
    - Water and Sewage Storage Facilities
  - Boat Dock: A boat dock will be provided in the vicinity of the loading dock.
  - Foundation integrity: Deep pile foundations per geotechnical recommendations will be used.
- Numbers of inpatient beds: Approximately 200 per VA 2005 CARES program, (or as determined by actuarial analysis).
- Numbers of nursing home beds: Approximately 60 Beds
- Special Facilities/Programs
  - Rehabilitation Medicine
  - Medical Surgery
  - Dialysis
  - Cardiac Surgery
  - Women's PTSD
  - PTSD
  - Mental Health
- Parking facilities:
  - 300 Elevated
  - 2000 Surface
- Administrative Space: In accordance with the 2005 CARES program, (as adjusted for actuarial analysis).

4.1.1. Estimated Timeline

An estimated macro timeline, based on experience with similar construction, is provided at Figure 6 below:

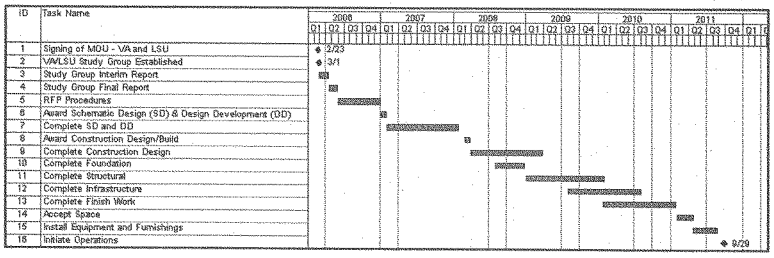


Figure 6: Estimated Macro Timeline.

4.1.2. Cooperative Arrangements with Others

Key to the success of a shared complex are the details concerning the day-to-day working arrangements and legal documents associated with a meaningful partnership. In this regard discussions have been on-going for several months but reached a critical point on February 16, 2006, when VA hosted a meeting in New Orleans. The purpose of this important meeting was to discuss ways in which VA and LSU (also other affiliates) could collaborate in providing quality, efficient healthcare in a mutually beneficial way to their individual constituencies.

In addition to VA representatives, the meeting was attended by representatives from the State of Louisiana, the Louisiana Recovery Authority, LSU, Tulane, Department of Health and Human Services, FEMA, and Congressional Staff (Sen. Landrieu and Rep. Baker). The office of Federal Support for the Recovery and Rebuilding of the Gulf Coast Region also was informed and provided with a complete brief.

VA and LSU both agreed to draft and sign a Memorandum of Understanding (MOU) that would create a ***"Collaborative Opportunities Study Group"*** to further analyze potential sharing agreements. The MOU was signed on 23 February, 2006 – a copy of which is included as Attachment C to this report. As indicated in the above schedule, this MOU initiates the important work to define the scope of the new facility. This information will be used for more extensive schematic and construction designs.

The parties involved in the joint study fully intend to achieve a mutually beneficial outcome. If for any reason a permanent, collaborative solution cannot be attained, the results of the study will be invaluable to VA in reaching an independent determination on how to address veterans' health care needs in New Orleans. VA fully anticipates that vast majority of the data obtained in the joint study could be utilized if an independent determination is ultimately required.

5. Conclusion

The Department of Veterans Affairs, together with the Louisiana State University Health Care Services Division, is committed to creating a modern, 21st century medical complex in the City of New Orleans. The need for a continued VA presence is supported by the latest demographic projections and the most favorable option for re-establishing this presence is the one which provides the maximum potential for sharing and leveraging a variety of medical capabilities. In the months ahead the plans for this modern complex will continue to be defined with the objective of initiating schematic design in early 2007.

VA values its affiliations with medical universities, medical schools and public and private healthcare facilities and views this initiative as a unique opportunity to re-establish world class care to veterans in the region, redefine the relationship with important affiliates, and assist in re-invigorating the healthcare environment in the City of New Orleans.

Exhibit No. 6

Memorandum of Understanding

Between

United States Department of Veterans Affairs

And

Louisiana State University Health Care Services Division

1.0 INTRODUCTION

This Memorandum of Understanding (MOU) is made between the United States Department of Veterans Affairs ("VA") and Louisiana State University Health Care Services Division ("LSU") (hereinafter referred to collectively as "the Parties").

1.1 The Parties intend by this MOU to establish a mutually beneficial relationship to foster discussions regarding the future of VA and LSU medical care delivery in the New Orleans, Louisiana region.

1.2 This MOU will address the basic framework for discussions between the Parties, but leaves for later agreement the more precise terms that will constitute the substance of the future relationship.

2.0 PURPOSE

2.1 Prior to the natural disaster known as Hurricane Katrina in August 2005, each of the Parties either directly owned and operated or had an interest (financial or governmental) in various medical facilities in the City of New Orleans. The facilities involved were various and included at least the following: New Orleans VA Medical Center, University Hospital and Charity Hospital, and ancillary support facilities, (collectively "the Facilities"). Each of the facilities referred to herein sustained significant damage from Hurricane Katrina and/or the resultant flooding in numerous parts of the City.

2.2 Each of the Facilities served a segment of the population of New Orleans region and provided various levels of medical services. In many case these services were complementary among the Facilities. Many valuable and productive relationships existed between the Parties to foster cooperation and collaboration in tertiary, specialty and primary care and especially medical education and training for the medical professionals employed at the Facilities.

2.3 This MOU will provide a framework for collaboration and discussion on reestablishing a health care presence in New Orleans and how the Parties could work together to achieve that mutually beneficial goal.

3.0 AUTHORITY

3.1 Under 38 USC § 513, the Secretary of Veterans Affairs may "enter into contracts or agreements with private or public agencies or persons... for such necessary services... as the Secretary may consider practicable."

3.2 Pursuant to 38 USC § 8153, when the Secretary determines it to be in the best interest of the prevailing standards of the Department [of Veterans Affairs] medical care program, he may make arrangements, by contract or other form of agreement for the mutual use, or exchange of use, of health-care resources between Department health-care facilities and any health-care provider, or other entity or individual.

3.3 Pursuant to Article 8, Section 7 of the Louisiana *Constitution*, the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College (Board) is granted authority to supervise and manage the institutions statewide and other programs administered through its system. The LSU Health Care Service Division is a part of the LSU System.

4.0 ROLES AND RESPONSIBILITIES OF THE PARTIES

4.1 The Parties shall draft a Charter for a study group to be known as VA/LSU Collaborative Opportunities Study Group (COSG) for New Orleans (the "Group").

4.2 Subject to federal law, regulation and VA policy, the VA shall commit the appropriate resources (time, assets, personnel, etc.) to the formation and support the ongoing functioning of the Group.

4.3 Subject to law, regulation and LSU policy, LSU shall commit the appropriate resources (time, assets, personnel, etc.) to the formation and the ongoing functioning of the Group.

4.4 The Parties understand that other entities or organizations may have an interest in the goals and activities described in this MOU. In recognition of this, the Parties will invite the participation of other entities, organizations or associations as determined by the Group.

4.5 The Parties agree that the Group shall be tasked to study the following areas of mutual interest:

4.5.1 The present and future demographics of the City of New Orleans ["City"] and metropolitan New Orleans area ["Region"];

4.5.2 The present and future need for LSU and VA health care services, medical research and medical education in the City and Region;

4.5.3 An analysis of the present and future need for LSU and VA primary, tertiary, specialty and emergency health care services in the City and Region;

4.5.4 Evaluation of state-of-the art joint and collaborative health care delivery models, including the model known as the Texas Medical Center;

4.5.5 An analysis of proposed sites and locations for future LSU and VA health care facilities, research and educational facilities in the City and Region, including analysis of sites for joint and collaborative facilities;

4.5.6 An analysis of how the VA/LSU collaboration can contribute to the National and Louisiana advancement of health care services, in cooperation with medical education.

5.0 FUNDING

The Parties shall attempt to secure reasonable funding to allow for the successful accomplishment of the activities and goals of this MOU. All Parties, however, expressly acknowledge that the activities and goals under this MOU shall be subject to their limited authority and the availability of appropriated and other funds, and the assets of each Party, including the approval of alternate sources of funding. Nothing in this MOU or elsewhere shall be construed as establishing a contract (or any other binding legal commitment) obligating any Party to this MOU to provide money, goods or services of any kind to any legal or governmental entity.

6.0 AGREEMENTS

In order to foster the success of this MOU, the Parties agree to the following:

6.1 Each Party pledges in good faith to go forward with this MOU and to further the goals and purposes of this MOU, subject to the terms and conditions of this MOU. The Parties agree to resolve disputes, if any, through good faith discussions.

6.2 By mutual agreement, which may be formal or informal, the Parties may modify the list of intended activities and goals set forth in Paragraph 4.0 above, including the practical manner by which the goals, activities and purposes of this MOU will be accomplished. However, any modification to any written portion of this MOU must be made in writing and signed by all Parties, or their designees.

6.3 Nothing in this MOU shall be construed to authorize or permit any violation of Federal, State or local law, including environmental laws and regulations, and public records laws, as applicable..

6.4 All Parties agree that they do not expect, nor will they ever seek to compel in any judicial or other forum, the payment of money, services or other thing of value from any other Party based upon the terms of this MOU. The Parties agree further that this provision does not affect in any way any legal rights accruing to any Party outside of this MOU by virtue of any other law or contract, or otherwise.

6.5 The Parties agree that participation in the goals activities and purposes of this MOU does not constitute an endorsement, express or implied, by a Party of any policy advocated by any other Party.

7.0 PRIMARY CONTACTS

The Parties intend that the work under this MOU shall be carried out in the most efficient manner possible. To that end, the Parties intend to designate individuals who will serve as primary contacts among the Parties. The Parties intend that, to the maximum extent practicable and unless otherwise approved by another Party, all significant communications between the

Parties shall be made through the primary contacts. The designated primary contacts for the Parties are listed in Attachment A to this MOU.

8.0 WITHDRAWAL FROM MOU

Any Party may unilaterally withdraw from this MOU at any time by transmitting a signed writing to that effect to the Primary Contact(s) of the other Parties listed in Attachment A. The withdrawal shall be effective sixty (60) days from the date of transmittal of the written withdrawal.

9.0 EFFECTIVE DATE

This MOU shall become effective immediately upon full execution of all signatories listed below and shall remain effective until there is a withdrawal pursuant to paragraph 8.0 hereof.

The Parties hereby agree to the foregoing MOU, executed this 23rd day of February 2006.

For the United States Department of Veterans Affairs:

Date: 2/23/06

Jonathan B. Perlin, M.D.
Under Secretary for Health
United States Department of Veterans Affairs
Washington, DC

For Louisiana State University Health Care Services Division:

Date: 2/23/06

Dr. William L. Jenkins
President
Louisiana State University System

ATTACHMENT A

PRIMARY CONTACTS

For the United States Department of Veterans Affairs:

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For Louisiana State University Health Care Services Division

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With a copy to:

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LSU System
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Baton Rouge, Louisiana 70808

Tel 225-578-0335

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Exhibit No. 8

3-30-07
Alan

Alan M. Miller, PhD, MD
Interim Senior Vice President for Health Sciences

March 19, 2007

The Honorable Joe Barton
2109 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Barton:

I would like to take this opportunity to thank you on behalf of Tulane University for allowing us the opportunity to provide testimony before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations on March 13, 2007. Your concern for the situation surrounding health care in the New Orleans region eighteen months after Hurricane Katrina is most reassuring. It is imperative that these hearings result in action that will help us move forward from our present situation toward a health care system that will truly serve the citizens of our region.

As you consider the testimony that you heard, I would urge you to give due consideration to two areas:

- Preservation of graduate medical education for New Orleans two medical schools and area teaching hospitals. Graduate medical education must be in the forefront of healthcare planning and not be left to be dealt with as an afterthought. To this end, we also ask that you convene hearings to review the issues regarding graduate medical education and how it should be addressed in future disaster situations. We also ask that Congress provide additional help to the New Orleans area teaching institutions by funding a time limited grant program to assist teaching institutions in recruiting clinical teaching physicians.

- Providing a mechanism for directly reimbursing physicians who provide care to uninsured individuals until such time as there is a healthcare system in place that can once again provide care to these individuals. Currently, physician costs are not considered an allowable cost and cannot receive reimbursement through the DSH program. It's our understanding that a request to receive federal match to pay phys ician UCC during was requested but not approved.

Health Sciences Center
School of Medicine • School of Public Health and Tropical Medicine • National Primate Research Center
1440 Canal St., Ste. 2400, TW-5, New Orleans, LA 70112-2709 *tel* 504.988.5295 *fax* 504. 988.7357 amiller@tulane.edu
www.tulane.edu

Thank you once again. We have many challenges to overcome that with the support of the American people and leaders such as yourself, we will recover.

Sincerely,

Alan M. Miller, PhD, MD

Cc: Chris Knauer
Peter Spencer

Exhibit No. 9

SCHOOL OF MEDICINE

Department of Medicine
Section of General Internal Medicine and Geriatrics

March 19, 2007

The Honorable Joe Barton
2109 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Barton:

This letter is written to express my gratitude for allowing us the opportunity to provide testimony before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations on March 13, 2007. Your attention to and concern for the critical health care situation in the New Orleans region eighteen months after Hurricane Katrina is most welcomed and reassuring.

As you heard recurrently from the testimony of the front-line providers, we need your help right now to ensure access to primary care for our citizens while we work towards agreement on the long term health policy issues. Specific measures that will be helpful in the short-term include:

1. Increase access to primary care in New Orleans for the uninsured through extending the SSBG deadline and providing bridging resources to the safety-net clinics through remaining Deficit Reduction Act funding

a. Most of these primary care clinics, now medical homes, have been sustained on cobbled together funding from a variety of sources including public funds, such as the Social Services Block Grant (SSBG) funds. On July 31, 2007, the SSBG funding is scheduled to end. For a variety of reasons, there were delays in getting the SSBG funds available to the providers. Fearing that their expenses wouldn't qualify for reimbursement, many clinics have avoided using the SSBG funding instead relying on other resources and on limiting services to their patients. We are now scrambling to spend the money by the deadline for spending all the allocated money. If we do not, the funding will be returned to the federal government. Providers in our community have repeatedly requested an extension of the deadline so that we can more effectively use the federal dollars we've been granted.

b. Please also consider encouraging the United States Secretary of Health and Human Services, Michael O. Leavitt to use discretionary Deficit Reduction Act funds to provide transitional financial support to fund a pilot to assess the impact of a medical home system of care on improving patient health, care quality and lowering overall cost. If successful, we could

transfer these best practices to the rest of our state and potentially the nation. It will also prevent slippage backwards into less efficient and effective forms of care.

2. Provide financial support for clinicians to help with retention and recruitment of primary care and specialty physicians

a. To recruit and retain health care professionals, resources are needed that will pay qualified providers for services, support educational loan repayment and defray malpractice costs. HHS and DHH have been working towards this goal, but the allocated resources are not likely to be enough. Additionally, application processes are complex and time consuming. The busy clinicians in this system need streamlined and accessible mechanisms through which they can apply for the financial support.

b. Payment for services rendered could be accomplished through expansion of coverage and though uncompensated care payments directed at physicians.

We look forward to working with you to ensure that these hearings result in action that will help us provide immediate access to health care for our most vulnerable citizens and move forward from our present support progressive improvements in our health care system that will truly serve the citizens of our region.

Thank you once again. We have many challenges to overcome that with the support of the American people and leaders such as yourself, we will recover.

Regards,

Karen B. DeSalvo, MD, MPH, MSc

Cc: Chris Knauer
Peter Spencer

Exhibit No. 10

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

April 2, 2007

The Honorable Michael O. Leavitt, Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

Dear Secretary Leavitt:

This letter is in response to the recent House of Representatives Subcommittee on Oversight and Investigations hearing on "Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region." The information in this letter draws from presentations made before the Subcommittee, as well as subsequent conversations with most of those individuals who testified and other stakeholders, including the Health Services Recovery Council (HSRC). The HSRC is a coalition of community representatives charged with restoring health services in the most devastated hurricane-impacted parishes. The Council recently prepared a report documenting the need for primary care services in hurricane-affected parishes across the state – this report is attached. I used this report as a guide and many of the items in the report are addressed in the requests below.

From my conversations with many who testified before Congress, identifying the immediate needs in the Orleans region is obvious: maintain and expand primary and behavioral health care capacities; recruit and retain health care professionals; and stabilize graduate medical education. It is clear that there remains an opportunity to meet immediate needs and at the same time build a foundation for an improved delivery system. The following explicitly outlines immediate assistance that is necessary to address the ongoing, critical needs of individuals in the New Orleans region.

A. Primary Care Capacity: Maintaining and expanding primary care capacity is necessary to increase access to services, decrease overcrowding at emergency departments and ensure an ongoing network of care for existing and new populations coming into the area.

Request:

1. Extend current SSBG funding until September 2008. SSBG funds have been key to restoring safety net services, including comprehensive and integrated primary, preventive, and behavioral health care services, for the uninsured and underinsured.
2. Provide operational funding for medical homes of sufficient size and scope to meet the primary care needs of the uninsured population in Region 1 for three years. The cost is estimated at $25 million per year.

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"AN EQUAL OPPORTUNITY EMPLOYER"

3. The State proposes a budget neutral solution to help support the above mentioned primary care sites. In order to support the actual provision of services, the state requests that section 1902(a)(13)(A) be waived to permit the use of DSH for payments for non-hospital and physician services provided to the uninsured. Please let us know what further information you might need in order to act on this waiver request. Requests for state plan amendments will be forthcoming.
4. Expedite pending and future Louisiana FQHC and FQHC look-alike applications, particularly those from the impacted region, to assist in meeting the immediate need for primary care capacity in a structure consistent with the medical home model of care.

B. Workforce Recruitment and Retention: The ability to expand capacity to meet the health care needs in the region is hindered by the lack of available workforce. Fifteen million dollars have been granted to the state to initiate the Greater New Orleans Health Services Corps.

Request:
1. The state requests the funds to fully implement the Greater New Orleans Health Services Corps Program. We estimate that it will cost an additional $105 million to fully implement the program. This will provide for guaranteed income assistance for primary care physicians, dentists, psychiatrists, registered nurses, and licensed professional staff; annual malpractice premium payment relief for physicians and dentists; and incentive payments for physicians, dentists, registered nurses and licensed professional staff. A portion of the fund would be available for use by medical schools for faculty recruitment and for specialists to support the medical homes. In exchange for the financial support, providers must commit to serve in the region for three years.

C. Unreimbursed Hospital Costs: The short supply of health care workforce is resulting in increased competition among providers for professional and non-professional staff. The effect is a significant rise in labor costs, which is not reflected in the prices established by the Medicare fixed payment system. HHS recently awarded Louisiana a $71 million grant for hospitals and skilled nursing facilities to address the increased costs providers are experiencing as a result of the rising labor costs and other unreimbursed costs. While helpful, this one-time grant does not address the entire three-year lag in the Medicare wage index increases.

Request:
1. The state requests full funding for estimated costs related to the Medicare wage index and other unreimbursed hospital costs. Early estimates for two years for the hospitals in the Orleans region were $67 million/year for hospitals and $6.9 million/year for skilled nursing facilities. The state proposes that the federal and state governments and local providers collaborate to determine the most accurate estimate of unreimbursed costs.

D. Graduate Medical Education (GME): Maintaining current graduate medical education programs in Louisiana as well as ensuring the recruitment and retention of medical students and residents is a major issue post-Katrina. Several pre-Katrina teaching sites in the city of New Orleans remain at limited clinical and teaching capacity. In your letter of March 21, 2007 to

Congressmen Stupak and Whitfield, you reaffirmed HHS' commitment to reviewing the GME situation.

Request:

1. We request financial relief for the medical schools and those hospitals which stepped forth to assist residency programs post-Katrina, specifically after the June 30, 2006, expiration of the emergency exemption from the three-year rolling average. Louisiana must secure the flexibility to continue the reallocation of resident slots within the region, to meet program, institutional, and state needs without placing undue financial burden on participating hospitals.

In addition, there remains concern within the GME community regarding allocation of residency positions during this time of flux among training sites and also in anticipation of the next disaster. Post-Katrina residency programs found themselves in the difficult position of needing to ensure an appropriate uninterrupted training experience for residents while decisions on moving slots remained with closed hospitals. Program directors would like the ability to exercise "stewardship" of residency positions for some agreed upon period of time to ensure continuity of training during disruption due to disasters. In an effort to address this, I propose to convene a meeting, within the next 30 days, of the stakeholders of this issue along with your staff to further clarify options.

E. Behavioral Health: The loss of psychiatric care beds in the area post-Katrina and the slow return of the community-based mental health services have exacerbated the lack of access to care and needed services that existed before Katrina.

Request:

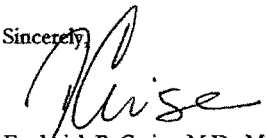
1. Expand the Medicaid eligibility to include those individuals with serious mental illness. This would allow us to provide broader access to services for these individuals as we implement improvements to the behavioral health system.

2. The state also requests support for a five-year redevelopment and mitigation/prevention plan for behavioral health services. This five-year plan, estimated at $32 million per year, would include crisis counseling under the existing FEMA Disaster Relief (1603-LA) grant through November 2008, as well as direct treatment dollars and facility replacement for psychiatric hospital beds, crisis intervention services, suicide prevention programs, substance abuse treatment and long-term ambulatory treatment of psychiatric conditions. This support will allow for the reestablishment and stabilization of a competent mental health system in the greater New Orleans region and other contiguous parishes.

The above requests are interrelated and are not necessarily mutually exclusive. I welcome the chance to follow up on these issues with your staff to refine and determine which financial requests may be funded with DRA funds and which are better pursued through Congress. These discussions would include representation from the hospital community as well as the Health Services Recovery Council where appropriate.

I look forward to working with your staff to discuss these needs and consider how HHS may structure assistance that would be most beneficial to the region in recovering essential service capacity.

Sincerely,



Frederick P. Cerise, M.D., M.P.H.
Secretary

Cc: U. S. Representative Bart Stupak
U. S. Representative Edward Whitfield
U. S. Representative John Dingell

Exhibit No. 11

April 3, 2007

The Hon. Secretary Michael O. Leavitt
United States Department of Health and Human Services
Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Leavitt:

This letter is written by the community members who recently testified to the House Committee on Energy and Commerce Sub-committee on Oversight and Investigations regarding the immediate needs aimed at improving access to care for the citizens of Greater New Orleans while the longer term policy solutions are debated and reconciled. In this letter we reaffirm our top priority areas mentioned at that time and suggest potential solutions that require attention at the federal level. Our intent is for this letter to complement the recent letter submitted by the Louisiana Department of Health and Hospitals.

1. Increase access to primary care for the uninsured in the New Orleans region

There is great demand for primary care services at the community level as evidenced by crowded emergency rooms and pent up demand as evidenced by overcrowded health fair events. The success of the safety-net clinics has dramatically reduced the strain on the city's remaining hospitals, but much of this effort has been funded by ad-hoc charitable efforts that will not maintain these sites until long-term sustainability options can be implemented. If we do not receive bridge relief prior to August 1, 2007, we will face a catastrophic situation for the people we serve and the institutions involved in delivering care while we're waiting for resolution between the state and feds around more fundamental health system redesign.

First, the Social Services Block Grant (SSBG) funding which supports recovery and expansion of primary care services for the uninsured is scheduled to end for the providers July 31, 2007 to meet the federal reporting deadline. This funding has been critical to ensuring access to basic primary care services for a relatively small proportion of those in need. However, the time limit, administrative challenges and cost-reimbursement basis of the funding, coupled with workforce and facility shortages, has severely limited our ability to expand services. We request your support as we ask Congress to pass an extension of the deadline for the SSBG funding for at least one year to avoid the collapse of this our current delivery system.

Second, we ask you to use $100 million of discretionary Deficit Reduction Act (DRA) funds to provide critical bridge support to an open network of safety-net clinics to add additional primary care physicians to serve a total of 100,000 uninsured citizens while the larger policy decisions are discussed. This funding would also support a demonstration project of a medical home system of care to provide critical information needed to help

evaluate the costs of operating such a delivery system prior to implementing broad reform. Moreover, the demonstration could provide an experience base of evidence-based best practices that can be adopted in the rest of our state and across the nation.

Third, we ask that you encourage HHS to allow flexibility on rules related to the expansion of Federally Qualified Health Centers (but with maintaining the statutory governance requirements) and the review, approval and designation of related programs such as "look-alike sites" and the development of alternative community-based health center models.

Fourth, we support the development of a longer term solution for sustainability of a primary care safety-net through state plan amendments or waivers related to the use of Disproportionate Share funds to support non-hospital and physicians services, (eg free standing Rural Health Clinics, Federally Qualified Health Centers and private provider services) for a locally coordinated and administered network plan.

2. Provide the financial support necessary to retain and recruit primary care and specialty physicians and health professionals to Greater New Orleans

Louisiana's health care system cannot recover without the return of a highly trained health care workforce. We therefore request additional federal funds for the state to use to recruit and retain health care professionals and support their practice. These funds should be made available for flexible programs aimed at reimbursing provider's annual medical malpractice premium payments, sign on bonuses, relocation expenses and income guarantees. Although we appreciate the $15 million recently provided to Louisiana for this purpose, the Louisiana Health Care Redesign Collaborative identified last October that the region needs an additional $105 million for these activities.

In addition, individual physicians continue to absorb high rates of uncompensated care and there is currently no federal funding stream to reimburse physicians for these costs. To address this, we request the federal government that Congress and HHS consider creating a mechanism to reimburse for physician services to uninsured individuals until such time as there is a healthcare system in place that can once again provide care to these individuals.

3. Sustain and Support Health Professional and Graduate Medical Education in Greater New Orleans

Temporary measures to preserve this workforce until permanent solutions are implemented are crucial to preserve the pipeline of future physicians and supporting workforce. We want to make you aware that we are requesting hearings in the next 2 months to review the issues regarding graduate medical education and revise regulations to stabilize GME in the New Orleans region and address how GME should be handled in the event of future disasters.

Regarding immediate needs, first we request that you provide greater flexibility in the three-year rolling average for reimbursing public and private hospitals that have taken in house staff following the closure of their home institutions. Also to provide the medical schools, which are responsible for the education and direct expenses related to the training of the displaced residents, with a greater role in the administration of those slots while the original facility remains at a diminished capacity to support these positions. Additionally, although we believe that Centers for Medicare and Medicaid Services (CMS) has administrative authority to address this issue, we have also asked Congress to consider legislation that will finally provide this much-needed relief to teaching hospitals.

Second, we request that CMS allow continued reallocation of residency positions to other facilities for the next several years until the Medical Center of Louisiana at New Orleans is of sufficient capacity to train them.

Third, we have asked that Congress provide additional help to the New Orleans area teaching institutions by funding a time limited grant program to assist teaching institutions in recruiting clinical teaching physicians, nurses, pharmacists and other essential health professional educators.

Finally, the long term capacity of Louisiana to train its future health care workforce will require, among other steps, a permanent teaching hospital to replace the hospital destroyed by Katrina, which was used by both the Louisiana State University and Tulane University Health Science Centers. We request your support for a permanent academic medical center a scale appropriate to meet the teaching and service needs of the region.

4. Provide Relief for Area Hospitals

As a result significant market changes and cost increases since the storm, current Medicare payments are inadequate. The Katrina Healthcare Provider Stabilization Grant authorized earlier this year does not fully address the drastic labor rate increases being absorbed by hospitals in the Greater New Orleans region.

We request that you address this issue through one of two mechanisms in discussion with Greater New Orleans hospitals. The preferred alternative would be to provide cost-based reimbursement similar to "critical access" hospitals. This reimbursement methodology would address the unprecedented increase in the cost for uncompensated care, labor and property and casualty insurance and utilities. A second alternative would be a permanent fix to the Medicare Wage Index now as opposed to October 2009 when the formula catches up with what has happened in our market to address the dramatic increases in the cost of labor.

As previously mentioned, we request that you eliminate via a waiver the three year rolling average for reimbursing public and private hospitals that stepped up to help with Graduate Medical Education through accepting residents for training in their institutions following the closure of their home institutions. Although we believe that CMS has

administrative authority to address this issue, we would like Congress to consider legislation that will finally provide this much-needed relief to teaching hospitals.

In conclusion, we wish to emphasize that these efforts aimed at immediately stabilizing the health system and improving access to care should be transparent, accountable and focused on the Greater New Orleans region given the critical situation of the area. We are also requesting that as much as possible the design, development, and management of these programs involve directly impacted providers and stakeholders.

We face an historic crisis. We are thankful for the time, support, interest and guidance you have given thus far. We are also hopeful that through the ongoing assistance of yourself and your staff, we are on the cusp of reaching realistic solutions to our immediate needs while we work towards agreement on and implementation of the longer term health policy issues.

Sincerely,

Thomas Koehl
Operation Blessing Disaster Relief Medical Center
(Operation Blessing does not request or receive any federal funding for its operations)

Bryan Bertucci, MD
St. Bernard Health Center

Karen DeSalvo, MD
Tulane University Community Health Center at Covenant House

Don Erwin, MD
St. Thomas Community Health Center

Evangeline Franklin, MD
Director, Clinical Services and Employee Health New Orleans Health Department

Gary Wiltz, MD
Region 3 Health Consortium; LPCA Board of Directors: NACHC Secretary

Leslie Hirsch
President and CEO of Touro Infirmary

Patrick Quinlan, MD
CEO of Ochsner Health System

Gary Muller
President and CEO of West Jefferson Medical Center

Alan Miller, MD
Interim Senior Vice President for Health Sciences at Tulane University Health Sciences Center

Kevin U. Stephens, Sr. MD, JD
Director, New Orleans Health Department

Cc: Secretary Fred Cerise
The Louisiana Delegation
Representative John Dingell
Representative Joe Barton
Representative Bart Stupak
Representative Ed Whitfield
Honorable Leslie Norwalk
Chairman Donald Powell

Exhibit No. 12

April 3, 2007

The Honorable John Dingell
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Barton
House Committee on Energy and Commerce
2109 Rayburn House Office Building
Washington, DC 20515

The Honorable Bart Stupak
Chairman
Subcommittee on Oversight & Investigation
House Committee on Energy and Commerce
2352 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ed Whitfield
2411 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Dingell, Ranking Member Barton, Chairman Stupak and Ranking Member Whitfield:

Thank you for providing an opportunity for us to share with the Committee the urgent needs of our community during the recent hearing on "Post-Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region". As you heard from the testimony of the front-line providers and institutions, we need your help right now to ensure access to care for our citizens while we work towards agreement on the longer term health policy issues.

Community members who testified on Panels I and II are submitting this letter to reiterate the essential immediate needs for the Greater New Orleans Health Care community and suggest potential solutions that require attention at the federal level. Our intent is for this letter to complement the recent letter submitted by the Louisiana Department of Health and Hospitals to Secretary Leavitt.

1. Increase access to primary care for the uninsured in the New Orleans region

There is great demand for primary care services at the community level as evidenced by crowded emergency rooms and pent up demand as demonstrated by overcrowded health fair events. The successful emergence and expansion of safety-net clinics the Partnership for Access to Healthcare (PATH) network and other entities has dramatically reduced the strain on the city's remaining hospitals. Much of this effort has been funded by ad-hoc charitable efforts that will not maintain these sites until long-term sustainability options can be implemented. If we do not receive bridge relief prior to August 1, 2007, we will face a catastrophic situation for the people we serve and the institutions involved in delivering care while we're waiting for resolution between the state and federal governments around more fundamental health system redesign.

For the first stage, we need to secure immediate relief in the next 12 months to prevent the collapse of the existing primary care system. For the second stage, we will require multi-year funding to build upon the network and build a transformational medical home system of care while we transition to the future health system.

First, the Social Services Block Grant (SSBG) supplemental funding which supports recovery and expansion of primary care services for the uninsured is scheduled to for the providers July 31, 2007 to meet the federal reporting deadline. This funding has been critical to ensuring access to basic primary care services for a relatively small proportion of those in need. However, the time limit, administrative challenges and cost-reimbursement basis of the funding, coupled with workforce and facility shortages, has severely limited these clinics' ability to expand services. We have asked Congress to pass an extension of the deadline for the SSBG funding until for at least one year to avoid the collapse of this our current delivery system.

Second, we ask you to please encourage the Secretary of Health and Human Services (HHS) to use $100 million of discretionary Deficit Reduction Act (DRA) funds to provide critical bridge support to an open network of safety-net facilities to add additional primary care physicians to serve a total of 100,000 uninsured citizens over the next three years while the larger policy decisions are discussed and rolled out. This funding would also support a demonstration project of a medical home system of care to provide critical information needed to help inform broad reform. Moreover, the demonstration could provide an experience base of evidence-based best practices that can be adopted in the rest of our state and across the nation if fully supported.

Third, we ask that you encourage HHS to allow flexibility on rules related to the expansion of Federally Qualified Health Centers (but with maintaining the statutory governance requirements) and the review, approval and designation of related programs such as "look-alike sites" and the development of alternative community-based health center models.

Fourth, we support the development of a longer term solution for sustainability of a primary care safety-net through state plan amendments or waivers related to the use of Disproportionate Share funds to support non-hospital and physicians services, (eg free standing Rural Health

Clinics, Federally Qualified Health Centers and private provider services) for a locally coordinated and administered network plan.

2. **Provide the financial support necessary to retain and recruit primary care and specialty physicians and health professionals to Greater New Orleans**

Louisiana's health care system cannot recover without the return of a highly trained health care workforce. We therefore request additional federal funds for the state to use to recruit and retain health care professionals and support their practice. These funds should be made available for flexible programs aimed at reimbursing provider's annual medical malpractice premium payments, sign on bonuses, relocation expenses and income guarantees. Although we appreciate the $15 million recently provided to Louisiana for this purpose, the Louisiana Health Care Redesign Collaborative identified last October that the region needs an additional $105 million for these activities.

In addition, individual physicians continue to absorb high rates of uncompensated care and there is currently no federal funding stream to reimburse physicians for these costs. To address this, we request the federal government that Congress and HHS create a mechanism to reimburse for physician services to uninsured individuals until such time as there is a healthcare system in place that can once again provide care to these individuals.

3. **Sustain and Support Health Professional and Graduate Medical Education in Greater New Orleans**

Temporary measures to preserve this workforce until permanent solutions are implemented are crucial to preserve the pipeline of future physicians and supporting workforce and provide critical support to training institutions. Broadly, we ask that you convene hearings in the next 2 months to review the issues regarding graduate medical education and revise regulations to provide long term stability for GME in the New Orleans region and address how GME should be handled in the event of future disasters.

Regarding immediate needs, first we request that you encourage HHS to provide greater flexibility in the three year rolling average for reimbursing public and private hospitals that have taken in house staff following the closure of their home institutions. Also to provide the medical schools, which are responsible for the education and direct expenses related to the training of the displaced residents, with a greater role in the administration of those slots while the original facility remains at a diminished capacity to support these positions. Additionally, although we believe that Centers for Medicare and Medicaid Services (CMS) has administrative authority to address this issue, we would like Congress to consider legislation that will finally provide this much-needed relief to teaching hospitals.

Second, we request that CMS allow continued reallocation of residency positions to other facilities for the next several years until the Medical Center of Louisiana at New Orleans is of sufficient capacity to train them.

Third, we also ask that Congress provide additional help to the New Orleans area teaching institutions by funding a time limited grant program to assist teaching institutions in recruiting clinical teaching physicians, nurses, pharmacists and other essential health professional educators.

Finally, the long term capacity of Louisiana to train its future health care workforce will require, among other steps, a permanent teaching hospital to replace the hospital destroyed by Katrina, which was used by both the Louisiana State University and Tulane University Health Science Centers. We request your support for a permanent academic medical center a scale appropriate to meet the teaching and service needs of the region.

4. Provide Relief for Area Hospitals

As a result of significant market changes and cost increases since the storm, current Medicare payments are inadequate. The Katrina Healthcare Provider Stabilization Grant authorized earlier this year does not fully address the drastic labor rate increases being absorbed by hospitals in the Greater New Orleans region.

We request that you address this issue through one of two mechanisms in discussion with Greater New Orleans hospitals. The preferred alternative would be to provide cost-based reimbursement similar to "critical access" hospitals. This reimbursement methodology would address the unprecedented increase in the cost for uncompensated care, labor and property and casualty insurance and utilities. A second alternative would be a permanent fix to the Medicare Wage Index now as opposed to October 2009 when the formula catches up with what has happened in our market to address the dramatic increases in the cost of labor.

As previously mentioned, we request a waiver of the three year rolling average requirement for reimbursing public and private hospitals that stepped up to help with Graduate Medical Education through accepting residents for training in their institutions following the closure of their home institutions. Although we believe that CMS has administrative authority to address this issue, we would like Congress to consider legislation that will finally provide this much-needed relief to teaching hospitals.

In conclusion, we wish to emphasize that these efforts aimed at immediately stabilizing the health system and improving access to care should be transparent, accountable and focused on the Greater New Orleans region given the critical situation of the area. We are also requesting that as much as possible the design, development, and management of these programs involve directly impacted providers and stakeholders.

Since the hearings, there has been improved dialogue with our federal partners which is encouraging. Though we face an historic crisis, we are thankful for your continued interest and

guidance and hopeful that through the ongoing assistance of the Sub-Committee, we are on the cusp of reaching realistic solutions to meeting the short term health needs of our population.

Sincerely,

Thomas Koehl
Operation Blessing Disaster Relief Medical Center
(Operation Blessing does not request or receive any federal funding for its operations)

Bryan Bertucci, MD
St. Bernard Health Center

Karen DeSalvo, MD
Tulane University Community Health Center at Covenant House

Don Erwin, MD
St. Thomas Community Health Center

Evangeline Franklin, MD
Director, Clinical Services and Employee Health, New Orleans Health Department

Gary Wiltz, MD
Region 3 Health Consortium; LPCA Board of Directors; NACHC Secretary

Leslie Hirsch
President and CEO of Touro Infirmary

Patrick Quinlan, MD
CEO of Ochsner Health System

Gary Muller
President and CEO of West Jefferson Medical Center

Alan Miller, MD
Interim Senior Vice President for Health Sciences at Tulane University Health Sciences Center

Kevin U. Stephens, Sr. MD, JD
Director, New Orleans Health Department

Cc: The Hon. Secretary Michael O. Leavitt
Secretary Fred Cerise
Louisiana Delegation
Honorable Leslie Norwalk
Chairman Donald Powell

Exhibit No. 13

KATHLEEN BABINEAUX BLANCO
GOVERNOR

CHAIRMAN
NORMAN C. FRANCIS

VICE CHAIRMAN
WALTER ISAACSON

MEMBERS
REV. HARRY BLAKE
DONALD "BOYSIE" BOLLINGER
KIM M. BOYLE
DONNA L. BRAZILE
JOHN BREWSTER
TIMOTHY P. COULON
RENE P. CROSS
JAMES E. DAVISON
DONNA D. FRAICHE
THOMAS G. HENNING
SIBAL S. HOLT
ALEX JOHNSON
LINDA M. JOHNSON
JOHN T LANDRY
WALTER J. LEGER, JR.
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DAVID RICHARD
VIRGIL ROBINSON, JR.
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REP. YVONNE DORSEY
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EXECUTIVE DIRECTOR
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LOUISIANA RECOVERY AUTHORITY
150 NORTH 3RD STREET, STE 200
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April 25, 2007

Mr. Alphonso Jackson
Secretary, U.S. Department of Housing
and Urban Development
451 7th Street SW, Room 10000
Washington, DC 20410

Mr. R. James Nicholson
Secretary, U.S. Department
of Veterans Affairs
810 Vermont Ave. NW
Washington, DC 20420

Dear Secretary Jackson and Secretary Nicholson:

Let us first thank you both for your personal commitments, and the commitments of your respective departments, to the swift and successful recovery of Louisiana from the most crippling disasters in our nation's history.

We are writing today to urge Secretary Jackson to immediately approve Louisiana's Action Plan Amendment 3 to Action Plan 2 (APA3), which provides the necessary funding for land acquisition and initial construction costs for the building of a new academic medical center in downtown New Orleans. We also urge Secretary Nicholson to accept the state's subsequent purchase of land for the medical center as Louisiana's commitment to the LSU-VA hospital collaboration, and to state unequivocally that the VA will be our partner in locating its new facility on this site, as together we build an exciting and unprecedented medical complex to serve our citizens and advance our recovery.

As you both know, the proposed LSU-VA medical centers will anchor the emerging biosciences and medical corridor in downtown New Orleans. The joint venture represents a recovery project that has no peer.

The Unified New Orleans Plan, a comprehensive guide to high priority recovery programs and projects to repair and rebuild the city over the next decade, highlights the significance of the proposed teaching hospital to the recovery of downtown New Orleans. The Plan identifies 91 programs or projects that promote the city's recovery; the downtown medical center and the restoration of affordable housing stock are the only two given perfect scores based on their value to recovery and breadth of impact on the region.

The Louisiana Recovery Authority has consistently recognized the importance of the hospital to the region's revival. During our negotiations with Chairman Powell for additional Community Development Block Grant allocations and the subsequent development of our action plans, the LRA has maintained a commitment to reserving $300 million for the new facility. That commitment translated into action when the LRA board, Governor Blanco and the Louisiana Legislature approved the allocation of $300 million in CDBG funds via APA3.

The opportunity to build the new LSU teaching hospital in conjunction with the planned VA medical center is one of the factors driving support for the project. Secretary Nicholson, we congratulate you and your staff for the foresight you have shown in pursuing a partnership with LSU that will yield considerable benefit for taxpayers and patients for decades to come.

Regrettably, we have heard questions raised about the status of that partnership in recent weeks. Let us reiterate that Governor Blanco's submission of APA3, with overwhelming legislative support, confirms the state's full commitment to the joint medical center project.

The proposal outlined in APA3 divides the $300 million CDBG allocation into two phases for state expenditure.

An initial allocation of $74 million is designated for land acquisition and architectural and engineering design. The state is poised to commence land acquisition as soon as HUD approves the proposal.

The remaining $226 million, for completion of design work and construction start-up, will be reserved until the Louisiana State Office of Facility Planning and Control (OPFC) has undertaken the following steps, this first two of which have been done:

1. Completed the business plan and feasibility study for the new medical center;
2. Submitted the business plan to the LRA board for review; and
3. Received approval of the business plan by the Joint Legislative Committee on the Budget and the full legislature.

As you are aware, state policymakers are engaged in a very appropriate debate about the business plan produced by OPFC. The LRA will continue to be an active participant in this debate, and we strongly believe that this discussion is as important to our state's future as the new medical center is to the recovery of the New Orleans region.

It is critical, however, to understand the nature of the debate. It is not a debate about whether to build a new academic medical center in downtown New Orleans or about whether to partner with the VA. The decisions to build a hospital and collaborate with the VA have been settled by the actions of the Governor and the Legislature, and they have tremendous public support.

Rather, the ongoing debate is about how the state should deliver and pay for health care for uninsured citizens and how that might influence the size and scope of the proposed university hospital in New Orleans. Because the closed Charity Hospital has long been the primary source of care for the uninsured, the new medical center's business plan—and its projections of bed size, payer mix and scope of services—are important factors to consider as formal design work on the hospital takes place over the next several months.

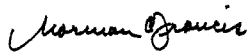
But this very healthy debate should not be interpreted by HUD as uncertainty about whether the state intends for $300 million in CDBG funds be used for a new hospital. Nor should it be interpreted by the VA as representing any hesitation regarding the joint venture. Instead, the debate represents the very important public discussion regarding how we build an efficient and effective hospital for our citizens, community and state.

So let me reiterate what Governor Blanco and the Louisiana Legislature have stated by their actions: Louisiana is committed to the building of a new academic medical center in downtown New Orleans and to the LSU-VA partnership.

Now we ask that each of you do your part to move this process forward—Secretary Jackson by immediately approving APA3, and Secretary Nicholson by stating clearly the VA's intent to be our partner in downtown New Orleans.

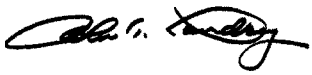
Thank you for your attention to this important component of the recovery. We look forward to continuing our work together on behalf of the citizens of Louisiana.

Sincerely,



Norman C. Francis
Chairman

Kim Boyle
Chair, Health Care Committee



John T. Landry
Chair, Infrastructure Task Force

Donna Fraiche
Chair, Long-Term Community Planning Task Force

Exhibit No. 14

Office of the President

May 3, 2007

The Honorable James Nicholson
Secretary
US Department of Veteran Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Nicholson,

Tulane University strongly endorses the site proposed by the City of New Orleans for a new VA hospital in the downtown medical district of New Orleans. This downtown site is backed by government and business leaders throughout the region including the leadership of the seven parishes that comprise the Regional Planning Commission. The inclusion of the VA hospital in the medical district is considered a major building block in the economic redevelopment of downtown New Orleans.

This site will best serve the patients and employees of the VA hospital as well as the clinical care and medical education mission of the hospital. The downtown site is convenient to public transportations, a major interstate highway, hotels and restaurants all of which provides benefit and convenience to VA patients and employees. Since the reopening of the downtown VA clinics, patients have returned in large numbers and are anxious to be able to once again receive their inpatient services in the downtown area.

The New Orleans VA is a dean's committee hospital of both Tulane and LSU Medical Schools. The downtown site is proximal to both of those medical schools. Tulane University School of Medicine faculty and staff have traditionally provided the majority of the medical care at the New Orleans VA and the VA patients recognize them as "their doctors". To date, no one associated with any sites other than the downtown site has consulted with Tulane regarding the location and how it would impact Tulane's ability to continue to provide medical education and clinical services at those sites. Tulane University has been and will continue to be dedicated to providing the highest quality medical care to the veterans of our nation.

Thank you for your years of service to the country and dedication you've shown to the recovery of care for Veterans in the Gulf Region. We strongly believe that this can best be accomplished at the proposed downtown site and we appreciate your continued consideration of these critical issues.

Sincerely,

Scott S. Cowen
President

Alan M. Miller, Ph.D., M.D.
Interim Senior Vice President

6823 St Charles Avenue, New Orleans LA 70118-5698 tel 504.865.5201 fax 504.865.5202 www.tulane.edu

Exhibit No. 15

GREATER NEW ORLEANS HEALTHCARE COMMUNITY STAKEHOLDERS

July 10, 2007

The Honorable Bart Stupak
Chairman
Subcommittee on Oversight & Investigation
House Committee on Energy and Commerce
2352 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Bart Stupak:

We are writing to thank the Sub-Committee for your assistance in acquiring support for some of the short term needs of the Greater New Orleans healthcare community. Since the hearings of March 2007, we have seen progress that will lead to immediate improvements in access to care for our most vulnerable populations.

There has been funding for Federally Qualified Health Centers in the Greater New Orleans area, and on May 24, 2007, Health and Human Services (HHS) Secretary Michael Leavitt announced the distribution of the residual $195 million of funds from the Deficit Reduction Act (DRA), of which $161 million will aid New Orleans. As you know, HHS allocated a significant portion of these resources, $100 million, for primary care access and stabilization which was a direct response to our requests for assistance in the community letter to HHS dated April 3, 2007. There was another $35 million in support for the recruitment and retention of physicians. Hospitals received $26 million in support, a step towards providing relief for their acute financial situation. These additional funds will help us to serve the needs of thousands more patients in the New Orleans region while we work towards additional near-term solutions to our healthcare crisis such as needed assistance for hospitals, graduate medical education and physicians.

We remain committed to the vision of a new model of healthcare in our region. This will require a systemic change as the healthcare system is rebuilt rather than recreating the structure that existed before Hurricane Katrina. By addressing the Primary Care Clinic portion of the continuum of care in Orleans and Jefferson Parishes, patients will now have access to care that previously was not available. We ask you to also focus additional resources on the Orleans and Jefferson hospitals and physicians that will be the primary specialty and acute care facilities and providers for many years to come. Current data show that the acute care part of the system is under-funded due to the increased volume of the uninsured and patients covered by Medicaid and Medicare, as well as unprecedented increases in the cost of labor, insurance and utilities. This is consistent with the testimony of hospital executives at the prior Energy and Commerce Sub-Committee on Energy and Oversight Hearing in Washington, DC in March 2007.

We know that you are aware of the continuing health care crisis that our community faces and appreciate the intense attention we have received from the Sub-Committee, including the

planned summer hearings. We look forward to our continued dialogue and combined efforts to stabilize and restore the healthcare in the New Orleans region while we work to ensure the short- and long-term sustainability of the health care system in Greater New Orleans as we rebuild this great American city.

Regards,

Karen DeSalvo, MD
Tulane University Community Health Center at Covenant House

Gary Muller
President and CEO of West Jefferson Medical Center

Bryan Bertucci MD
Bryan Bertucci, MD
St. Bernard Health Center

Don Erwin, MD
St. Thomas Community Health Center

Evangeline Franklin, MD, MPH
Director, Clinical Services and Employee Health, New Orleans Health Department

Gary Wiltz, MD
Region 3 Health Consortium; LPCA Board of Directors; NACHC Secretary

Leslie Hirsch
President and CEO of Touro Center

Kevin U. Stephens, Sr. MD, JD
Director, New Orleans Health Department

Alan M. Miller, PhD, MD
Interim Senior Vice President for Health Sciences at Tulane University

Patrick Quinlan, MD
CEO of Ochsner Health System

Cc: The Hon. Secretary Michael O. Leavitt
Secretary Fred Cerise
The Louisiana Delegation
Representative John Dingell
Representative Joe Barton
Representative Ed Whitfield
Honorable Leslie Norwalk
Chairman Donald Powell

Exhibit No. 16

GREATER NEW ORLEANS HEALTHCARE COMMUNITY STAKEHOLDERS

July 10, 2007

The Hon. Secretary Michael O. Leavitt
US Dept of Health and Human Services
Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

The Honorable Secretary Leavitt:

We are writing to thank you for your timely response to our letter of April 3, 2007, requesting support for some of the short term needs of the Greater New Orleans healthcare community. We are pleased that HHS emphasized primary care access, retention and recruitment of providers and Medicare funding shortfalls for existing hospital facilities as a bridge to the future. We will work to live up to your expectations and make the most of the grant resources in an efficient and effective way.

In particular, the guidance provided to Louisiana officials by the U.S. Department of Health and Human Services (HHS) with regard to the support of the Federally Qualified Health Centers and the distribution of funds from the Deficit Reduction Act (DRA) was responsive to our requests for assistance. The community has repeatedly placed a priority on emphasizing primary care in the rebuilding of the New Orleans health care system in local planning efforts.

We remain committed to the vision of a new model of healthcare in our region. This will require a systemic change as the healthcare system is rebuilt rather than recreating the structure that existed before Hurricane Katrina. By addressing the Primary Care Clinic portion of the continuum of care in Orleans and Jefferson Parishes, patients will now have access to care that previously was not available. We ask you to also focus additional resources on the Orleans and Jefferson hospitals and physicians that will be the primary specialty and acute care facilities and providers for many years to come. Current data show that the acute care part of the system is underfunded due to the increased volume of uninsured, Medicare and Medicaid patients, as well as unprecedented increases in the cost of labor, insurance and utilities.

We look forward to continuing to work with you and other federal officials to find short-term relief and ensure the long-term sustainability of the health care system in Greater New Orleans as we rebuild this great American city.

With Regards,

Karen DeSalvo, MD
Tulane University Community
Health Center at Covenant House

Gary Muller
President and CEO of West Jefferson
Medical Center

Bryan Bertucci, MD
St. Bernard Health Center

Don Erwin, MD
St. Thomas Community Health Center

Evangeline Franklin, MD, MPH
Director, Clinical Services and Employee
Health, New Orleans Health Department

Gary Wiltz, MD
Region 3 Health Consortium; LPCA Board
of Directors; NACHC Secretary

Leslie Hirsch
President and CEO of Touro Infirmary

Kevin U. Stephens, Sr. MD, JD
Director, New Orleans Health Department

Alan M. Miller, PhD, MD
Interim Senior Vice President for Health
Sciences at Tulane University

Patrick Quinlan, MD
CEO of Ochsner Health System

Cc: Secretary Fred Cerise
The Louisiana Delegation
Representative John Dingell
Representative Joe Barton
Representative Bart Stupak
Representative Ed Whitfield
Honorable Leslie Norwalk
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