The Honorable Bart Stupak

"Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region

March 13, 2007

It has now been over a year and a half since Hurricane Katrina touched land on August 29, 2005. Nearly a year ago, this Subcommittee held a hearing in New Orleans to examine public health care conditions in the region. What we found then was a system overwhelmed with far more patient demand than capacity. Since that time, this Committee has continued to monitor and assess the ongoing health care needs faced by those in the Katrina region. A few weeks ago, our majority and minority Committee staff returned from the area to report on where health care stands today. Unfortunately, what our staffs found is that much of the region's health care infrastructure still remains crippled and major problems remain unresolved.

In the four worst-hit parishes of Orleans, Plaquemines, Jefferson, and St. Bernard, the loss of hundreds of thousands of homes and the closure of many healthcare facilities displaced thousands of physicians, mental health providers, nurses, dentists, optometrists, lab technicians, and other allied health professionals. While estimates are that approximately half of the city's former residents have returned, it appears that many of those previously employed in the health care sector have found work elsewhere and may not come back. Medical specialists and support staff are in high-demand in other parts of the country. This demand continues to place significant pressure on New Orleans' outpatient clinics and hospitals to attract needed medical personnel. At the same time, the region has experienced an influx of construction workers and day laborers, who often lack insurance.

Key hospital facilities remain destroyed or closed. The flagship hospital for the State-run public health system in downtown New Orleans was known as "Big Charity". Big Charity was the predominant source of health care for the large percentage of poor and uninsured. It will never reopen in the old building and the path to building a new hospital is littered with controversy and obstacles. In addition, privately-owned Methodist Hospital and Chalmette Medical Center – which provided hospital services for residents east of the city – are closed. This is what those two hospitals look like today (show photos).

Hospitals that were able to remain open during the storms, or have since reopened, continue to struggle with critical staffing shortages, rapidly spiraling costs, and inadequate and delayed reimbursement. These challenges are compounded as they treat New Orleans' poor and uninsured who were previously provided for by Big Charity.

Many of today's witnesses have made tremendous personal sacrifices to help their community and its medical infrastructure recover while they cope with the loss of their own homes and neighborhoods as well. Along the way they have forged many new and innovative partnerships. Their courage and heroism is an inspiration to all of us.

It is clear, however, that there is so much more to be done – and soon. Our hearing today will focus on what the health care providers believe are the most urgent health care issues that need to be address in the short term.

For example, as debate continues about when, where, how big, or even whether to rebuild a new "Charity" hospital in New Orleans, there is no consensus on how to cost-effectively deal with the growing number of uninsured or under-insured patients now flooding the region. Many who were once able to rely on Charity hospital must now turn to either University hospital -- which has only 100 beds -- or travel to other parts of the state for treatment at one of the State's other public hospitals. Traveling for health care is impractical for many residents, particularly given the transportation problems still plaguing the State. Others are seen by the region's private hospitals. However, aside from loading an uninsured person with complications from diabetes into an ambulance and delivering him or her to an emergency room – the most expensive avenue for treatment -- there is no other way to allow an uninsured patient to easily access private care.

Because Louisiana state law has directed that the bulk of the Medicaid Disproportionate Share (DSH or "Dish") dollars go to the State's public healthcare system, significant challenges remain about how to allow the uninsured access to existing capacity while providing fair compensation to the doctors and hospitals that provide the care. Given that "Big Charity" is no longer viable -- and won't be for at least five to seven years – access to health care for the uninsured and poor must be resolved. And while we must find a way to compensate those private hospitals that are currently providing care, we must also ensure that private hospitals shoulder the full spectrum of the uncompensated care patients -- not just the healthiest. All this must be done in a way that is reasonably fair to both the institution and the taxpayers.

Another area that must be addressed immediately involves the many out-patient clinics now providing critical "safety net" care. Many of these clinics -- including those that make up the PATH network -- are seeing patients that otherwise would have little or no access to health care services. These clinics are filling critical health care where there was once a public hospital and clinic system. They also provide ambulatory and preventive care that would otherwise require an expensive trip to an emergency room.

Nonetheless, more needs to be done to integrate these important health care providers into the existing hospital structure and reimbursement structure. For example, if somebody with

complications from diabetes shows up at a smaller primary care clinic, there is no formal way to refer him or her to the surrounding hospitals -- particularly a private hospital -- other than placing the patient in an ambulance and sending them to the emergency room. If the patient is under or uninsured, this makes the effort even more daunting. As these clinics are often working on small budgets comprised of donations and small grants, a formal mechanism to reimburse them for the care they provide must be explored. These clinics will play a significant role in providing care for the region's poor for the foreseeable future.

Another area that needs immediate attention is the State's ability to train its own health care providers. The New Orleans region was a significant training center for the State's future doctors, nurses, and other health care practitioners. Since both of the primary teaching facilities – the Veterans hospital and Big Charity were destroyed -- the region's two medical schools -- LSU and Tulane -- have struggled to keep their teaching programs together. And while LSU and Tulane have managed to hold many of their programs together by placing their students around the region in other hospitals, this stopgap measure will only last so long. As reported to this Committee by officials from both medical schools, key programs have already lost accreditation, and others are now threatened. Shoring up the region's medical schools and teaching facilities is of significant urgency – and this alone will be a daunting task. A solid plan must be developed to LSU and Tulane can continue to train much needed health care professionals.

I want to talk for a minute here about the model that has been used so far to attempt to address some of the rather daunting health care challenges that have faced the region post-Katrina. Last year, the Secretary of HHS asked the State to come up with a plan to fix the region's health care infrastructure, including some of the issues I just raised. That process became what is generally referred to as the "Collaborative" and is a very important chapter in the State and Federal government's response to the region's post-Katrina health care needs.

The "Collaborative" brought together a vast array of stakeholders – private and public, local and state – to find ways to restructure the health care delivery system for the area most affected by the storm. This area, referred to as "Region 1" encompasses Orleans, Jefferson, St. Bernard and Plaquemines parishes. While many of the participants in the Collaborative had significant differences of opinion, they worked hard to achieve consensus on some major points. Last October, the Governor submitted the Collaborative plan to the Department of Helath and Human Services (HHS). But what came back from HHS just a few weeks ago appears to be a proposal that is very different in both size and scope than what the State sent to HHS. Instead of working on the various points of consensus and rolling out a pilot plan for Region 1, HHS answered with a plan to replace Louisiana's State-wide public hospital system with what appears to be an insurance model.

Putting aside the viability of HHS' plan, or one's views on the State's public healthcare system, HHS' plan may simply be too ambitious at this point in the recovery process. Applying just some of the concepts of the Collaborative merely to Region 1 would be difficult enough. But having Louisiana implement a sweeping state-wide redesign of its complex, publicly-funded hospital system may simply be unworkable in the current environment. While HHS may have

good intentions in this effort, much smaller bites at this apple must be taken if we are going to provide access to health care in New Orleans.

Unfortunately, the State and the Federal government now appear to be at an impasse. Instead of breaking off pieces of a complex health care system and forging ahead with ways to solve each piece, I fear that the State and Federal government will become locked into a colossal fight of dueling spreadsheets and armies of actuaries. Answering the question whether HHS' proposal can work or would instead obliterate the safety net for hundreds of thousands of low income residents across the whole State -- as Louisiana's Secretary of Health and Hospitals now suggests -- seems less important than the amount of time and energy that will be expended in this fight. Perhaps rather than a "one size fits all" plan, the Secretaries of Health for both the State and the Federal government should attempt to address smaller portions of this problem and provide health care to all citizens in Region 1.

There is an old African proverb that goes something like this: "When elephants fight, it is the grass that suffers."

I am afraid that is where the New Orleans region finds itself with health care today. Tremendous energy has already gone into attempting to solve the health care needs of the region. My admiration goes out to all of the witnesses that are in this room today: Those representing the small clinics, those representing the public and private hospitals, and those representing both the State of Louisiana and Federal government. Each of you has greatly contributed to keeping this region alive through your creativity and your countless hours if service. Nonetheless, I fear that if you do not find new ways to work through these issues – soon – the health care situation in the region may grow worse.

Let me be clear as to why you are here today. This hearing is not about pointing fingers nor is it about attacking one another. I understand that many of you have very valid philosophical differences about how to get the job done. But frankly, you have all worked too hard to allow this ongoing effort to devolve into a bitter exercise of blaming one another for poor choices. Instead, I challenge you to use today's hearing as an opportunity to seek common ground. I am looking forward to hearing from each of you about what problems you think need immediate focus, and some proposals for ways we might be able to work together -- the Congress, the Executive Branch, State and local government, private and public providers -- to address the health care needs of your region. Too many lives are counting on your collective efforts and I intend to do my best to use this Committee to play our small part.

Let me conclude by again thanking every single witness that will be testifying today. Many of you have undertaken great expense to be here and have left your practices of providing needed health care to the region to be here. Your input and your willingness to be here is both commendable and appreciated by us and the people of the New Orleans region. Let my also thank my colleagues on the other side of the aisle. Mr. Whitfield, you and many of our colleagues on this dais, have been particularly gracious with your time and attention to this matter. Moreover, I want to thank your staff for the excellent input they have provided into this

inquiry. We look forward to working with all of you as we continue to stay involved in this critical matter.