HEARING ON THE LACK OF HOSPITAL EMERGENCY SURGE CAPACITY: WILL THE ADMINISTRATION'S MEDICAID REGULATIONS MAKE IT WORSE? DAY ONE

Monday, May 5, 2008

House of Representatives,

Committee on Oversight and

Government Reform,

Washington, D.C.

Committee Hearings

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The committee met, pursuant to call, at 10:00 a.m., in Room 2154, Rayburn House Office Building, Hon. Henry A. Waxman [chairman of the committee] presiding.

Present: Representatives Waxman, Watson, Norton, Shays, Issa, and Bilbray.

Staff Present: Phil Barnett, Staff Director and Chief Counsel; Karen Lightfoot, Communications Director and Senior Policy Advisor; Andy Schneider, Chief Health Counsel; Sarah Despres, Senior Health Counsel; Steve Cha, Professional Staff

Member; Earley Green, Chief Clerk; Carren Audhman, Press Assistant; Ella Hoffman, Press Assistant; Leneal Scott, Information Systems Manager; Kerry Gutknecht, Staff Assistant; William Ragland, Staff Assistant; Larry Halloran, Minority Staff Director; Jennifer Safavian, Minority Chief Counsel for Oversight and Investigations; Christopher Bright, Minority Professional Staff Member; Jill Schmaltz, Minority Professional Staff Member; John Cuaderes, Minority Senior Investigator & Policy Advisor; Benjamin Chance, Minority Professional Staff Member; Ali Ahmad, Minority Deputy Press Secretary; and Todd Greenwood, Minority Professional Staff Member.

Chairman WAXMAN. The meeting of the committee will please come to order. Today we're holding the first of 2 days of hearings on the impact of the administration's Medicaid regulations on hospital emergency surge capacity, the ability of hospital emergency rooms to respond to a sudden influx of casualties from a terrorist attack.

The committee held a hearing in June of 2007 on the Nation's emergency care crisis. We heard from emergency care physicians that America's emergency departments are already operating over capacity. We're warned that if the Nation does not address the chronic overcrowding of emergency rooms their ability to respond to a public health disaster or terrorist attack will be severely jeopardized.

The Department of Health and Human Services was represented at that hearing, but despite the warnings the Department has issued three Medicaid regulations that will reduce Federal funds to public and teaching hospitals by tens of billions of dollars over the next 5 years. The committee held a hearing on these and other Medicaid regulations in November of 2007. An emergency room physician told us that if these regulations are allowed to go into effect, the Nation's emergency rooms will take a devastating financial hit.

The two hearings that we will be holding this week will focus on the impact of these Medicaid regulations on our

capacity to respond to the most likely terrorist attack, one using bombs or other conventional explosives.

Today we will be hearing from an independent expert on terrorism, an emergency room physician, a trauma surgeon, a nurse with expertise in emergency preparedness, and a State official responsible for planning for disasters like a terrorist attack.

On Wednesday, we'll hear testimony from the two Federal officials with lead responsibility for Homeland Security and for Medicaid, the Secretary of Homeland Security, Michael Chertoff, and the Secretary of Health and Human Services, Michael Leavitt.

In preparation for this hearing the committee majority staff conducted a survey of emergency room capacity in five cities considered at greatest risk of a terrific attack, Washington, D.C., New York, Los Angeles, Chicago and Houston, as well as Denver and Minneapolis, where the nominating conventions will be held later this year. The survey took place on Tuesday, March 25 at 4:30 in the afternoon. Thirty-four Level 1 trauma centers participated in the survey.

What the survey found was truly alarming. The 34 hospitals surveyed did not have sufficient ER capacity to treat a sudden influx of victims from a terrorist bombing. The hospitals had virtually no free intensive care unit beds

to treat the most seriously injured casualties. The hospitals did not have enough regular inpatient beds to handle the less seriously injured victims.

The situation in Washington, D.C. and Los Angeles was particularly dire. There was no available space in the emergency rooms at the main trauma centers serving Washington, D.C. One emergency room was operating at over 200 percent of capacity. More than half the patients receiving emergency care in the hospital had been diverted to hallways and waiting rooms for treatment.

And in Los Angeles three of the five Level 1 trauma centers were so overcrowded that they went on diversion, which means they closed their doors to new patients. If a terrorist attack had occurred in Washington, D.C. or Los Angeles on March 25 when we did our survey, the consequences could have been catastrophic. The emergency care systems were stretched to the breaking point and had no capacity to respond to a surge of victims.

Our investigation has also revealed what appears to be a complete breakdown in communications between the Department of Homeland Security and the Department of Health and Human Services.

In October of 2007, the President issued Homeland Security Directive No. 21. The directive requires the Secretary of HHS to identify any regulatory barriers to

public health and medical preparedness that can be eliminated by appropriate regulatory action. It also requires the Secretary of HHS to coordinate with the Secretary of DHS to ensure we maintain a robust capacity to provide emergency care. Yet when the committee requested documents reflecting an analysis of the potential implications of the Medicaid regulations on hospital emergency surge capacity, neither department was able to produce a single document.

This is incomprehensible. It appears that Secretary Leavitt signed regulations that will take hundreds and millions of dollars away from hospital emergency rooms without once considering the impact on national preparedness. And it appears that Secretary Chertoff never raised a single objection.

The Department of Health and Human Services was represented at the committee's June 2007 hearing on emergency care crisis. The importance of adequate Federal funding for emergency and trauma care was repeatedly stressed by the expert witnesses at the hearing. If Secretary Leavitt approves the Medicaid regulations without considering their impact on preparedness and consulting with Secretary Chertoff, that would be a shocking and inexplicable breach of responsibilities.

The most damaging of the administration's Medicaid regulations will go into affect on May 26th, just 3 weeks

from today. As the House voted overwhelmingly, the regulation should be stopped until their true impacts can be understood. I don't know whether the House legislation will pass the Senate or, if it does, whether the bill will survive a threatened presidential veto. But I do know that Secretary Leavitt and Secretary Chertoff have the power to stop these destructive regulations from going into effect. And I intend to ask them whether they will use their authority to protect hospital emergency rooms.

The Federal Government has poured billions of dollars into homeland security since the 9/11 attack, as investigations by this committee have documented much of this investment was squandered on boondoggle contracts. This was evident after Hurricane Katrina when our capacity to respond fell tragically short.

The question we will be exploring today and on Wednesday is whether a key component of our national response hospital emergency rooms will be ready when the next disaster strikes.

I want to recognize Mr. Shays. He is acting as the ranking Republican for today.

[The information follows:]

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Mr. SHAYS. Thank you, Mr. Chairman. I appreciate, Chairman Waxman, your calling today's hearing to review the relationship between emergency medical surge capacity and Medicaid reimbursement policies. The sad reality we must contend with every day is the need to be ready for that one horrible day when terrorism sends mass casualties to an already overburdened medical system.

Medicaid reimbursement policies may need to change to better support large urban emergency and trauma centers, but those changes alone will never assure adequatesurge capacity. We cannot afford to build and maintain idle trauma facilities waiting for the tragic day we pray never comes when they will be needed.

In 2004, 10 terrorist bombs exploded simultaneously on commuter trains in Madrid, Spain, killing 177 people and injuring more than 2000. The nearest hospital had to absorb and care for almost 300 patients in a very short time.

In the event of a similar attack here our hospitals will be tasked with saving the greatest number of lives while confronting a large surge of patients and coping with the wave of the worried well. Many will arrive suffering injuries not typically seen in emergency departments. Medical staff will be facing the crisis with imperfect information about the causes and scope of the event and under severe emotional stress. To reduce the stress and treat mass

casualties effectively decisions need to be made, resources allocated, and communication established now, not during the unexpected but perhaps inevitable catastrophic event.

Today's hearing is intended to focus on a single aspect of emergency preparedness, Federal reimbursement policies and their implications for Level 1 trauma centers in major metropolitan areas.

I appreciate Chairman Waxman's perspective on the administration's proposed Medicaid regulation changes and join him in voting for a moratorium on their implementation. But I am concerned that a narrow focus on just one component of medical preparedness risks oversimplifying the far more complex realities the health system will face when confronting a catastrophic event.

Stabilizing Medicaid payment policies alone won't guarantee readiness against bombs or epidemics any more than an annual cost to assure people they're safe against inflation or recession. It is a factor to be sure, but not the sole or even the determinative element to worry about when disaster strikes.

We should not miss this opportunity to address the full range of interrelated issues that must be woven together to build and maintain a prepared health system. That being said, there is no question emergency departments are overcrowded, often are understaffed and operating with

strained resources on a day-to-day basis. Ambulances are often diverted to distant hospitals and patients are parked in substandard areas while waiting for an inpatient bed.

In 2006, the Institutes of Medicine, IOM, found few financial incentives for hospitals to address emergency room overcrowding. Admissions from emergency departments are often the lowest priority because patients from other areas of the hospital generate more revenue. This is not to disparage hospitals. They operate on tight margins and must navigate challenging, often perverse financial incentives, including Federal reimbursement standards. Strong management, regional cooperation and greater hospital efficiencies offer some hope for alleviating the strain on emergency departments, but during a catastrophic event bringing so-called surge capacity online involves very different elements.

In a mass casualty response regional capacity is more important than any single hospital capability. Hospitals that normally compete with each other need to be prepared to share information about resources and personnel. They need to agree beforehand to cancel elective surgeries, move noncritical patients and expand beyond the daily triage and intake rates.

Unlike daily operations, surge and emergency response requires interoperable and backup communication systems,

interoperable and backup communication systems, altered standards of care, unique legal liability determinations and transportation logistics. Should regional resources or capacity prove inadequate, State assets will be brought to bear. Available beds and patients will need to be tracked in realtime so resources can be efficiently and effectively matched with urgent needs. Civilian and even military transportation systems will have to be coordinated. If needed, Federal resources and mobile units will be integrated into the ongoing response. All of these levels and systems have to fall into place in a short time during a chaotic situation.

So it is clear daily emergency department operations are at best an indirect and imperfect predictor of emergency response capabilities. The better approach is for local, State and the Federal Governments to plan for mass casualty scenarios and exercise those plans. That way specific gaps can be identified and funding can be targeted to address disconnects and dysfunctions in the regional response. Fluctuating per capita Medicaid payments probably will not and often cannot be used to fund those larger structural elements of surge capacity.

Today's hearing can be an opportunity to evaluate all the elements of emergency medical preparedness. We value the expertise our witnesses bring to this important discussion,

and we look forward to their testimony.

Chairman WAXMAN. Thank you very much. Mr. Shays.

While the rules provide for just the chairman and the ranking member to give opening statements, I do want to give an opportunity for the two other members that are with us to make any comments they wish to make.

Ms. Watson.

Ms. WATSON. Thank you very much, Mr. Chairman the Los Angeles County board of supervisors visited Capitol Hill last week. And the number one theme that continued to surface in my conversations with many of the supervisors was the widening gap between the demand for Medicare/Medicaid assistance and the administration's new regulations that will limit the amount of Medicaid/Medicare reimbursement to the State.

The administration estimates that the total fiscal impact of the regulatory changes of 15 billion, but a committee report, based on States that responded to the committee's request for information, concludes that the change in regulations would reduce Federal payments to States by 49.7 billion over the next 5 years. The cost to California alone is estimated to be 10.8 billion over 5 years.

Mr. Chairman, as you well know, in the case of California the reductions and Federal funding would

destabilize an already fragile medical care delivery service for low income residents and the uninsured. The impact of these changes will be far reaching and potentially catastrophic. In the last year we have witnessed the closing of many of King/Drew's hospital medical facilities located in Watts, California. The emergency care facility has been closed now for some time. The impact of this closing is that residents from this underserved area of Los Angeles are transported to other areas of town and the critical minutes that are needed to administer care to save lives are now lost.

The impact of King/Drew closing has had a cascading effect on all the other area hospitals, including those outside of the Los Angeles area, that now must pick up the slack. I cannot imagine what would happen in these areas in the case of a mass catastrophic event such as a terrorist attack using conventional explosives or a natural disaster since they are already suffering from a lack of adequate emergency medical care facilities.

So I look forward to the testimony from today's witnesses who are experts in medicine and medical delivery services and counterterrorism. Again, thank you, Mr. Chairman, for holding this hearing.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman, for holding this hearing. I ask that my entire opening statement be put in the record.

Chairman WAXMAN. Without objection.

[Prepared statement of Mr. Issa follows:]

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Mr. ISSA. Mr. Chairman, I'm troubled with today's hearing for one reason. I think there's a legitimate problem, overcrowding of our emergency rooms. That overcrowding comes from a combination of illegal immigration, legal immigration and a pattern of going to emergency rooms when in fact urgent care would be a better alternative. I think it is part of a bigger problem we particularly in California face that we have in fact a large amount of uninsured. But they are not insured, they are insured at the emergency room. That overcrowding needs to be dealt with.

And I trust that on a bipartisan basis in good time we will deal with the challenges created by illegal immigration, individuals who either because of that or because they lack insurance are choosing the emergency room over more effective and efficient delivery systems.

Having said that, I particularly am concerned that a partisan amateur survey was done in order to justify or politicize today's hearing. It's very clear both by the ranking member's opening statement and by the facts that we will clearly see here today that a survey of emergency rooms done by Democrat staff for the purpose of getting the answer they wanted, which was of course we're overcrowded at the emergency room, is self-serving and unfortunately short-sighted.

The number of beds that could be made available in a

hospital, the number of health care professionals, doctors, nurses and the like that could be brought to bear within a period of time would have been part of any effective analysis of what the surge capacity could be, the number of patients who, although in the hospital, could be removed to other facilities of lesser capability to make room for severely injured people.

Although this would not change the fact that if we had a Madrid type occurrence, even in a city like Los Angeles, 2000 severely injured people would strain our capacity in the first few hours. And undoubtedly, undoubtedly, just like a 200-car pileup on the 405, we would have loss of life that we would have not have in a lesser occurrence.

I do believe that the challenges of Medicare and Medicaid in dealing with escalating costs, and particularly for California the cost of reimbursement which has not been sufficient, needs to be looked at. I hope that we can work on a bipartisan basis to deal with these problems. I hope that today's hearings will in fact cause us all to understand the causes and the cures for overcrowding of our emergency rooms.

However, I must reiterate that the Federal response for this type of emergency needs to be to pay to train and to pay to test for these kinds of emergencies. That's the appropriate area for the Federal Government to deal with in

addition to providing certain life saving resources such as mass antibiotics like Cipro and of course also smallpox and other vaccinations in case of an attack.

These are the Federal responses that were agreed to after 9/11 on a bipartisan basis, and I would trust that at a minimum we would not allow an issue such as how much is reimbursed to California on a day-to-day basis to get in the way of making sure that we fully fund those items which would not and could not be funded locally or by States.

Mr. Chairman, I look forward to today's hearing. You have a distinguished panel that I believe can do a great deal to have us understand the problem. With that, I yield back.

Chairman WAXMAN. Our witnesses today do amount to a very distinguished panel and we're looking forward to hearing from them. Dr. Bruce Hoffman is Professor of the Edmund A. Walsh School of Foreign Service at Georgetown University here to discuss mass casually events involving conventional explosives in general and suicide terrorism in particular. He will also discuss his research on the Australian, British and Israeli--and British responses to these types of terrorist attacks.

Dr. Wayne Meredith is a Professor and Chairman of the Department of General Surgery at Wake Forest University Baptist Medical Center. In his role as a trauma surgeon Dr. Meredith will discuss the clinical importance of immediate

response to trauma such as that resulting from a blast attack as well as the importance of adequate financing to maintain a coordinated trauma care system.

Dr. Colleen Conway-Welch is the Dean of the School of Nursing at Vanderbilt University. She'll discuss the implications of the Medicaid regulations for hospital emergency and trauma care capacity, including whether States or localities will be able to hold hospitals harmless against the loss of Federal funds that will result from the regulations.

Dr. Roger Lewis is an Attending Physician and Professor in the Department of Emergency Medicine at Harbor-UCLA Medical Center. He will discuss the connections between emergency department crowding, surge capacity and disaster preparedness. He will also discuss the impact of the Medicaid regulations on his hospital, which participated in the majority staff snapshot survey.

Dr. Lisa Kaplowitz is the Deputy Commissioner for Emergency Preparedness and Response at the Virginia Department of Health. She will present the State perspective on emergency preparedness in response to mass casualty events, including the lessons learned from the Virginia Tech shootings.

We're pleased to have you all here today. We welcome you to our hearing. It's the policy of this committee that

all witnesses that testify before us do so under oath. So if you would please rise and raise your right hand, I would appreciate it.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that each of the witnesses answered in the affirmative. Your prepared statements will be made part of the record in full. What we'd like to ask you to do is to acknowledge the fact that there's a clock that will be running, indicating 5 minutes. For the first 4 minutes it will be green, for the last minute will be orange, and then when the time is up it will be red. And when you see the red light we would appreciate it if you would try to conclude your oral presentation to us. If you need another minute or so and it is important to get the points across, we're not going to be so rigid about it, but this is some way of trying to keep some time period that's fair to everybody.

Dr. Hoffman, let's start with you. There's a button on the base of the mike, we'd like to hear what you have to say.

STATEMENTS OF BRUCE HOFFMAN, PH.D., PROFESSOR, EDMUND A. WALSH SCHOOL OF FOREIGN SERVICE, SECURITY STUDIES PROGRAM, GEORGETOWN UNIVERSITY; JAY WAYNE MEREDITH, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF GENERAL SURGERY, WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER; COLLEEN CONWAY-WELCH, PH.D., DEAN, VANDERBILT SCHOOL OF NURSING; ROGER LEWIS, M.D., PH.D., DEPARTMENT OF EMERGENCY MEDICINE, HARBOR-UCLA MEDICAL CENTER; AND LISA KAPLOWITZ, M.D., DEPUTY COMMISSION FOR EMERGENCY PREPAREDNESS AND RESPONSE, VIRGINIA DEPARTMENT OF HEALTH

STATEMENT OF BRUCE HOFFMAN, PH.D.

Mr. HOFFMAN. Thank you, Mr. Chairman, for the opportunity to testify before this committee on this important issue. As a counterterrorism specialist and a Ph.D., not an M.D., let me share with the committee my impressions of the unique challenges conventional terrorist bombings and suicide attacks present.

This is not a place to have a wristwatch, Dr. Shmuel "Shmulik" Shapira observed as we looked at X-rays of suicide bombing victims in his office in Jerusalem's Hadassah Ein Kerem Hospital nearly 6 years ago. The presence of such foreign objects in the bodies of his patients no longer

surprised Dr. Shapira, a pioneering figure in the field called terror medicine. We had cases with a nail in the neck or nuts and bolts in the thigh, a ball bearing in the skull, he recounted. Such are the weapons of terrorists today, nuts and bolts, screws and ball bearings or any metal shards or odd bits of broken machinery that can be packed together with enough homemade explosive or military ordnance and then strapped to the body of a suicide terrorist dispatched to attack any place people gather.

According to one estimate, the total cost of a typical Palestinian suicide operation, for example, is about $150. Yet for this--yet this modest sum yields a very attractive return. On average suicide operations worldwide kill about four times as many persons as other kinds of terrorist attacks. In Israel the average is even higher, inflicting six times the number of deaths and roughly 26 times the number of casualties than other acts of terrorism.

Despite the potential array of atypical medical contingencies that the United States health system could face if confronted with mass casualty events, MCE, resulting from terrorist attacks using conventional explosives, it is not clear that we are sufficiently prepared. Historically the bias and most MCE planning has been towards the worst case scenarios, often containing weapons of mass destruction, such as chemical, biological, radiological and nuclear weapons, on

the assumption that any other MCEs, including those where conventional explosions are used, could simply be addressed as a lesser included contingency.

By contrast, Israeli surgeons have found that the metal debris and other anti-personnel matter packed around the explosive charge causes injury to victims, victims that are completely atypical of other emergency traumas in severity, complexity and number.

Unlike gunshot wounds from high velocity bullets that generally pass through the victim, for instance, these secondary fragments remain lodged in the victim's body. Indeed, although much is known about the ballistic characteristics of high velocity bullets and shrapnel used in military ordnance, very little research has yet to be done on the ballistic properties of the improvised and anti-personnel materials used in terrorist bombs.

The over pressure caused by the explosion is especially damaging to the air filled organs of one's body. For this reason the greatest risk of injury are to the lungs, gastrointestinal tract and auditory system. The lungs are the most sensitive organ. And ascertaining the extent of damage can be particularly challenging given that signs of respiratory failure may not appear until up to 24 hours after the explosion.

And over 40 percent of victims injured by secondary

fragments from bombs suffer multiple wounds in different places of their body. By comparison fewer than 10 percent of gunshot victims typically are wounded in more than one place on their body. A single victim may thus be affected in a variety of radically different ways.

In addition, severe burn injuries may have been sustained by victims on top of all the above trauma. Thus critical injuries account for 25 percent of terrorist victims in Israel overall compared with 3 percent with nonterrorism-related injuries.

Australia's principal experiences with terrorist MCEs has primarily been as a result of the October 2002 bombings in Bali, Indonesia, where 91 Australian citizens were killed and 66 injured. The survivors were air lifted to Darwin where the vast majority were treated at the Royal Darwin Hospital.

Forty-five percent of these survivors were suffering from major trauma and all had severe burns. The large number of burn victims presented a special challenge to the Royal Darwin Hospital, as indeed no one hospital in the entirety of Australia had the capacity or capabilities to manage that many blast and burn victims. Accordingly, the Australian medical authorities decided to move them to other hospitals across Australia.

London's emergency preparedness and response in the

event of terrorist MCEs had been based on New York City's experience with the 9/11 attacks. However, the suicide bombings of the three subway cars and bus on 7 July 2005 was a significantly different medical challenge.

In New York City on 9/11 many persons died and only a few survived. The opposite occurred on 7/7 when only a small proportion of victims lost their lives, 52 persons tragically, but more than 10 times that number were injured. London's long experience with Irish terrorism, coupled with extensive planning, drills and other exercises ensured that the city's emergency services responded quickly and effectively in a highly coordinated manner. But even London's well-honed response to the MCE on 7/7/05 was not without problems. For example, communications between first responders with hospitals or their control rooms were not as good as they should have been, which resulted in uneven and inappropriate distribution of casualties among area hospitals.

What emerges from this discussion the medical communities emergency response and preparedness for terrorist MCEs involving conventional explosions and suicide attacks are two main points: First, that there are lessons we can learn from other countries' experiences with terrorist bombings and suicide attacks that would significantly improve and speed our recovery should terrorists strike here.

Israel, Australian, Britain and others are highly relevant examples.

The second is that the best way to save as many lives as possible after a terrorist bombing or suicide attack is for physicians and other health care workers to undergo intensive training and preparation before an attack, including staging drills at hospitals to cope with sudden overflow of victims with a variety of injuries from terrorist attacks.

Medical professionals and first responders must also understand that the specific demands of responding to bombings and suicide attacks are uniquely challenging. Death and injury may come not only from shrapnel and projectiles, but also from collapsed and pulverized vital organs, horrific burns, seared lungs and internal bleeding.

It is crucial that emergency responders evaluate their response protocols and be prepared for the unusual circumstances created by bomb attacks. Moreover, given the increased financial stress on our Nation's health system in general and urban hospitals in particular, any degradation of our existing capabilities will pose major challenges to our Nation's readiness for attack. Indeed, the opposite is required, a strengthening of our capabilities of hospitals and for the emergency services that we require to effectively respond to a terrorist MCE involving conventional bombing and suicide attacks.

Thank you.

[Prepared statement of Mr. Hoffman follows:]

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Chairman WAXMAN. Thank you very much, Dr. Hoffman.

Dr. Meredith.

STATEMENT OF JAY WAYNE MEREDITH, M.D.

Dr. MEREDITH. Thank you, Chairman Waxman, Representative Shays, distinguished members of the community, and guests. Thank you for the opportunity to appear before you today to discuss the impact of the proposed Medicaid regulations we have on trauma centers and trauma center preparedness in our country.

My name is Wayne Meredith. I'm the Chairman of the Surgery Department at Wake Forest University School of Medicine, and I volunteer as the Medical Director of Trauma Programs at the American College of Surgeons.

What is trauma? Trauma is a major public health problem of which I am sure you are aware, but want to emphasize for you it is the number one killer of people under the age of 44. That means if your children or grandchildren are going to die the reason they are going to die is most likely going to be from an injury. And the appropriate best way to keep that injury from happening is to have them treated in a trauma center, to make a trauma center available to them. That's been shown to reduce their risk of dying from a

serious 25 percent. That's better than many other treatments that we consider standard treatment for any other condition. It is not standard treatment across America today because trauma center care, the systems are disorganized, the availability of trauma centers for providing that system are disorganized.

Trauma care is emergent, but not all emergency care is trauma care. These are serious injuries. It requires a level of readiness of the hospital, it requires a level of expertise of the people to be there to make it so that they can be available when it occurs.

I've had the great privilege of treating well over 10,000 patients over the years who have survived and overcome significant injuries. Just a small sampling of those patients include such patients as Greg Thomas, who was a 40-year old social worker riding to work. He was struck by a car and severely injured, he was wish-boned, tearing your leg apart and splitting your body halfway up the middle. He--he had a crushed chest, his pelvis was broken in two, his left leg finally had to be amputated, but he was able to survive because he got to a trauma center immediately, he had the kind of care he required. He now comes back to volunteer at our hospital to help with the psychological help for other people that are being treated there.

Josh Brown was being a good Samaritan, stopped to help

someone change a tire, was struck by a car while he was doing that. Arrived bleeding to death in shock, and he had available to him a team of people waiting 24/7 to be available to take care of him and is therefore able to be discharged.

And a story I particularly like, Jason Hong was a student at our college. He worked--he was working in his family's convenience store in town. The convenience store was robbed. He was shot in his thigh, striking a major artery and vein in his thigh and was bleeding to death from that. Took him to the trauma center immediately. We opened his leg, stanched the bleeding which was profuse. Repaired those injuries by taking vein from his other leg and placing it there. He survived, and, kept his leg. Now he ultimately came back to decide he wanted to be a doctor. He is now graduating from medical school this May and he will be joining our residency and starting to be a surgery resident in July of this year.

Trauma centers have to be prepared to respond on a minute's notice for all kinds of trauma, including those of terrorist attacks. They are the baseline of readiness, in my opinion, for any sort of capability to be prepared for the everyday type of terrorism that we can expect.

Are they ready? Unfortunate--and could they meet the surge of 450 type victims that occurred at 9/11? I think the

result--the answer to that is no. We're not ready to be able to surge at that level the way trauma centers are set up today.

Saving people--there are other studies the National Foundation for Trauma Care, which I was the founding member of the board, also did a study about a year and a half ago which showed that our overall preparedness with trauma centers is about C-minus, if you look at that, for being prepared in our trauma centers to surge to a terrorist event.

Saving people from the brink of death, however, or from everyday trauma, even a terrorist attack, is costly and it's resources intensive but absolutely necessary. Our trauma care delivery system has several requirements all of which must be met.

Coordinated trauma system care. I talked in the very beginning statement that got you off track, Mr. Shays, extemporaneously talked about our lack of a coordinated system across our country. It is a very patchwork quilt of system currently and it needs to be organized.

The workforce issues. Trauma surgeons are in great debt. We have a tremendous lack of trauma surgeons. Over half of our surgery--of our trauma fellowships go unfilled, we have no nurses. We have--if you more than regionalize trauma care there are not as many neurosurgeons in America today as there are emergency rooms in America today. There

is not one--if they stayed in the house all the time, lived there, were chained there, could not leave, there aren't as many neurosurgeons in America as there are emergency rooms. Workforce shortage is going to be something that you--that we'll be facing dramatically going forward.

Trauma centers have to have sufficient resources to care for all their victims and to do the cost shifting it takes to take care of the uncompensated care and prepare for them. We must be prepared for the trauma that we see every day. Jason Hong gets shot in the leg on an everyday basis. We need to be prepared for the catastrophic events, the bridge collapses that occurred in Minnesota. We need to prepare for national disasters whether they are Katrina level or just earthquakes or tornados. And we need to be prepared for the major events that could occur from terrorism, which I think are more likely to be bombing in a cafe than they are an anthrax attack or some major bio event, I think is much more likely. So trauma centers are threatened by that.

The effects of the Medicaid changes will be dramatic in our hospital. It is estimated it will cost us--let me see. Medicaid regulations is not something--it will be $36 million from our hospital. It currently costs about $4-1/2 million of infrastructure to keep the trauma center alive. And we use about $13 million in costs in uncompensated care. Add to that $36 million our trauma center will go under. We will

not be a part of the infrastructure for health care in our part of the region. We serve western--all of western North Carolina.

So with that I'll truncate my remarks and thank you for this. I just beg you to stop the Medicaid cuts and enact H.R. 5613, the Dingell-Murphy bill, fully funded the trauma systems planning program and ensure maintenance of systems and adequately fund H.R. 5942, the Towns-Burgess-Waxman-Blackburn legislation, and fully fund the hospital preparedness program and hospital partnership grants to ensure the highest level of preparedness, funding for all hospitals and most particularly for trauma centers. I want to thank the committee for having these hearings and to thank you for having me participate in them.

[Prepared statement of Dr. Meredith follows:]

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Chairman WAXMAN. Thank you very much, Dr. Meredith. Dr. Welch.

STATEMENT OF COLLEEN CONWAY-WELCH, PH.D.

Dr. CONWAY-WELCH. Good morning. My name is Colleen Conway-Welch. I've been Dean at the School of Nursing at Vanderbilt for 24 years.

Chairman WAXMAN. Would you pull the mike just a little closer? You don't have to move closer, pull the mike closer.

Dr. CONWAY-WELCH. Thank you.

Over the last decade, however, I have taken a special interest in the area of emergency preparedness. I am here today to make the link between the consequences of reduced Medicaid funding, a fragmented public health infrastructure, and a reduced level of emergency preparedness, and to urge the committee to recommend a moratorium on these actions until at least March of 2009.

I want to make three specific points about implementation of the following three changes, limiting Medicaid payments to public providers only, dropping Medicaid funding for graduate medical education and limiting Medicaid dollars for services in out patient settings.

If the changes anticipated for May 26th occur, it will

be virtually impossible to fix these rules legislatively in a rushed and piecemeal manner. And DHHS will be hard pressed to effectively respond HSPD 21, which directs the Department to look at regulations that impact emergency preparedness.

If Medicaid dollars are reduced in these three areas, a reduction in personnel and readiness will occur in our hospitals and emergency departments across the country and, even worse, it will occur in the midst of a serious and intractable nursing and nursing faculty shortage and limit our ability to respond to a disaster, particularly a blast or explosive injury with serious burns.

It is also reasonable to assume that States, including Tennessee, will not hold the providers harmless if Federal matching funds are lost. There would be no easy way to redirect or make up money to those who are losing it, such as the medical schools and safety net provider hospitals. Even if the State were able to redirect State dollars to areas eligible for a Federal match, those funds would most likely be distributed in Tennessee to the managed care organizations and then be part of the overall payment structure of all of our hospitals.

I want to speak now specifically to the three changes. Number one, limiting payment only to providers who are a unit of government puts our rural, community, private, and 501(c)(3) hospitals at even greater risk since they must

already pick up the slack of escalating numbers of uncompensated care and are tied to a public health infrastructure that is increasingly unfunded, unavailable and marginally functional. In Tennessee this would result in only one hospital, Nashville Metro General Hospital, being included. The TennCare Medicaid program would lose over $200 million per year in matching funds. This would put all of the hospitals in Tennessee, except Metro General, in a position of cost shifting and service reductions, as well as limiting access even further.

For example, Vanderbilt already provides more than $240 million a year in uncompensated care. While I'm discussing Tennessee, these are issues across the country.

All disasters are local, that is true, and conventional explosive attacks are especially local. The casualties are immediate and nobody should expect outside help for at least 24 hours. Only a true system of local, functional, systematically linked emergency departments and hospitals can address the casualties of this most probable form of attack.

Proposal two, eliminating Federal support for graduate medical education programs will result in a reduction of medical residents in a wide variety of settings, including ERs, trauma burn and intensive care units. They will also not have the support of my skilled trauma nurses since these numbers will be reduced as well.

As an example, in Tennessee the four medical schools in the State would lose $32 million annually. These schools also serve as the safety net providers and would be forced to reduce their numbers of students.

Proposal three, limiting the amount and scope of Medicaid payment for outpatient services will weaken our ER ability to handle a surge of victims. Our large hospitals will quickly experience automobile gridlock.

It is also absurd to think about evacuating hospitals in a time of disaster with the high acuity level we maintain every single day, including patients on ventilators. At Vanderbilt, for example, the burn unit and the ICUs are already at capacity. If disaster hits, health care providers will need to be dispatched to community and rural clinics to help them care for patients with serious injuries who cannot be transported or accommodated by hospitals. As clinics, we do services and personnel commensurate with reduced Medicaid dollars. Their ability to avoid triage and care to patients will be significantly impacted.

Federal disaster preparedness money that comes to Tennessee is much appreciated. However, Federal money does not require an outcome of increased documented operational capacity building and it should. Tabletop exercises are marginally useful, are an income opportunity for Beltway bandits. However, lessons learned from one exercise are not

necessarily applied to the next.

To many health care professionals of both political parties in the field of emergency preparedness, it appears that DHHS and DHS do not have a mechanism to assess and monitor the extent to which States, counties and cities have the capability and game plan in place to respond to a disaster such as a blast explosion and are not able to provide guidance on which to base these plans.

There is no one place anywhere in our Nation or at any level of government where one can go to receive reliable information on resources; for example, how many burn beds there are in Tennessee or how many ICU beds there are in Nevada. There is no one-stop shop to answer it on a Federal level and disasters are frequently not limited to one State. So regional statistics and information are needed. For example, Tennessee has 48 burn beds, 28 of which are at Vanderbilt and the eight Southeast States have a total of 240, but I had to go to the American Burn Association to get those numbers.

In summary, I am encouraging a moratorium on these Medicaid changes, a requirement that coordination between and among various Federal, State and local entities be enhanced to achieve a double whammy; namely, improving emergency preparedness response while improving the fractured public health infrastructure. It is important to point out that

continued cuts to providers negatively impact every service a hospital provides. Vanderbilt has historically soaked up these reductions and looked for other sources of revenue, but that is becoming more and more difficult.

It is logical to assume that we would have to cut such programs as helicopter transport, HIV/AIDS programs and certain medical and surgical specialties, including emergency preparedness. We now support emergency preparedness in a robust way, but we would need to limit our participation and regional drills and internal administrative planning, as well as reduce our commitment or eliminate stockpiling of medical supplies and equipment that are critical.

In conclusion, please extend the moratorium until next year. Charge DHHS and DHS to thoughtfully work together to address the declining public health infrastructure from the prospective of improving our emergency preparedness, and urge that the rules be withdrawn since Congress did not direct their propagation. A simple and immediate cut in Medicaid funding to these three areas is not a thoughtful solution, will not work and will have a devastating effect on our hospitals and providers to respond in a disaster. In the final analysis if these rules are enacted as proposed when our citizens need us most, we will not be there.

Thank you.

[Prepared statement of Ms. Conway-Welch follows:]

******** INSERT 1-3 ********

Chairman WAXMAN. Thank you very much, Dr. Welch.

Dr. Lewis.

STATEMENT OF ROGER LEWIS, M.D., PH.D.

Dr. LEWIS. Mr. Chairman, members of the committee, thank you for inviting me. My name is Roger Lewis. I'm a Professor and Attending Physician at the Department of Emergency Medicine at Harbor-UCLA Medical Center, and I've been working as a physician at that hospital since 1987.

Harbor-UCLA Medical Center is a publicly funded Level 1 trauma center and a teaching hospital. We're also a Federally funded disaster resource center and in that capacity work with eight of the surrounding community hospitals to ensure disaster preparedness and, in the event of a disaster, an effective disaster response serving a population of approximately 2 million people. We're proud of that work and believe it is important.

Over the last 5 or 10 years my colleagues and I at Harbor-UCLA have witnessed an extraordinary increase in the demand for emergency care services of all types. We have seen an increasing volume in the number of patients who come to our emergency department and in their degree of illness and their need for care.

At the same time we've had a constant decrease in our available inpatient hospital resources and this has predictably led to a frequent occurrence of emergency department gridlock and overcrowding. Patients wait hours to be seen, ambulances carrying sick individuals are diverted to hospitals that are farther away and admitted patients in the emergency may wait hours or days for an inpatient bed.

Now I became an emergency physician because I wanted to be the kind of doctor that could treat anybody at the time of their greatest need. And similarly, my institution is proud of its work as a disaster resource center because it wants to be the kind of institution that can provide for the community as a whole in its time of greatest need.

It never occurred to me during my training that I'd be in the position in which patients that I knew clearly needed to be treated in minutes instead had to wait for hours, that ambulances carrying sick patients would be diverted to hospitals farther away, or that we would pretend that hospitals that have no available beds and a full emergency department would have adequate surge capacity to respond to the most likely type of mass casualty incidents; namely, the results of a conventional explosive. Yet that is exact the situation in which we find ourselves.

Now in trying to think about how to illustrate this situation several people suggested to me that I give an

anecdote, that I tell a patient's story. And without detracting from the important examples that have been given by the other panel members, I would just like to comment that I don't think any single patient's story really captures the scope and the impact of the problem. This is the situation in which one has to think carefully about the meaning of the statistics that are widely available.

In fact, yesterday's anecdote, those stories about individuals who deteriorate in the emergency department or on the way to the hospital because their ambulance has been diverted, are really today's norm. These events are happening every day. Right now an ambulance in this country is diverted from the closest hospital approximately once every minute.

There is a common misconception that emergency department overcrowding is caused by misuse of an emergency department by patients who have routine illnesses or could be treated in urgent care settings. This is clearly not true. Numerous studies done by nonpartisan investigators have shown that only 14 percent of patients in the emergency department have routine illnesses that can be treated elsewhere. And much more importantly, those patients use a very small fraction of the emergency department resources and virtually never require an inpatient bed.

Emergency department overcrowding is a direct result of

inadequate and decreasing hospital inpatient capacity. It is a hospital problem, not an emergency department problem. There is a direct cause and effect relationship between the hospital resources, inpatient capacity, emergency department overcrowding and surge capacity.

The hospital preparedness program, a Federally funded program that is intended to increase disaster preparedness, has focused on bioterrorism and on the provision of supplies and equipment for participating hospitals. And whereas these things are important, they focus on one of the less probable types of mass casualty incidents and do not in any way directly address surge capacity.

For my hospital the proposed Medicaid rules are estimated to result in a 9 percent decrease in the total funding for the institution. That would have an exponential effect on the degree of overcrowding and directly result in reductions in our inpatient capacity. For Los Angeles County as a whole the projected impact is $245 million. That would require a reduction to services equal to one acute care hospital and trauma center. We have already witnessed what happens in our area with the closure of such a hospital.

So in summary, hospitals and emergency departments across the United States increasingly function over capacity and prior fiscal pressures have resulted in a reduction in the number of inpatient beds and overcrowding. Current

Federal programs intended to enhance disaster response capability have emphasized supplies and equipment and it largely ignored surge capacity.

The proposed Medicaid regulations will directly result in further reductions in hospital ED capacity and ironically specifically target the trauma centers, teaching hospitals and public institutions whose surge capacity we must maintain if they are to function at the time of a disaster.

Thank you very much, Mr. Chairman.

[Prepared statement of Dr. Lewis follows:]

******** INSERT 1-4 ********

RPTS MERCHANT

DCMN SECKMAN

Chairman WAXMAN. Thank you very much, Dr. Lewis.

Dr. Kaplowitz.

[Prepared statement of Dr. Lewis follows:]

******** INSERT 2-1 ********

STATEMENT OF LISA KAPLOWITZ, M.D.

Dr. KAPLOWITZ. Good morning Mr. Chairman, Members of the Committee. I'm Lisa Kaplowitz. I'm Deputy Commissioner for Emergency Preparedness and Response for Virginia Department of Health. In that role, I'm responsible for both the public health and health care response to any emergency. And we take a very all-hazards approach to emergencies in Virginia.

Virginia is large and diverse and has been impacted by any number of emergencies since 9/11. Certainly we were impacted by the Pentagon, which is located within Arlington County, but we have experienced the anthrax attack, sniper episode, Virginia Tech and multiple weather emergencies.

A few lessons from 9/11. First of all, this truly was a mass fatality event, not really a mass casualty event. But we certainly have learned that one key to response is coordination of all the health care facilities in the area, cross borders in the national capital region; that's Virginia, Washington, D.C. and Maryland. And we all need to work together, both in the NCR and throughout the Commonwealth. We knew we needed a much improved communication system among health care facilities and with public health communications really was inadequate during

9/11. We had no back-up communications present. We needed a mass fatality plan, and we needed to include mental health planning in all emergency planning.

The Congress allocated funds for both public health and health care preparedness as a result of 9/11 and anthrax. I won't spend a lot of time on the public health preparedness--I'm responsible for that--except to mention that we have coordinated our public health and health care response. They work very closely together.

In terms of our health care system preparedness, the key to our success has been partnership with the hospital association which contracts with hospitals throughout the Commonwealth, and we got buy-in from the hospitals very quickly. We also do regional planning. We have three hospital planning regions, a hospital coordinator and a regional coordinating center for each of our regions.

The funding from ASPR has been very, very valuable. It's enabled us to purchase redundant communication systems for hospitals, to develop a statewide Web based tracking system. We can now track beds in a realtime basis throughout the Commonwealth during any emergency. We've purchased supplies and equipment often done on a regional or statewide basis. This has included portable facilities that are located in four regions of the Commonwealth and can be moved all around. We've purchased ventilators that are the same

ventilators statewide that are being used in hospitals so people know how to use them. We've purchased over 300 ventilators for use in a surge. We've purchased antivirals and antibiotic medication located in hospitals. And we've developed a volunteer management system.

Before I move on to trauma and burn care systems, I do want to say that the ASPR funds are very valuable but are only a fraction of hospital funding for emergency response. The trauma system in Virginia was established in 1980. We now have five Level 1 trauma centers, three Level 2 and five Level 3 centers in the Commonwealth. We have three burn centers, for a total of 37 burn beds within the Commonwealth.

Our general assembly did a study in 2004 documenting a large amount of unreimbursed trauma care. In 2003, it amounted to over $44 million, and I know it's vastly greater than that 5 years later. As a result of this study, the general assembly did create a trauma fund which helps with our reimbursed care but, again, only provides a fraction of unreimbursed care. It's based on fees for reinstatement of driver's license and DUI violations.

I do want to talk a little bit about lessons learned from Virginia Tech. Nobody expected to have a shooting event, a mass shooting event in rural Virginia, such as occurred a year ago. What many people don't realize is that, because of the winds and the snow, none of the injured could

be transported to a Level 1 trauma center or even a Level 2 trauma center. The three closest hospitals, two were Level 3 trauma centers; one was not a designated trauma center. We had planned for this, recognizing that all facilities need the capability of handling trauma care. And we're very proud of the fact that none of the injured transported to hospitals from Norris Hall died. That's due to our coordination of EMS, as well as hospitals, public health and our regional coordinating center. So some of our lessons learned from Virginia Tech concerning mass trauma include the need for coordination of all parts of public health in the health care system.

Cross training is key. This has been mentioned already. In a mass casualty event, all facilities need to be able to handle trauma care. That not only involves supplies but training of staff in all facilities. We have purchased supplies for all facilities in the Commonwealth to handle a certain level of trauma and burn care. We know that burn care will be key here, and we want all facilities to be able to handle that. And we need a real time patient tracking system which didn't exist, and we're working very closely on that now so that patients can be tracked from the time EMS picks them up until the time they're in the hospital and, unfortunately, for our chief medical examiner as well. We're very fortunate to have a very strong Medical Examiner's

Office because this was a crime scene and had to be handled as a crime scene, and they handled it very well.

We need to recognize that at any mass casualty event, there will be fatalities. So, in terms of trauma surge planning in Virginia, we've focused on a number of different aspects here:

Again, as I mentioned, purchase of key supplies and medications for burn and trauma care in all facilities, and this has been very basic, looking at basic supplies to be stockpiled.

Training of physicians and staff in all hospitals to provide basic trauma and burn care, because we don't know where trauma is going to occur, and we'll need the help of all our facilities.

Training of EMS and hospital staff on appropriate triage. Unfortunately, during a mass casualty event, we won't have the luxury of transporting people to solely our trauma centers. But we're very dependent on these centers to have the expertise that they can then use to train others.

And we need mass fatality planning as a component of mass casualty planning.

I was asked to make a few comments about our recent tornadoes. We were fortunate; nobody died as a result of those tornadoes, and there were only three serious injuries. But I will say that there was excellent communication among

the hospitals in the area. Once again, this was a very rural area. They communicated well. We called on our medical reserve corps to help. Our public health folks were available immediately and are working in the area now. So our planning has really paid off there.

A few comments in summary. Hospital and health system emergency preparedness can be achieved only through close collaboration and regional planning efforts for public health and health care. There must be a system prepared to respond, especially for mass casualty and fatality events. Preparedness is tested not only through exercises but through actual events. We do an after-action report for every single event and take our lessons learned to modify our plans. A coordinated trauma system is essential, but we have to have a well thought out trauma and health care surge plan to effectively respond to large-scale events. Trauma care provided only through designated trauma centers will not be adequate, but we need those centers as resources to train others.

We desperately need continued Federal funding for public health and health care preparedness. Our CDC and ASPR funds have been very valuable, but I need to point out that it's only a fraction of the moneys used for preparedness. It's a relatively small amount in the Commonwealth. It doesn't even come close to covering, for example, unreimbursed care, and

it's not for operational funding. But it has been very valuable, and I plead with you not to have further cuts in either CDC or ASPR funding. Thank you again for the opportunity to share Virginia's plans, challenges and accomplishments, and I'll be glad to answer questions.

[Prepared statement of Dr. Kaplowitz follows:]

******** INSERT 2-2 ********

Chairman WAXMAN. Thank you very much. We're going to proceed with questions where 10 minutes will be controlled by the majority; 10 minutes controlled by the minority; and then we'll go right to the 5-minute rule.

But before I even begin questions, let me just get for the record something that I'm not sure I fully understand, Dr. Kaplowitz. What is a Level 1 trauma center? What is a Level 2 trauma center? What is an emergency room? How do these all fit in as you plan for emergency preparedness?

Dr. KAPLOWITZ. Well, actually, many people on the panel are better able to discuss the differences of Level 1, 2 and 3. Level 1 trauma centers require expertise to be present within the fatality all the time, to be able to handle any level of trauma. Level 2 and Level 3, some of that expertise can be outside the facility but available very quickly. So, again, Level 1 trauma centers have tremendous costs just to maintain that ability to provide trauma care. And that's a big part of what costs a great deal to maintain trauma centers. It's not only the care per se, but the infrastructure as well as a quality improvement plan, which we have a very good one in Virginia.

Emergency rooms are places where people can show up for emergency care in any facility, whether they're a designated trauma center or not. I will say that there are fewer and fewer designated trauma centers in the Commonwealth because

of the cost to maintain a trauma center. It's been very, very difficult and becoming more and more expensive, and that's been very problematic.

Chairman WAXMAN. Thank you very much.

As I indicated in my opening statement, we asked the staff to do a survey of emergency care capacity in seven U.S. cities. At the time of the survey, none of the 34 Level 1 trauma centers that participated had enough treatment spaces in their emergency rooms to handle the victims of a terrorist attack like the one that happened in Madrid in 2004. In fact, more than half of the ERs were already operating above capacity. That means, on an average day, patients were already being treated in hallways, waiting rooms and administrative offices.

Dr. Meredith, should the findings in this survey be of concerns to Americans?

Dr. MEREDITH. Yes, sir. I think the capacity available today in our safety net hospitals is a problem, it is a threat. If you think about a bottle-neck theory, the patients are building up in the emergency departments, not because there's so many patients coming to them who shouldn't be there but because there's no place for them to go. The ability for our hospitals to absorb them just in terms of numbers of beds and numbers of doctors that take care of patients is lacking. And that's what's causing this

emergency department overflow overloading and buildup. And the other pieces, one of the strategies is to move patients around, but as several of the other people on our panel have said, most of the kinds of patients that are occupying intensive care unit beds, ventilator beds, burn unit beds are not going to be very easily moved. They will be very difficult to move. And to move them from the Level 1 trauma centers and the burn units to other facilities is probably not the best way to manage them. So it's a problem.

Chairman WAXMAN. It's been over 6 years since we suffered the attacks on 9/11. Are our emergency rooms prepared to handle a surge of victims that could result from a terrorist attack?

Dr. MEREDITH. If you just--no, sir. I will just tell you from going to trauma center to trauma center, and I've been in a lot of them, there is very little surge capacity available in the trauma centers in the safety net hospitals in our country today.

Chairman WAXMAN. One of the striking findings of the survey is how overcrowded emergency rooms are on a normal day. This day, when our staff called the trauma centers and emergency rooms in the major cities, was just an ordinary day, and they were already having overcapacity. They had to treat patients in hallways and waiting rooms. I would like to ask, is overcrowding in emergency rooms jeopardizing the

health of patients and the ability of hospitals to provide the best care possible?

Dr. Lewis.

Dr. LEWIS. First of all, the day that that survey was conducted was a typical day, at least in Los Angeles. During that week in the prior 4 days we had been on diversion--I'm sorry, in the prior week, we had been on diversion for more than the equivalent of 4 days. So that was a typical situation. It absolutely negatively impacts the availability of the emergency department resources and the ability of patients to receive care for emergent medical conditions. There are delays in treating patients with chest pains, patients with potentially important infections and with a wide variety of illnesses and injuries.

Chairman WAXMAN. Well, the ability to respond to a bombing, such as occurred in Madrid, is called surge capacity. Surge capacity depends on more than just the emergency room. A hospital needs enough resources in places like the intensive care unit and hospital beds. But in the survey by committee staff, the problems extended beyond the emergency room. One major problem is something called boarding. Could you tell us, Dr.--who is best? Dr. Lewis. What is boarding, and what impact does this have on emergency room abilities to deal with a surge?

Dr. LEWIS. Mr. Chairman the term boarding refers to the

holding of a patient.

Chairman WAXMAN. Is your mike on?

Dr. LEWIS. Yes, it is. The term boarding refers to the use of emergency department treatment spaces for the holding of patients who are ill enough to require admission to the hospital, whose emergency care has been completed, they have been stabilized, and who the decision has been made to admit them into the hospital but there is no room in the hospital to treat that patient. Boarding has a number of important effects. The two most important effects are a reduction in the quality of care for that individual patient, because they are not receiving the ICU care in a comfortable and streamlined environment. But more importantly from my point of view and the purpose of this hearing is it reduces the total effective capacity of that emergency department. On a typical day in my emergency department, for example, one-quarter or as much as a third of the treatment spaces and the most intensive treatment spaces may be taken up by a boarder once we get to the afternoon hours, and that reduces the effective size of my emergency department by that percentage.

Chairman WAXMAN. Well, what happened in Madrid was a terrorist bombing, just a bombing, and not a--when I say "just a bombing," not weapons of mass destruction or anything catastrophic other than what a terrorist attack using bombs

can produce; 89 patients needed to be hospitalized, and 20 needed critical care. But not one of the hospitals surveyed had that many in-patient beds or critical care beds. In fact, the average hospital surveyed only had five intensive care unit beds, just a fraction of the 29 critical care beds needed in Madrid. Six hospitals had no ICU beds at all. Dr. Lewis and Dr. Conway-Welsh, are you concerned about these findings?

Dr. LEWIS. Obviously I'm concerned about the findings. One of the comments that's made in response to data like that is this idea that many of those patients could be rapidly moved out of the hospital in the event of an unexpected and catastrophic event. But, in fact, the information on intensive care unit availability is particularly problematic because those are patients that are too ill even to be in the normal treatment area of the hospital. So, as was mentioned by some of my colleagues, those patients are virtually impossible to move out. And so those spaces if they are used are truly encumbered and will not be available even in the setting of a mass casualty incident.

Dr. Welsh.

Dr. CONWAY-WELSH. There is another issue to that as well, and that is automobile gridlock. Many of our emergency rooms have not been designed to handle a large influx of private vehicles, which is what would happen. And I know, at

Vanderbilt, if we got 50 cars lined up for our ER, that's it. I mean, they're not going anywhere. So I think that the gridlock issue as a concern for our emergency rooms is also very real.

I think Dr. Lewis made an important point when he said that the ER overcrowding, if you will, is actually a hospital problem. And I believe that that is absolutely correct. And we're trying to fix something piecemeal when there's much larger problems, of which you are well aware, that really need to be addressed in a coordinated fashion by DHS and DHHS.

Chairman WAXMAN. Could you expand on that?

Dr. CONWAY-WELSH. Well, the role of coordination and guidance among those two offices is, frankly, very murky. And there is--if we recall the problems that happened with Katrina, it was sort of a right hand not knowing what the left hand was doing. There was, frankly, nobody to step in as a parent and say, you will play well in the sand box, you will get this done. And there was a lot of uproar between it's a State issue or a Federal issue or a city issue. That simply has to be stopped.

Chairman WAXMAN. It's been suggested that all of these things are supposed to be handled at the local level. The State ought to be able to coordinate emergency services. The hospitals ought to be prepared for whatever needs they might

have. Some people have said that it won't really matter whether a hospital ER is operating way above capacity or even under diversion. If a bombing occurs, hundreds of casualties need immediate care, then the hospital will simply clear out all patients who don't have life-threatening conditions. And if a local ER somehow can't create enough capacity, then care will be available in neighboring hospitals, in nearby communities or from emergency response teams deployed by the Federal Government. I wonder, is this grounded in reality, or is this an exercise in denial about the lack of emergency care surge capacity at the cities at the highest risk of a terrorist attack? Whichever one of you wants to respond.

Dr. CONWAY-WELSH. I think Tennessee accepts the responsibility that we must care for our own citizens. Frequently there are, particularly with blast explosions that can occur across State lines. Something else that is a real problem is that, for instance, the National Guard, which would be called up, they wouldn't get there immediately, but they would be called up, rely on the hospitals for a large part of their plans for response.

Chairman WAXMAN. Let me, before my time is expired, but just ask one last question. Because we talked about whether we're prepared and what the consequences would be for Medicaid funding to the States. Medicaid, of course, is health care for the very poor. Whether people agree or not

about this particular issue on the Medicaid, it will reduce Federal Medicaid revenues to Level 1 trauma centers and other hospitals throughout the country. Now, when that loss of Federal funds, which probably will vary from hospital to hospital, and for some Level 1 trauma centers, will these losses be substantial, forcing reductions in services and degrading emergency response capacity?

Dr. Meredith.

Dr. MEREDITH. Without question, that is one of my greatest fears as a result of this, is that the trauma centers which serve as the nucleus for this preparedness piece and for the problems that occur every day, every car wreck, the number one killer of Americans under the age of 44, will not be able to survive without--if they have this much drop loss to their bottom line, they won't be able to do the things it takes to be able to be ready on an every day basis, much less be able to participate in any sort of surge. And that is frightening to me as a trauma surgeon.

Chairman WAXMAN. Thank you very much.

Mr. Shays.

Mr. SHAYS. Thank you very much, Mr. Chairman.

Dr. Lewis, are you familiar with research conducted at Johns Hopkins University and published in the Society for Academic Emergency Medicine that found there are key differences between daily surge capacity and catastrophic

surge capacity? Specifically the research found that, quote, daily surge is predominantly an economic hospital-based issue with much of the problem related to in-patient capacity but with the consequences concentrated in the emergency department. By contrast, catastrophic surge has significantly more components.

Do you agree with the statement?

Dr. LEWIS. I agree with the statement, absolutely. The point that was being made--

Mr. SHAYS. Translate. Give me some meaning to this. Tell me what it means.

Dr. LEWIS. I think the distinction that's being made has to do with the ability of the hospital to respond to every day fluctuations in the need for care. For example, when there's a multi-car vehicle incident on the 405, and many of the hospitals in Los Angeles County have difficulty responding to those things but are able to respond by bringing in overtime staff, bringing in staff that aren't usually covered by the budget but for this one time can be brought in to open up beds that although physically available are not covered by nursing staff, those kinds of thing. However, doing that on a day-to-day basis over a fiscal year drives the hospital into the red. And so there are economic constraints on our ability to deal with so-called daily surge. In the setting of a mass casualty incident or a

disaster surge, obviously there are some extraordinary things that would be done. I think the critical question is the extent with which those critical things could be done and how effective they would be given the number of acutely ill patients who in fact could not be moved out of the hospital.

Mr. SHAYS. Thank you.

Dr. Meredith, did you want to comment on it? You just seemed to light up a bit.

Dr. MEREDITH. Well, I think there is a lot--that's exactly right, and there's a lot of truth to that. You're much more able to lift a 300-pound weight if it's on your foot than you can if it's just sitting in the room. So we are able to be able to surge differently for an emergency and for a short period of time than you can do for a long period of time. There's also a disproportionate availability of bed capacity in our hospitals between the big urban and the Level 1 trauma hospitals and the smaller rural hospitals so that if you just look at the overall bed capacity over the country, it's mismatched between where these would occur, where the capacity is and so forth.

Mr. SHAYS. Mr. Chairman, I would request unanimous consent that the following articles published in the Society for Academic Emergency Medicine be entered into the record. There are 1, 2, 3, 4 of them. And I have them listed here if I could.

Chairman WAXMAN. Without objection, they will be entered in the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. SHAYS. Thank you very much.

Dr. Hoffman, I find it nonsensical that we talk about the capacity in emergency centers and so on, that we are strained, when particularly in California my sense is that a lot of this deals with the uncompensated care, not the undocumented worker because that doesn't describe them. It's individuals who are literally here illegally. Is there any sense of a disconnect when we say we are providing national security for our homeland when in fact we allow individuals to literally come into this country at will, then call them undocumented, as if somehow they don't represent a national security issue?

Mr. HOFFMAN. Well, Congressman, it's an issue somewhat outside of my ken. In looking at the terrorist threat, I would say, when one focuses back on 9/11, all of the 19 hijackers entered the country, firstly, legally and withproper documentation. So certainly you're right in pointing to the threat that illegal aliens and undocumented people have, but I think the threat is even much wider than that.

Mr. SHAYS. But isn't it the responsibility of the National Government to defend its borders. And we have a visa process and so on that let's us know who is here and who is not. People here illegally are here without our knowledge. Doesn't that strike you as somewhat absurd to

then suggest that we have the capability to deal with a potential terrorist threat?

Mr. HOFFMAN. I think the lesson that 9/11 teaches us is that we have to have the kind of dynamic and flexible approach that can deal at multiple levels.

Mr. SHAYS. Let me ask you, those in the hospital, how is it that we need to be able to deal with a surge capacity when we are dealing in a sense with a surge of illegal immigrants? How do we sort that out? How does that fit into the equation? Isn't it a fact that illegal residents tend to use the emergency facilities of a hospital more than just knocking on--going through the regular process of interacting with a doctor? Unless we have, and we have expanded our community-based health care clinics, but without community-based health care--let me ask it this way. Aren't these facilities being overworked by the fact that we have illegal residents who are using these facilities?

Dr. LEWIS. It is not my impression that any significant part of the overcrowding or the use of the resources is directly tied to the illegal immigrants who work in Los Angeles County.

Mr. SHAYS. How would you know that? Do you find out if they're here illegally?

Dr. LEWIS. One often finds out when one is taking a social history and asking about family background, travel

history, that sort of thing.

Mr. SHAYS. So you're under oath right now, and you're saying that, under oath, you do not believe that you have an overuse of these facilities by people who have no other ability to have health care, and that this is not in any way caused by illegal immigrants?

Dr. LEWIS. Let me just ask a clarifying question. When you use the term "overuse," do you mean any use?

Mr. SHAYS. Any use.

Dr. LEWIS. If you define any use of our emergency department by people who are in the country illegally, the answer is, absolutely, there is such use. If you mean overuse in the sense that the use is disproportionate because of their illegal status,I believe the answer is no.

Mr. SHAYS. I actually mean both. Why wouldn't it be? Logically it would seem to me to make sense that if they had nowhere else to go, they're going to go to the hospital. That's what we are encountering on our side in the East Coast. Every hospital tells me that you have an overuse in our emergency wards by people who simply have no other place to go.

Dr. LEWIS. I think that we're mixing a couple of different distinctions. My impression, and I have not collected data on this and I'm not prepared to give you numbers, is that most of the illegal immigrants when they

have nonurgent medical conditions choose to seek care in a variety of outpatient facilities that are scattered around the city, and they don't actually want to come to the emergency department. The second, if I could just answer the second part of your question.

Mr. SHAYS. Make it shorter, though, please.

Dr. LEWIS. When you are told that a significant burden on the system is by people who have nowhere else to go, the majority of those people are legal residents or citizens of this country who have no place else to go because they don't have health insurance, not because of their legal status.

Mr. SHAYS. Thank you.

I yield the balance of my time.

Mr. ISSA. Thank you.

Dr. Lewis, I'll follow up in this same area. And I agree with you as a fellow Californian that we can't have it both ways. We can't say that the uninsured seek emergency room care disproportionately because they can go there, they essentially are covered by the umbrella of last resort because they're poor and uninsured, and then not use the term broadly uninsured rather than illegal versus legal, et cetera. So, although I think illegal represents more than perhaps you're saying, I think it is appropriate, at least in California, to look at it in terms of the uninsured using the emergency room as essentially the guaranteed insured area for

the poor and uninsured.

I'm concerned about this survey that was done. You participated in the survey. And UCLA Medical Center that day said that there were 14 patients boarded by the emergency department presumably waiting for in-patient beds to become available. How do you explain the fact that you had 14 in-patient beds available that same day? Wouldn't it be fair to assume that, to a certain extent, you could have made them all, you could have put them all in immediately if you gave them the highest priority? And rather, quite frankly, there has to be some credibility to the reserve for higher-paying accounts, wouldn't be that correct?

Dr. LEWIS. No.

Mr. ISSA. So you're saying that you had 14 boarded patients and you had 48 in-patient beds available and that that--I'm trying to understand. Clearly you had beds available, and you could have shifted people into them, isn't that correct?

Dr. LEWIS. I believe that you are making a common misinterpretation of the information that was given to you, and I've seen the same information. It has to do with how one defines an available bed. To a hospital administrator, an available bed is a bed that is physically there; you walk in the room, there is a bed, and there is no patient in it.

Mr. ISSA. Okay. So as a follow-up, what you're saying

is you were not staffed to put people into those beds?

Dr. LEWIS. That's a very important distinction because the staffing is directly related to the level of hospital resources.

Mr. ISSA. And I just would like to follow up.

Chairman WAXMAN. The gentleman's time is up, but did you complete your answer?

Dr. LEWIS. No. I was trying to make the point that the issue has to do with staffing. And therefore, when one is trying to get data on the number of available beds, especially in the setting of disaster preparedness, the important question is what number of beds are available or could be staffed in the next few hours. And I don't believe the questionnaire was clear in that regard.

Mr. ISSA. Mr. Chairman, I know you went on for a little while. This will be very short.

Chairman WAXMAN. The gentleman's time is expired.

Ms. Watson.

Ms. WATSON. Mr. Chairman, I think some of the questions that are being asked of the witnesses ought to be asked of the Members sitting up here who make the policy.

Dr. Lewis, I am so glad you're here. I am intimately familiar with the situation down in Watts, California, and Martin Luther King Hospital. And when that hospital's Medicare funds were pulled and Medicaid funds were reduced,

many of the patients that would have gone to King had to come to surrounding hospitals. They're overcrowded. And I know on the day of the survey, 33 of your ER patients were being treated in chairs or hallways. I have been in that situation myself in one of our most prominent hospitals waiting 2 hours and 15 minutes, and people had been there for 4 days. We have a critical problem in our community, in our county hospital system. And we probably have one of the largest ones in the State in the Los Angeles area. The day we took this survey, was that an unusual day for your hospital?

Dr. LEWIS. In reviewing the numbers, and I should clarify that I was not working that day, but in reviewing the numbers that were submitted, my impression was that was a slightly less busy than usual day. It was done on a weekday.

Ms. WATSON. Now, Saint Francis Hospital, you're aware of it?

Dr. LEWIS. Yes.

Ms. WATSON. Is a DSH hospital, and it, too, is complaining--Doctors Hospital. I can name all the hospitals in the area. I chaired the Health and Human Services Committee in Sacramento in the Senate for 17 years. I am intimately aware of our problem. What is it that we need to have a functional and comprehensive care system for the indigent? And I know you're not in the business of doing the work of immigration officials and seeking; you treat people

as needed. What would you want to see in this Los Angeles County area, and maybe some of the rest of you in other States would want to respond, too, that would make our system viable to care for the needy, to care for the people who come through your doors, regardless of whether they're there legally or illegally?

Dr. LEWIS. If I was limited to a single answer--

Ms. WATSON. Yes.

Dr. LEWIS. --my answer would be an increase in the number of available in-patient beds in the hospital that are staffed by qualified nursing personnel who are available 24 hours, 7 days a week.

Ms. WATSON. When Dr. Levitt--thank you for your response.

When Dr. Levitt cut the Medicare dollars from King, or from L.A. County, that was 50 percent of the resources. So it impacted all of not only the county hospitals but private hospitals as well. Staffing of emergency personnel, what would you like to see there, and you talked about other beds, but emergency and trauma?

Dr. LEWIS. The most pressing shortage that we have right now in Los Angeles County is related to nurses in the emergency department. There's a nationwide nursing shortage. The working conditions and the stress level in the emergency department makes it not a popular long-term career choice for

the best nurses. And that is the most pressing immediate personnel need that we have.

Ms. WATSON. Okay. How do we solve that problem, and I will ask that of all of the witnesses?

Dr. Welsh.

Dr. CONWAY-WELSH. I have several suggestions. The amount of Federal dollars that are available for nurses to go back to school and to become either BSNs or masters-prepared nurses is very, very limited. The faculty scholarship program is very, very limited.

Let me take a little bit different cut though on your question about what could be done. The School of Nursing at Vanderbilt has just received status as a clinic, a nurse-run faculty clinic, as an FQHC. That process took us almost 10 years to be designated as an FQHC. There are schools of nursing all over this country that close their clinics once their education dollars run out from HRSA because they can't maintain it because all of our patients are indigent and poor. An increase in the amount of FQHC support would be extremely helpful.

And then the last point I might make is that we have many, many nurse practitioners who are not able to practice in the full scope of their practice because of State problems with the Medical Practice Act and the Nurse Practice Act. We need a Federal preemption that would allow the current nurse

practitioners to practice in the full scope of practice.

The other thing that we need to do is nurses are hunters and gatherers in hospitals. There's 30 to 40 percent of what they do that they shouldn't be doing. But the system doesn't allow them to give that up. There's not enough support of the non-nurse personnel for nurses to stop being hunters and gatherers. We would significantly address the nursing shortage in this country if we could just allow nurses to nurse and if we could fully utilize our nurse practitioners.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Issa, you're now recognized for just 5 minutes.

Mr. ISSA. Thank you, Mr. Chairman.

Can I ask unanimous consent to submit eight documents into the record that reflect the Commonwealth of Virginia's emergency response preparedness, both alone and in conjunction with the rest of the National Capital Region?

Chairman WAXMAN. We'll review the documents before we're willing to give unanimous consent, and we'll see if we can get the unanimous consent.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. ISSA. So you're reserving an objection?

Chairman WAXMAN. I object until I get a chance to review the documents.

Ms. WATSON. Mr. Chairman can we see the documents, too? I don't want to vote unless I know what it is.

Mr. ISSA. Mr. Chairman, here are the documents.

Dr. Lewis, because I ended the last round, I was just going to comment that in your own statement, you had said that you had surge capacity; you could bring in people that you wouldn't otherwise have, but it would put you into the red. And I'm not going to further elaborate because of the shortness of time, but if you have 48 beds and you don't fill them and 14 people say boarded, to me it sounds like you were unwilling to go into the red in order to board those people. But you did have 48 capacity, assuming those higher cost resources were available, but your hospital chose not to do it that day.

Dr. Kaplowitz, I'm very intrigued by your testimony, these documents that are pending going into the record. If I understand you correctly, if there were a significant crash or something on the Orange Line or Blue Line today representing dozens or even maybe a hundred significant injuries, you would be prepared to put together the resources to take care of that. Is that correct?

Dr. KAPLOWITZ. We would be working very closely with

the District of Columbia and Maryland in terms of appropriate distribution of patients working through EMS as well as the hospitals. We would activate our Northern Virginia coordinating hospital, which is at Innova Fairfax, and do the best we can for optimal distribution of patients. I can't tell you what would happen. You know, first of all, that could be anywhere.

Mr. ISSA. Sure, I understand on a given day that you can't answer. But in general, and we'll go back to Virginia Tech. Virginia Tech was an example of the worst of all worlds, a place you didn't expect it, a weather condition that wasn't cooperative and hospitals that generally were not prepared. And yet the response, looking back, you were able to rise using resources as you could transport people and/or--people one direction or the other. Is that correct?

Dr. KAPLOWITZ. Virginia Tech was not truly a mass casualty event. It stressed rural hospitals. And we were prepared to pull in people. However, no hospital was pushed beyond what they were capable of doing and wasn't hundreds of people at the same time.

Mr. ISSA. And, Doctor, I know it's always unfair to do hypotheticals, but in general, the amount of times that America is going to be attacked in mass by a dirty bomb, chemical attack or aircraft from the sky, compared to the amount of time in which an airplane crashes as it is landing

in Iowa, a DC-10, the Blue Line does have an electrical failure and people are damaged or burned, a gasoline truck on the 405 jackknives and bursts into flames, a fire in a refinery, such as Long Beach, a widespread hurricane or tornado that injures many; aren't all of these dramatically more likely? And I'll be self-serving and say, since it happens every year in America, every single year one or more of these, actually almost all of them happen at least once or twice a year, mass casualties occur every year in America. Isn't it true that, in fact, if we take the war on terror, the likelihood of another attack like 9/11 completely out of the scenario, that the need is greater in frequency and even likelihood of dozens or hundreds of people needing care, isn't it greater based on these? And I will throw in just one more for good measure, Dr. Lewis, an earthquake in Northridge?

Dr. MEREDITH. Yes, it is, and we're not ready to deal with that. Whether you survive an injury in America today on Interstate 40 from Wilmington, North Carolina, to Barstow, California, depends on how well you get hurt and how well the trauma system is organized between those two points.

Mr. ISSA. And, Dr. Kaplowitz, I'm particularly intrigued because you seem to be positive in saying that, at least within the resources available, Northern Virginia and Virginia in general has done a good job of being prepared.

And I'm particularly concerned because I'm a Californian, and it appears as though California feels they're not prepared. Could you comment further on why you feel fairly prepared within the resources available?

Dr. KAPLOWITZ. Preparedness is all relative. We've put a great many things in place to go beyond where we were on 9/11. I can't tell you how we would handle hundreds, you know, whether people would be happy with how we handled hundreds. We would have a plan, a communication system.

Mr. ISSA. One final question for the panel. If I had a billion dollars sitting in the center of this room and I gave it to you for preparation, training for these mass events or I spread it around the country to staff up or reimburse Medicaid, which would you rather have that billion dollars go to, assuming there was only one pile of $1 billion available today?

Dr. KAPLOWITZ. I would like to see our emergency departments and our capability, able to function on a daily basis. Because much as I've talked about surge, I also agree that if we don't do a better job on handling emergencies on a daily basis, we're going to be at a disadvantage when there is a mass casualty event. We have to be able to empty our emergency rooms more rapidly because that's going to be even more important in an emergency event. Again, I'm positive in terms of what we've put in place in the kinds of

communications. However, I recognize full well the stresses on our emergency system on a daily basis, and we can't ignore that. They're interrelated.

Mr. ISSA. Mr. Chairman, I would appreciate it if the others could answer for the record which way they would spend the money or if you would like to give them additional time.

Chairman WAXMAN. Well, whichever of you want to respond.

Yes, Dr. Lewis.

Dr. LEWIS. I agree absolutely with what Dr. Kaplowitz said. But in addition, I would like to point out that even if one chose to spend the $1 billion on training and equipment and things that would only be used in those very unusual events that you pointed out, one of the key decisions is whether we want to be prepared for the most likely of those catastrophic events or whether we want to instead be prepared for the least likely, meaning bioterrorism or nerve agents.

Mr. ISSA. Good point.

Dr. CONWAY-WELSH. I would take the $1 billion and apply it to the public health infrastructure in our country. That is critical to any kind of a response in any kind of a disaster. And we are in grave danger of a really crumbling public health infrastructure in our country.

Dr. MEREDITH. You could fund the Federal infrastructure

to support the States to develop trauma systems for $20 million or $10 million--million, million dollars. You know, you'll drop that on the way to work in the morning. So that should be done.

The next piece is just to your question, Representative Issa, can we plan to surge on a daily basis and always be ready nationwide? I don't think that is do-able or the smart way to do it. But I do think we are not ready on a daily basis to do what we have to do every day. And that frightens me immensely because we're not prepared for the bomb in a cafe or the mall or a bus falling off a bridge because we don't have the capacity on the every day basis.

Mr. HOFFMAN. This isn't exactly my expertise, but I would say that I agree completely with Dr. Lewis' statement. And I would point out that as unlikely as a terrorist attack may or may not be in the future of the United States, I think that the American people would expect that, years after 9/11, we would be prepared adequately to respond to any kind of threat like that.

Chairman WAXMAN. Thank you. And of course, they would expect we're not going to make things worse by Medicaid cuts.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

And I must say, because I represent the city, I'm especially grateful that you brought some sunlight to this

really urgent problem as we face Medicaid cuts. I want to note that I have constituents from Anacostia High School who would be very much affected if in fact there was such an event here.

Mr. Chairman, since 9/11, I've been trying to get funds out for what are called ER-1. It was to be a demonstration here. People came from hospitals all over the country to see how we did it here and then to see if they could replicate it. And essentially it would add to the Metropolitan Hospital Center a surge capacity and a way to quickly add on that capacity.

I want to--my concern, I will say to the panel, is that you have a mix of residents here. So if you try to separate out who you're talking about, undocumented, poor, who overuse, of course, emergency rooms from the ordinary emergency, you're going to have a hard time, which is why this ER-1 notion was to try to say this is the place, it is close to the Capitol, to send trauma victims. We have a burn center, for example. They brought people there from Virginia after 9/11. On top of 600,000 people who live here, we've got 200,000 Federal workers and other workers who just come in every day and go out, creating a potential for a true catastrophic situation. They won't be able to get out on the roads. Some of them will try to get out if they are hurt. So the point is to let them know quickly what the place is to

go.

Now, Virginia, and Dr. Kaplowitz you testified about what Virginia is trying to do with what money it had, and that caught my attention, placing key, according to your testimony, key supplies and medications in various places. Of course, Virginia went through 9/11 and trying to deal with surge in its various hospitals. I would like to ask you, and then that inclined me to look at how much in Medicaid funds Virginia would lose to see whether Medicaid funds were implicated. And I learned that Virginia--and when we talk about Virginia, Maryland and the District of Columbia, we're talking about one place virtually, except that if the event occurred here, unlike the Pentagon, if the event occurred here in this crowded space and people went to various hospitals, you would only make the situation worse, which is why we're working on this ER-1. The administration has supported it. We have not been able to get it through appropriations, even though they found considerable support for it.

Virginia would lose $93 million in Federal Medicaid funds over the next 5 years. I'm trying to discern what impact the loss of Federal Medicaid funds would have on the surge capacity they're trying to create out of whole cloth.

Dr. KAPLOWITZ. I've been thinking about that, knowing I was going to be here today. I know you've heard from Dr.

Sheldon Retchin, who spoke about the impact on the VCU health system. Again, if we lose much of the capability to handle emergencies on a daily basis, it's going to definitely put us at a disadvantage.

I know full well how much Level 1 trauma centers depend on Medicaid funding in general, not only for trauma care but in general, whether it's the VCU health system or Innova Fairfax. And I'm very, very concerned of the impact it's going to have on the ability of those facilities to function, not only in an emergency but on a daily basis. And they do work together. It's hard to expect a facility to add surge if they're to stressed on a daily basis. Nonetheless, we are planning for surge capability, surge beds for an emergency no matter what the situation is on a daily basis. We have to plan for the emergency and recognize that there are stresses on a daily basis. So I know there's going to be enormous impact on a number of facilities, especially our Level 1 trauma centers on a daily basis. It will impact their ability to surge in emergencies. That's not going to stop us from continuing to plan for that large event looking at distribution of patients and hoping facilities respond appropriately.

Ms. NORTON. Level 1 trauma centers are the ones that, because they are the hospitals that have the greatest capacity, tend to be the ones that are overcrowded?

Dr. KAPLOWITZ. Absolutely. There's one other point here that's not related to Medicaid funding but related to surge. And that is the concern that hospitals have of the funding they're going to receive after an emergency. I bring this up because it's a major issue when hospitals are talking about surging in emergencies. Most hospitals, most health care is private. And there's been a lot of discussion and stress about what kind of reimbursement they would get in responding to emergencies. They're going to respond, but are they going to be dramatically hurt financially?

Ms. NORTON. Following 9/11, it was easier to get funds out after the fact, and this is what's so frustrating to me. Because in the face of a catastrophe and living in a country that doesn't prepare for anything, money went out. But preparing for such an event is very bothersome. I am concerned, and I would like finally to ask this, if in fact these patients are distributed to the trauma centers wherever they are in a place like the District of Columbia, rather than to have a place that is specially outfitted to deal with traumas, if you would tell me how an emergency room is supposed to decide how to quickly separate the traumas that come, let us say from the District of Columbia, the other people who have serious emergency problems who come in, the people who shouldn't be in the emergency room but perhaps should be referred? I mean, I'm worried about the chaos of

just sending everybody to trauma centers in the first place.

Dr. Meredith, did you have an--

Chairman WAXMAN. The gentlelady's time is expired but we'll get an answer to the question.

Dr. MEREDITH. The trauma center itself is designed to do that exact question. A lot of work has been done to define what kind of patient is the trauma patient and how should they move. And those questions are answered. There are about 230 Level 1 trauma centers and about 320 Level 2 trauma centers, so we're talking about saving 550-ish maybe between that and 600 hospitals that are a core of the safety net for patients in the country.

Ms. NORTON. Thank you.

Mr. Chairman, I want to just say I'm very concerned that if people simply go to the hospital closest to them as opposed to the hospital that in fact has been most prepared to handle the surge from the event, all of the placement that Virginia is trying to do for example, kind of a little bit everywhere without Medicaid funds, will not serve us well in the event of a truly major capacity. If I may say so Virginia was not the kind of event that we in the District of Columbia are most afraid of following 9/11.

Chairman WAXMAN. Thank you, Ms. Norton.

I want to ask this. We have a health care system in this country that's the most expensive in the world, and yet

we have 47 million people who are uninsured. Most of them are working people, and they don't have insurance. So if they get sick, they go to the emergency room. If they don't have insurance, the hospital doesn't get paid for the care that they're given. So hospitals then have to figure out how to survive economically without getting paid for a lot of these emergency room patients. Isn't it true that the people that are in hospitals today because of this whole crazy system we have are some of the sickest people, unlike in other countries where they're not the sickest, they're not the ones that you just can't deny hospital care, but in our country, it's the sickest?

Is that right, Dr. Meredith, do you know.

Dr. MEREDITH. I don't know. It's a hard system to figure out, and I work in it every single day.

Chairman WAXMAN. Well, it's a hard system to figure out. But let's look at the system. There's not enough money in the system for all the people who use it who don't have health insurance coverage.

Now, does it make any sense--Dr. Hoffman, does it advance the goal of Homeland Security for the Federal Government to then be withdrawing funds from Level 1 trauma centers, whether through the Medicaid program or some other funding source? It's reasonable for the Federal Government to assume that States or localities--is it reasonable for the

Federal Government to assume that States and localities are going to make up these losses to the hospitals or the market forces will make up for the short fall?

Mr. HOFFMAN. Mr. Chairman, you know, I think we've already learned the lesson of not being adequately prepared before 9/11, so, no, it doesn't make sense from my perspective as a terrorist analyst.

Chairman WAXMAN. As a terrorist analyst.

How about those of you who are in the medical field? Does it make sense when you're struggling to keep these hospitals going under ordinary circumstances and trying to find out how to fund them for the Federal Government to withdraw Medicaid funds?

Dr. MEREDITH. Market forces will not make up for the loss that this money represents to the safety net hospitals and to these few trauma centers, I'm certain, because of the way the patients are moved around now. They will still get those patients. And when it represents such a loss that they can't sustain it, they will stop being trauma centers, and we'll lose them from the system, and it will be tragic.

Chairman WAXMAN. A lot of hospitals are already closing their doors for the emergency rooms because they can't afford to keep them open.

Dr. Kaplowitz, you're trying to find out how to plan, you're trying to plan for an ordinary catastrophe or a

terrorist kind of catastrophe. Does it help your planning efforts when the Federal Government withdraws money from the Medicaid program or some other funding source?

Dr. KAPLOWITZ. Not at all. And as I mentioned already, we're very grateful for getting some funding for emergency planning. But that's only a fraction of the funds hospitals receive. It couldn't then begin to replace the Medicaid dollars or the other dollars they need to maintain their infrastructure. So absolutely it makes no sense at all to lose that much funding.

Chairman WAXMAN. Now, some people say disasters are local. Local communities need to prepare for a terrorist bombing or similar attack. But it's also true that the Federal Government has a responsibility here, which starts with at least doing no harm. And that means not withdrawing Federal Medicaid funds that now support Level 1 trauma centers in the highest risk cities. I wanted to pursue another point about how we prepare for a terrorist attack. There has been, Dr. Hoffman, evaluations of potential terrorist attacks. In fact, I think the Centers for Disease Control brought together a panel. Is it the consensus of people looking at possible terrorist attacks, if we're going to have one, it's going to be using conventional terrorist weapons rather than a weapon of mass destruction?

Mr. HOFFMAN. Absolutely. Again, I don't think we can

rule out any potentiality. But certainly the higher probability event is conventional explosives and perhaps with suicide attacks.

Chairman WAXMAN. In fact, according to that report that was produced, they said a terrorist bombing attack in the U.S. would be a predictable surprise, like a hurricane is a predictable surprise or a major automobile traffic accident could be a predictable surprise. Yet the Federal Government under existing law has a responsibility for developing a national medical surge capacity to respond to a mass casualty event, such as a terrorist attack with weapons of mass destruction. In last October, the President issued Homeland Security Presidential Directive 21, which established a national strategy for public health and medical preparedness for this kind of an event. It's crucial that we be prepared for that kind of event using a dirty bomb or biochemical weapon. But I don't know that there's any national strategy to prepare for or respond to a terrorist attack using conventional explosives, such as happened in Madrid or here in Oklahoma City or at Centennial Park in Atlanta. Dr. Hoffman, is there such a Federal response being prepared by this administration that says, the buck stops here?

RPTS DEAN

DCMN BURRELL

[12:00 p.m.]

Mr. HOFFMAN. No, my understanding is that incidents like terrorist attacks involving conventional explosives are viewed to a lesser included contingency, and the assumption has long been, going back from what I testified before a subcommittee of this committee that Congressman Shays chaired nearly a decade ago, is that generally these more conventional types of terrorist attacks don't receive the same type of attention that the high end, less likely threats do.

Chairman WAXMAN. Well, this is exactly what we want to ask the Secretary of Health and Human Services and the Secretary of Homeland Security. What is the Federal Government doing? What do we have in place? What are we planning in case a predictable event such as a terrorist attack occurs. And some people think that's partisan to ask those questions. I think it is something we ought to be asking on a bipartisan basis.

Mr. Shays.

Mr. SHAYS. Thank you. Dr. Hoffman, Hadassah Hospital in Jerusalem has a facility that has a whole floor designed for a surge capacity, but they have no doctors to man it. In other words, it's--and it is there for a potential chemical

attack, and so on, where they can isolate patients and so on. I see the logic of doing that, but I don't see the logic of staffing it. And so then they compromise and they bring other people in from different places. Isn't that a model that makes sense for the United States?

Mr. HOFFMAN. Well, sir, I used to think I was in a depressing field studying terrorism until I sat on this panel with my distinguished colleagues. And given everything that I've heard about the capacity of our trauma centers this morning, it's a different situation.

Mr. SHAYS. I don't know why it's different. They have to deal with a terrorist attack and that's what we're talking about right now. I mean, you know, Dr. Lewis, your hospital was kind of shut down for a while because they required you to have more people present. I mean the requirements changed and so it took a while to get back up to speed because of, I think, new regulations; is that correct?

Dr. LEWIS. I don't believe our hospital was shut down at any time.

Mr. SHAYS. I mean--you know what I'm making reference to. Do you want to explain it?

Dr. LEWIS. Actually I'm not sure. Are you talking about a citation we received in response to long waiting times in the emergency department?

Mr. SHAYS. Right. I meant only--I'm sorry, I didn't

mean hospital, I meant in the emergency room. This is not a trick question. I mean, the point that I'm trying to make was that you had to staff it at certain level and you weren't able do that, correct?

Dr. LEWIS. The citation was in response to delays in seeing patients with acute medical conditions because of the long waiting time in the emergency department.

Mr. SHAYS. Right, but--

Dr. LEWIS. Let me try to answer your question. The staffing was simply a way of more quickly screen--additional staffing to screen those patients.

The question you asked about how Israel is different, one very important way that Israel is different is that because of the constant concern over mass casualty incidents they do not allow their emergency departments to become overcrowded. And one way they accomplish that is that if the emergency department becomes overburdened they immediately move those patients up into non-normal treatment areas inside the hospital so the emergency department does not get gridlocked. And that's a reflection of their greater day-to-day awareness of this threat.

Mr. SHAYS. So but the bottom line is they have a surge capacity in space, not necessarily in terms of doctors on duty and nurses on duty. And it would strike me that that's part of the model. It would strike me that part of the model

that we have to work on is better coordination and how we move patients and so on. And we're connecting two things that maybe need to be connected. But in the process we're really talking about two separate issues. One, do you have the capability to deal with your basic emergency needs day in and day out? I mean I'd love to know--I'd love to keep going because I'd love to know is there a rule of thumb with so much population you need a trauma 1, a trauma 2 and a trauma 3. Some States may not have it. I think West Virginia doesn't. Is there--should every hospital have an emergency facility? And I understand that some don't now. You know, so those are all legitimate, you know, questions that I have no answer to.

Dr. LEWIS. I'd just like to comment that there are standard rules regarding for a population of a given size the number of inpatient hospital beds. Prior fiscal pressures have forced many hospitals to reduce the number of inpatient beds that they either maintain physically or maintain staffing for. So fiscal pressures over the last 10 or 15 years have resulted in most or at least many metropolitan areas having a number of inpatient beds far below the originally recommended number.

Mr. SHAYS. Right.

Dr. LEWIS. That's the direct cause of the ED overcrowding that we've been talking about. So there are

rules of thumb and we violate them.

Mr. SHAYS. But what would be a shame in this process is I happen to have opposed the changes in requirements. And we voted to try to hold them, but what would be a shame would be to not be having the dialogue about all the other things that don't take money necessarily, but talk about coordination, which we're not even getting into.

Dr. Kaplowitz, my understanding is Virginia does a better job of anticipating these kinds of challenges.

Dr. KAPLOWITZ. Well, we've had to out of necessity but I wanted to make the comment about Israel. I've been there. Israel provides health care coverage for everybody in their population.

Mr. SHAYS. Right.

Dr. KAPLOWITZ. Their facilities are not under the same financial stresses as ours are here. Not only do they deal with suicide bombing, but every single one of their hospitals is a hospital when they have a war. It's a different mindset, but the fact that everybody has coverage, everybody has a medical home, it's made an enormous difference in terms of their emergency preparedness and the stresses on their individual hospitals.

Mr. SHAYS. Let me just end with this comment. First, one area where the administration doesn't get enough credit is the effort they have gone with community-based health care

clinics. We've expanded from 10 million to about 16, 17 million people covered. That's one area where they do deserve credit. And there's areas where they, you know, rightfully should be criticized.

I happen to be on legislation cosponsoring with Jim Langevin that says we're going to go to universal coverage giving--providing the same health care benefits that Federal employees have as a choice to everyone. Where I have my big disconnect, and it seems like it's an issue we don't want to ever discuss in this country, is how we deal with the 13 to 20 million people who are here illegally. They are not undocumented. Undocumented means that somehow all they have to do is be documented. By not being documented they are here illegally and they are here illegally. And it doesn't seem to come up. And I know for a fact these are folks that don't have coverage and intuitively they are going to go wherever they can get help and they are going to go to emergency wards. And the fact that we like want to dance around this just blows me away.

That's my comment.

Dr. KAPLOWITZ. I did want to make a comment about a public health study that has shown that recent immigrants actually used less medical care than the rest of Americans. This was brought up in the recent series about disparities in care. So while I acknowledge that there are significant

numbers of people who may we here illegally, they actually used less medical care than--

Mr. SHAYS. And let me tell you why I think that is an irrelevant statement. They use less care and when they do use it they go where they can get it, which is an emergency ward. And therefore the logic is that when they do use it, they are using it there.

Dr. KAPLOWITZ. They--

Mr. SHAYS. Thank you.

Dr. KAPLOWITZ. I will add another comment. They are not only going to emergency rooms. I'm on the board of a free clinic--free clinics--an enormous amount of care, including to undocumented persons. So they don't all go to emergency rooms.

Mr. SHAYS. They go to community-based health care clinics, we know that, and that's one thing the administration has done well.

Chairman WAXMAN. I want to raise a point that I think this issue of illegal immigrants is a red herring.

Mr. SHAYS. Why?

Chairman WAXMAN. The reason it is a red herring is that illegal immigrants are not eligible for Medicaid, they are not eligible for Medicare. They may get private insurance, and if they do, their insurance company is paying the bills based on their payment to the insurance company.

Mr. SHAYS. But isn't that--

Chairman WAXMAN. I'll take a time and then I'll let you take a time.

Mr. SHAYS. Thank you. Okay, no problem.

Chairman WAXMAN. I'm not going to get interrupted.

So when the people who are illegal come to an emergency room, it's usually as a result of a trauma.

Dr. Lewis and Dr. Meredith, from your experience and knowledge of what goes on in emergency rooms, are most of the people in emergency rooms for trauma undocumented aliens or are they people that don't have insurance coverage when the hospital ends up with a bad debt?

Dr. MEREDITH. Most of the people in the emergency departments are not for trauma, they are for other emergency conditions. Trauma is very important to me, but a smaller part of what goes on in emergency departments. Most of the patients who are trauma patients are not undocumented or illegal, they are a spectrum of American civilization. They--everybody gets hurt, and they are a complete spectrum of people, a complete spectrum of people. We take care of them all. We just stop their bleeding, that's all we can do.

Chairman WAXMAN. Dr. Lewis.

Dr. LEWIS. I agree with the statement, trauma is a nondiscriminate force and it doesn't ask you about your legality status before you get hurt.

Chairman WAXMAN. Now, let's say Dr. Meredith rightfully pointed out that emergency care is not just trauma care. So someone gets sick, and they don't know where else to go, and they don't have health insurance and end up in emergency rooms to see somebody to see what needs to be done. Of course that's the most expensive setting for people to get health care, which is one of the problems in our non-system of health care in the country. People get seen and treated in the most expensive way. They could go to a community health clinic.

When you see people who come in because they have no health insurance with a minor problem, do they get something extraordinary? Do they get a lot of time and attention which will encourage them to come back with these smaller problems?

Dr. LEWIS. It is my impression that the--if we're focusing specifically on illegal immigrants in Los Angeles County who come to my hospital, my impression is that the vast majority have attempted to seek care in other facilities first for the same problem, except for acute serious illness that couldn't be treated anywhere else. And occasionally they find that the community health clinics, some of which are federally supported, some of which are just free-standing, have been unable to take care of their problem because it has either gotten worse despite treatment or there has been some complication. But it is my impression the vast

majority of them attempt other avenues for seeking medical care before they come to my department.

Chairman WAXMAN. Now there are 47 million people without health insurance. I've heard an estimate that there may be as many as 5 million illegal immigrants. Now 47 to 5, of those 5 million illegal immigrants, some of them have health insurance, isn't that true? They have a job where they are provided health insurance, probably most of them don't. And if they need health care, they'll go to a clinic and it's the right thing to do for us to have put in more money into the community health centers programs. But it doesn't deal with the problem that we have. Let's say 47 plus 5, 51 million people. Yet if something terrible happens to them they have to go to get care immediately, they are not going to go to a clinic, they are going to go to an emergency room.

What should the Federal response be for emergency rooms that are facing 47 plus 5, 52 million people without insurance? Well, the hospitals can't turn them away. Well, what most hospitals do if they are private hospitals they will close their emergency room. And then if they don't have an emergency room, they have--then these people have to go to places where there are emergency rooms. But if those emergency rooms are already overburdened, they are diverted to other emergency rooms. Isn't that what happens?

Dr. LEWIS. Yes, that's correct. And although I don't have a good suggestion for what the Federal Government should do, what I am sure that it should not do is reduce the funding for those safety net hospitals prior to having a viable alternative solution.

Chairman WAXMAN. And certainly they shouldn't do it without finding out what the consequences are. That's what's so shocking to me about these Medicaid cuts. The Center for Medicaid Services and the Department of Health and Human Services never even did an evaluation of what the impact would make--on what the impact would be if these kinds of cuts took place. They simply said we'll let the States and local governments figure out how to deal with this.

Well, it seems like they are trying to make the States and local governments have to deal with everything. And at least when it comes to a terrorist attack there certainly ought to be a Federal responsibility. I believe there ought to be a Federal responsibility for all people in this country who don't have access to health care because this is distorting our whole health care system. So that's why I say it is a red herring to say the problem is all these illegal immigrants. It's not just that, that's an over simplification and a diversion from the much more serious problem that this administration for 7 years has not given us any ideas for, except maybe give a tax break, which is

inadequateto even buy health insurance to a lot of people who couldn't then afford to buy health insurance even with that tax break.

Mr. Shays, I will recognize you for the last 5 minutes, and then we will continue.

Mr. SHAYS. Thank you. And I would be happy to have you interrupt me if you'd like--I mean to ask a question.

Chairman WAXMAN. No, I will not interrupt you.

Mr. SHAYS. What I'm looking for is meaningful dialogue. I don't have any dog in this race. I mean I'm just trying to understand something. And I get confused because in the Medicare Modernization Act funds were included for hospitals in States with high numbers of illegal immigrants because these hospitals complained about the problem of illegal immigrants who were in fact stressing their hospitals. So you know--

Chairman WAXMAN. In the Medicare--

Mr. SHAYS. In the Modernization Act.

Chairman WAXMAN. Do any of you know whether that's accurate, because I don't believe that's accurate.

Mr. SHAYS. The question I have is first off, I do not believe that this is the cause of the problem. I think it is a part of the problem. It is news to me that if we have anywhere from 13 to 20 million people there illegally, that only 5 million don't have health coverage. That's news to

me. And we have 13--we have 12 million people who are here legally who are documented, but not citizens. We have a range between 13 and 20 million who are not here legally. They are here illegally and I make an assumption, maybe incorrectly, that a majority don't have health care. Because it would really be surprising to think that 85 percent of Americans have health care, but you know undocumented workers have that same average or even half that.

I happen to believe that we need to have universal coverage. All I want is an answer from folks who are there that my understanding is you got two options for someone without health care. You go to a community-based health care clinic or you go to the emergency ward. I mean, I don't know if there are other options. And so it strikes me that we are stressing the emergency rooms. And they are hugely costly. I went where I had three stitches. The hospital got into a dispute with the insurer and sent me a bill for 1,300 bucks for three stupid stitches. Had I gone somewhere else it wouldn't have been obviously that expensive.

And so I'm just trying to make the point to you, Henry, that I think that we spend a fortune on health care, far more than other countries, and that we keep saying well, we just have to spend more money. We're at 18 percent of our gross domestic product and I don't think we can actually find a lot more money. And so what I struggle with is are there things

that don't involve money where we can deal with the surge capacity.

And Dr. Hoffman, you didn't seem to want to jump in on some of this, like all of a sudden this was outside your expertise. But it strikes me that we can learn from what other places do. And they don't put a lot more money in, they have extra bed space with no doctors.

What I was confused by Dr. Lewis in the dialogue with Mr. Issa, you said, well, we have 45 beds, but they are unmanned. Is that a bad thing that they are unmanned? Is it good that you have this space in case you have a need for surge capacity?

And another question I ask all of you, aren't there times when we're going to have to break the rules of so many nurses and so many doctors when you have an emergency. Then it seems to me you throw it out the window, you may have doctors working overtime, nurses working overtime and some rules being broken during a surge--a needed surge.

Dr. LEWIS. First of all, I agree with you 100 percent that there are issues of coordination and response to major, very infrequent events that could be used without substantial funding to improve our ability to respond. I think there's no question that that is correct.

The issue regarding the unstaffed beds in the hospital has something to do with the funding source. We're a

publicly funded institution. The vast majority of our funds either come from or come through Los Angeles County. These are public funds. Such--the similar kind or type that you're responsible for administering.

Our hospital administrators cannot make a decision to go over their budget and staff those beds. It is not their authority. It is a public process that's overseen by the board of supervisors, who I understand were here recently. So it's--I got the impression or the implication was made that a hospital administrator was not staffing them to avoid losing money. That's not the case. It is just not an option.

Secondly, with respect to the money that is already being spent in preparedness, I think a number of us have tried to point out the disconnect between the most likely unusual mass casualty incidents and the types of incidents that seem to have been focused on by the existing hospital preparedness program. That program used to have the term, I believe, bioterrorism in its name. They took out the bioterrorism part of the name, but still maintained most of the focus on supplies and equipment that are related to relatively unlikely events.

So one thing that we can do without asking for additional money is to focus on the most likely events, and I'm not talking about the everyday surge events, the most

likely true mass casualty incidents.

And then lastly, I'd like to simply point out that in Los Angeles County the public funds that support our institution, part of them come from tax revenues. Those tax revenues are driven by the economic activity in that area. I'm in no position to speculate regarding what the effect of removing those illegal workers would be from our economy, but I'm not actually sure that the net effect on the funding of our health care system would be beneficial. I actually think it would probably be detrimental. Clearly a health economist would have to look at that, hopefully one not driven by partisan concerns.

Chairman WAXMAN. Thank you, Mr. Shays.

Ms. Watson, did you--

Ms. WATSON. I sure do. And I just want to say, I don't think it's really clear to some members that if you are an illegal immigrant you are not eligible, you're not eligible for Medicare and Medicaid.

As Dr. Lewis astutely notes, there are some Federal policy makers who still do not see the relationship between maintaining robust emergency and trauma care capacity and a successful homeland defense strategy. Hello.

I would like to ask Dr. Hoffman and Dr. Kaplowitz, both of whom know a great deal about emergency preparedness and response, to help us connect the dots. While there is much

dispute about whether the Medicaid regulations are justified, there's no dispute that they will reduce the amount of Federal Medicaid revenues to Level 1 trauma centers and other hospitals throughout the country.

There is also no dispute that the loss of Federal funds will vary from hospital to hospital and that for some Level 1 trauma centers these losses will be substantial, potentially forcing reductions in services and degrading their emergency response capacity.

So Mr. Hoffman, does it advance the goal of Homeland Security for the Federal Government to be withdrawing funding from Level 1 trauma centers whether through the Medicaid program or some other funding source? And is it reasonable for the Federal Government to assume that States or localities will make up these losses to the hospitals or that market forces will make up for the shortfall?

Mr. Hoffman--Dr. Hoffman, excuse me.

Mr. HOFFMAN. Well, I think certainly not in those cities, for instance, that the Department of Homeland Security have identified at least the most likely threat of a terrorist attack.

Ms. WATSON. Excuse me, when you say most likely those areas, how do you define the areas that are most likely the target of terrorist attacks?

Mr. HOFFMAN. Well, the Department of Homeland Security

and also private risk management firms have assessed on a variety of indicators in terms of terrorist interests, in terms of the vulnerability facilities in those cities, which cities in the United States would be more likely than others perhaps.

Ms. WATSON. Would you consider the West Coast or Los Angeles area?

Mr. HOFFMAN. Certainly Los Angeles and southern California. San Francisco probably falls into that category as well.

Ms. WATSON. Okay.

Mr. HOFFMAN. I mean given the pattern of terrorists, and certainly since 9/11 there is a very high concentration of these activities, fortunately not yet in the United States but overseas in major cities that are at least if not the capital of their nations, then at least are business centers or transportation hubs.

Ms. WATSON. I just wanted to hear your response. Thank you.

Mr. HOFFMAN. But if I could just finish for a second?

Ms. WATSON. Yes.

Mr. HOFFMAN. I would go back to what Dr. Kaplowitz said about Israel, which I think is absolutely correct, is that their energy services are not as over stressed in terms of their personnel as it appears in the United States. London

by contrast though I think is very similar to the United States in that respect with emergency rooms that have--that already are burdened by a health system with lots of people in urban areas coming into them. You can see the difference in the response of the London hospitals to the 7/7/05 attacks. There I think the coordination was not as good, even though they had extensive drills and extensive training, the planning--the system broke down in essence because there were insufficient personnel on that because the systems themselves were stressed.

Ms. WATSON. Dr. Kaplowitz, as a State official you've been involved in a great deal of planning for emergency preparedness and response throughout Virginia. Does it help your planning efforts when the Federal Government withdraws funding from Level 1 trauma centers, whether through the Medicaid program or some other funding sources?

Dr. KAPLOWITZ. Not at all. I need those facilities to survive. And I know what kind of stress they are under on a daily basis. You remove Medicaid funding, it could be disastrous. We have seen any number of hospitals need to close their doors. The last thing I need is for any more hospitals to not be able to survive financially. And the stressors for trauma centers are enormous. The additional cost it takes to keep your trauma center open is significant. And these facilities are functioning with very small

margins. So I need them to be able to function and stay open, and I need them to maintain their expertise in order to appropriately respond to emergencies.

I've been at the Health Department almost 6 years. In my prior life I was at the VCU health system for 20 years, including working in hospital administration, and I know what kind of stress that facility is under on a day-to-day basis. You take away significant Medicaid funding, it's going to be disastrous. And the sameis true of all trauma centers in the Commonwealth.

Ms. WATSON. Thank you for that.

Chairman WAXMAN. Thank you, Ms. Watson. And I want to thank this panel. I think you've given us a lot of good information, some of it quite startling, and I think we have to pay a lot of attention to it and ask the people in charge, the Secretary of Health and Human Services and the Secretary of Homeland Security, both of whom are going to be here Wednesday, how to respond to some of these concerns what the Federal Government is doing and at least find out whether we're doing harm with some of the proposals that are being pushed.

That concludes our hearing today--oh, yes, there was one item, Mr. Issa requested unanimous consent to put in documents. I have no objection. Does anybody?

Ms. WATSON. No objection.

Chairman WAXMAN. Without objection, those documents will be part of the record. We stand adjourned.

[The information follows:]

******** INSERT 3-1 ********

[The information follows:]

******** INSERT 3-2 ********

[Whereupon, at 12:30 p.m., the committee was adjourned.]