Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

TESTIMONY

Hearing on

Post-*Katrina Recovery: Restoring Health Care in the New Orleans Region*

December 3, 2009

Statement of

Alan Levine

Secretary, Louisiana Department of Health and Hospitals

Before the

Committee on Oversight and Government Reform

U.S. House of Representatives

Chairman Towns, Ranking Minority Member Issa, committee members, thank you for the opportunity today to testify about my state's health care challenges and how they will impact the ongoing recovery of the Greater New Orleans region, southeast Louisiana and our entire state. I'm also glad to be here to share with you some of the successes and challenges we have experienced in strengthening health care access through the Primary Care Access Stabilization Grant program.

New Orleans, our state, and, indeed the Gulf Coast Region, have made progress in the recovery since Hurricane Katrina made landfall. Approximately 65 percent of businesses have reopened, and the population is about 78 percent of pre-storm and growing. The health care workforce initially experienced significant losses, but has since exceeded national averages. This is due to the innovative programs that provided financial incentives for providers to return or remain in the region. The supply of medical services continues to transition to the new population levels, with various components of the system facing challenges, such as geographic disparities and other barriers that may limit access to health care to meet the needs of the residents. For example, the majority of the health care delivery sites are located in Jefferson Parish (66 percent) with only one-third (33 percent) in Orleans parish and less than 2 percent in Plaquemines and St. Bernard Parishes. The health care delivery sites ratio for St. Bernard Parish is 3,715 people to every clinic, while Jefferson Parish ratios are at 547 people per clinic in 2007. While the overall physician-to-population ratios for the overall region are better than the national average, we cannot ignore the geographic disparities that are not as well defined or measured.

Louisiana's health care system was ailing for years prior to the 2005 hurricanes, and many of these challenges have only intensified in the aftermath. Thanks to the support of the federal government, some of these issues were mitigated, although we have deep concerns about the sustainability of the gains we have made.

Throughout its history, much of Louisiana's care for the poor has been provided in the public hospital system. With many of the policy changes being contemplated in Washington, including the new rules affecting the funding mechanism for the public hospitals, the Disproportionate Share Hospital (DSH) Audit Rule, as well as the possible expansions of Medicaid, Louisiana must hasten its efforts to prepare its infrastructure for these changes. Next year alone, we face the loss of what could be more than $140 million in DSH payments from the federal government, in addition to substantial reductions in the federal participation in Medicaid. Both of these changes are occurring

at the very moment of a possible expansion of the Medicaid program, which currently covers more than 26 percent of our population. Given this possibility and the funding challenges, the reforms we need to make become even more critical. Overall, Louisiana's Medicaid program has significant challenges, led most importantly by the chronically poor outcomes produced despite the best efforts of our providers—who struggle because they offer services in a fragmented system with little coordination of care. Our rates of avoidable hospitalization have been shown to be among the highest in the nation, and our quality metrics are poor by most measures. When compared to other states, Louisiana spends a great deal of money on health care with a very low return. Louisiana has ranked 50th on many measures of our health system's performance for 16 of the last 19 years, according to the United Health Foundation.

But, progress is being made. Because of our state's commitment to improving child immunizations, for example, our ranking this year has improved from 44th in the nation to 2nd in the CDC rankings. We are proud of this improvement, and it is one of the contributing factors to the most recent report by the United Health Foundation's overall rankings, which ranked Louisiana 47th overall. While this is still too low, *it is the highest ranking Louisiana has received in the 19 years since this ranking has been done.* While this is a step forward, one that we hope to replicate each year, 47th clearly shows that we have tremendous work still ahead of us.

Extensive studies and analyses of Louisiana's health care infrastructure have been performed—all with the same observation. Our state-operated Medicaid program suffers from poor coordination and extensive fragmentation. Governor Bobby Jindal and I have proposed a sweeping reform of the Medicaid funded system, which would provide networks of coordinated care, consumer choice and a focus on transparent quality measures tied to performance – with a goal of moving away from the fragmented, volume incentivized model. We must move toward a system that incentivizes improvement in metrics we know improve health, rather than simply rewarding higher levels of utilization.

I cannot overstate the importance of implementing this model, as our current fee-for-service system cannot manage a Medicaid expansion of the magnitude being debated by Congress without fundamental reforms to our structure. Even today, we struggle to find providers to serve our most vulnerable citizens, and when we do find the providers, we have significant challenges coordinating the care. On top of this, in the next 20 years, the number of people over the age of 55 will nearly

double, placing a huge strain on the demand side of our health care system at the very same time a shortage of more than 125,000 physicians is expected. As utilization demands increase, we must find ways to better manage conditions in the lowest-cost setting or we will find ourselves with unmanageable rates of hospitalization and costs we cannot sustain.

As we develop our new model, we are in the process of deploying a disease management initiative focused on managing chronic asthma, congestive heart failure and diabetes, with the goal of reducing ambulatory sensitive hospitalizations. All of our new Coordinated Care Networks will be required to provide these services, which will also include Chronic Obstructive Pulmonary Disease, Sickle Cell and other chronic conditions at high risk of avoidable hospitalization.

The financial challenges we face over the next several years are profound, and without significant structural changes to our program, the state is not in a position to manage this challenge. To put it in perspective, the state is currently facing a shortfall in Medicaid with an annualized impact of $1.2 billion beginning in July 2011. In the state fiscal year that begins July 2010, the shortfall is expected to exceed $700 million.

Louisiana's people are grateful for the federal assistance provided by Congress and our other federal partners to restore and expand access to primary care and mental health services. In addition to the funds made available to the state through the Primary Care Access Stabilization Grant, the state effectively utilized funding available through the Professional Workforce Supply Grant, Social Services Block Grant (SSBG) and Crisis Counseling Assistance and Training Program (CCP) Grant.

In 2005, under the Deficit Reduction Act, $15 million was provided to recruit and retain primary care, mental health, dental and pharmacy professionals to health professional shortage areas in the Greater New Orleans area. An additional $35 million was awarded in 2007 to continue the successful work of the Greater New Orleans Health Service Corps. Today, the program has made awards to 1,228 professionals. Specifically, we've kept more than 150 primary care physicians, 24 specialists, 560 nurses, 50 pharmacists and more than 130 mental health professionals, as well as many others, in the New Orleans area. The state has work closely with the Human Resources and Services Administration, a division of the U.S. Department of Health and Human Services, to expedite the contracting process, recruit needed medical professionals and address issues that impact retention. My department just received a no cost extension to provide contract oversight of professional health care grantees until September 2012. In addition to assuring

contract compliance, we will expand data collection on recruitment and retention to assist us as we determine what strategies were most effective and can be successfully replicated. Despite these efforts, and similar to our sister states, we are still experiencing varying levels of professional health care shortages within the region—a problem likely to get much worse.

While the Administration for Children and Families administers the Social Services Block Grant funding to assist states in delivering *social services*, an exception was made in the 2006 appropriation to include the provision of health care services. This allowed the state the flexibility to provide services based on the needs of the individual rather than the rules of the bureaucracy. The state received more than $220 million in SSBG funding, and the Louisiana Department of Social Services served as the administrator, working with the Governor's office and the Louisiana Department of Health and Hospitals to identify needs and fund the services.

LDHH received $101.7 million and designated $80 million for mental health services, including substance abuse programs and services for people with developmental disabilities, to help these individuals address what was clearly an emerging mental health crisis. For adults, the funding was utilized for Assertive Community Treatment (ACT) teams, intensive case management, mobile crisis intervention teams, transitional housing and crisis triage services. For children and adolescents, school-based mental health, case management, family preservation, in-home crisis stabilization, after-school mentoring, multi-systemic therapy and crisis housing services were funded. Most of these community-based services did not exist prior to the storms. Even today, we continue to offer many of these services, which the state has funded as the grants have expired. Last year, the state increased the mental health budget by more than $89 million, with much of that funding being used to continue programs begun with the federal grants.

As an example of the weakness in Louisiana's health care system prior to the storm—a weakness exacerbated and revealed by the storm—I point to the history of our mental health services. Whereas in most states, at least 60 percent of the mental health budgets are spent on community-based services, we face the opposite in Louisiana. More than 65 percent of our mental health funding has paid for institutional care. This is not the model proven to be most effective, and we have taken steps to change this approach. With the increased funding for community-based services, and our efforts to integrate care in the setting closest to where people actually live, we believe the quality and availability of mental health services will improve.

The state designated $21.7 million of the SSBG for primary care. Each local parish was encouraged to develop proposals for restoring services according to its unique needs. Seven parishes received funding to address primary care challenges in their area with funds allocated to more than 39 facilities. Contracts were administered by local government entities to provide oversight at the parish and/or regional level as needs crossed parish lines. The funds were awarded based on the needs outlined in the application process—to fill the gap in operational costs for the clinic or facility for the year. Awards were made to replace lost equipment, destroyed supplies and/or increased demand due to need, salaries and benefits to assure access, operational expenses and professional services to stabilize care delivery. While this funding was critical, the sustainability becomes a challenge when it is used for reoccurring expenses, which was done.

Another critical piece in addressing the mental health crisis post-Katrina and Rita was the crisis counseling program, Louisiana Spirit, made possible by CCP grants from the Substance Abuse Mental Health Services Administration (SAMHSA). The grant award of $29 million was intended to meet the short-term mental health needs of people affected by the disasters. In all cases, Louisiana Spirit was either able to de-escalate crises related to storm trauma or refer those in need of greater crisis intervention services to the appropriate resources in the public and private sector. Louisiana Spirit completed 1.9 million face-to-face contacts with affected individuals through individual crisis counseling, group sessions or brief contacts in the New Orleans area alone. These services were extended in the aftermath of Hurricanes Gustav and Ike through an award of an additional $2.8 million, adding more than 200,000 additional contacts with affected individuals in the New Orleans area. More than 4.7 million contacts were made statewide with individuals impacted by Katrina, Rita, Gustav and Ike through individual or group counseling, or supportive or educational sessions.

There are three critical issues that will have a tremendous impact on the success or failure of the recovery of the Greater New Orleans region's health care infrastructure and system. I would also like to offer my recommendations on how we address these issues.

First, the Primary Care Access and Stabilization Grant program has been a critical element in preserving access to services in the region. While many hospitals and clinics were damaged or destroyed during the storm and its aftermath—and some remain closed today—the PCASG grant currently funds more than 90 clinic sites, providing primary and behavioral health care to more than 175,000 individuals in the New Orleans area annually and providing community-based access to

more than 74,000 of the region's uninsured. The Louisiana Department of Health and Hospitals was awarded the $100 million PCASG grant in July 2007 to support the restoration of primary care services and develop a community-based care network focused on primary care and integrated behavioral health care for low-income populations. This grant has been in place for two years, and significant, measurable improvements in quality have been made.

Consider the St. Bernard Health Center, made possible by the PCASG program, and over four years after the storm, the only multi-specialty health care facility currently open in St. Bernard Parish. With more than 50 employees providing services, including doctors, nurses and other staff, parish residents do not need to drive to Orleans or Jefferson Parish to get primary care services—services we know they would likely do without if it was not available in their community. Even more critical, the facility also effectively acts as an urgent care facility with a 24-hour call center and ambulance service when necessary. The St. Bernard Health Center reports that they receive between 3,500 and 4,000 patient visits each month. Without PCASG funding, many of these individuals receiving primary care services would have had nowhere else to go but to an emergency department to receive their care.

We awarded the PCASG funds to twenty-five public and private not-for-profit organizations providing primary and behavioral health care in Orleans, Jefferson, St. Bernard and Plaquemines parishes. Today, 91 clinic sites vary in scope and scale and include primary and behavioral health care clinics, school-based health centers, dental and mobile clinics. The total system volume (number of individuals served) has increased by 15 percent every six-month period starting March 2007. We did not simply want to use the money to pay for the services without implementing performance criteria to improve quality and the system. As evidence of our commitment to using these dollars to transform our system, we point to the fact that thirteen of the 25 organizations have since achieved recognition by the National Committee on Quality Assurance (NCQA) as Patient Centered Medical Homes at 36 clinic locations. Even more clinics are expected to achieve the recognition this year. This is a significant success story—one that is difficult to do even in the best of circumstances.

According to a recent release by the Bureau of Labor Statistics, the Current Population Survey showed Louisiana's poverty rate increasing. In 2007, 20.6 percent of New Orleans residents (47,487 people) were living in poverty. More than 40 percent of New Orleans residents report a chronic health condition or disability, highlighting the importance of primary care. The Louisiana Public

Health Institute estimates that, without a continued source of funding, the participating providers would be forced to scale back 30 to 40 percent of current capacity. The clinics serving high numbers of uninsured individuals in urban areas would bear the brunt of the loss. As a result, many of the most vulnerable patients would lose access to the care they need to stay healthy and help avoid reliance on costly, episodic emergency department care.

We must preserve and sustain these 91 clinics in the region and expand access to primary care and related services statewide. All estimates around national health care reform point to a substantial expansion of eligibility for Medicaid. Louisiana's current eligibility levels for adults are at 12 percent of the Federal Poverty Level (FPL). With the expansions proposed by Congress, eligibility would increase to up to 150 percent of the FPL. I strongly urge Congress to consider the continued federal funding annually to sustain these clinics until health reform is implemented or the debate is resolved. The expansion of Medicaid without sustaining access to primary care would be a terrible combination of events for the people we are trying to preserve access for.

Another funding solution currently being evaluated is through the process of an 1115 waiver, which would propose to permit the state to redirect Disproportionate Share Hospital (DSH) funds used in the hospital setting to the clinic setting. The waiver would provide a coverage model statewide for primary care services, limited diagnostics and pharmacy, as well as the ability to create networks of providers to serve as an individual's medical home. PCSAG clinics, Louisiana State University (LSU) clinics, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), community clinics and private providers would have the ability to participate using the existing successful model. While this potential model has promise, the challenge will be that the state must fund the state match portion of the DSH funding—something that today we may not be in a position to do, particularly with the massive federal reductions we are facing in the Medicaid and DSH programs. We have asked about the possibility of Congress permitting unused Community Development Block Grant (CDBG) funding to be redirected for other purposes, with this being one of the potential uses.

The second critical issue facing our state is one I have previously mentioned related to our funding challenges in Medicaid. Louisiana, a state with traditionally low per-capita personal income and the second highest percentage of people living in chronic poverty, will face an unprecedented drop in Federal Medical Assistance Percentage (FMAP). This substantial loss

in federal support for the Medicaid program is due to the dramatic and temporary inflation in the state's per capita personal income resulting from public and private recovery dollars infused into the state after the 2005 storms. The federal match formula was not designed to recognize the short-lived nature of sudden and temporary economic activity resulting from a natural disaster, and Congress never intended for major disasters to result in lost federal match for Medicaid. Historically, Louisiana's federal match has ranged from approximately 70 percent to 73 percent, with small fluctuations from year to year. In January 2011, upon the expiration of the American Recovery and Reinvestment Act of 2009 ARRA), our federal match will drop from our ARRA enhanced rate of over 81 percent to 63.16 percent. The disaster-related loss from our prior match rate of 72.47 percent to 63.16 percent will cost the state more than $500 million per year. This comes on top of the $450 million per year in lost funding due to the expiration of ARRA. Add to this the loss of $140 million in federal match for the DSH program, and we are facing a total annualized loss of more than $1 billion.

The impact to our state cannot be overstated. A revenue loss of this magnitude would necessitate deep cuts in the Medicaid program, which serves the health care needs of nearly 27 percent of Louisiana's population, mostly children and people with disabilities. In the five parishes most impacted by Hurricane Katrina (Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany) there are 267,848 Medicaid or CHIP recipients as of October 2009 who would likely be affected by program reductions and access barriers.

As a condition of accepting the enhanced match, ARRA placed maintenance of efforts requirements on the states. Language in the Act explicitly prohibits a state from adopting any "standards, methodologies, or procedures" in their Medicaid program that are "more restrictive" than those in effect on July 1, 2008. Additionally, every major health reform proposal also includes some form of continued maintenance of effort beyond the expiration of ARRA. This places limits on each state's ability to address shortfalls other than provider rate reductions. Rate reductions of this magnitude will most certainly impair access.

If we are required to make cuts of this magnitude to providers, it will have a significant impact on the 27 hospitals and 3,529 physician's offices that currently accept Medicaid in the Katrina-affected parishes and seriously cut access for more than 250,000 people. Many of these individuals with chronic conditions would seek more costly care in emergency rooms—thus impairing the progress

we have already made, and frankly, causing the unintended consequence of costs increasing at an even faster rate. Some hospitals and physician practices may not survive the deep cuts that would be necessary to the Medicaid program.

To solve this rare and devastating problem, we are seeking a policy that looks to a state's historic pre-disaster per capita personal income growth rate or federal medical assistance percentage (FMAP) as the method for providing relief to Louisiana, and potentially relief to other states that experience major natural disasters. The solution we seek provides nothing more than what we would have received had we not been hit by four major hurricanes.

A third critical issue facing New Orleans and our state is the fact that we must produce our own physicians and allied health personnel to address the supply challenges, and in doing so, we must have a viable teaching hospital to help retain post medical students for residency and help us compete nationally for residents from out of state. The public hospital in New Orleans, known as Big Charity, was severely damaged during Katrina, and today, still has not been rebuilt due in part to lack of payment from FEMA for the cost of the hospital, its plant and equipment. In Louisiana, the system of charity hospitals plays two major roles: providing care to the uninsured and training medical students, residents and allied health professionals. Louisiana's statewide shortage of health care professionals is well established: 97 percent of the state's parishes are designated primary care Health Care Professional Shortage Areas. A strong predictor of where physicians eventually establish their practice is where they complete their residency program. But, according to the American Association of Medical Colleges, Louisiana is one of only six states that actually saw a *decline* in the number of residents entering the state—a 12.6 percent decrease from 1997-2006. Given that 24 percent of practicing physicians in Louisiana are 60 years of age or older (the 11th highest percentage in the nation), our state has been working on a system of graduate medical education that will not only retain or attract a sufficient number of residents, but residents of the highest quality in the specialties we need most.

Three months ago, Gov. Bobby Jindal announced a major step forward in building a new medical center in New Orleans with Louisiana State University and Tulane University signing a governance agreement that departs from the long history of operating the hospital as a government agency. A new private, non-profit board with representatives from LSU, Tulane and other expert stakeholders will operate the new teaching hospital—a model familiar to the nation's most successful academic

teaching hospitals. Louisiana's focus is now on financing the new $1.2 billion hospital. The state has already set aside $300 million and maintains that FEMA owes the state $492 million for the full replacement value of Big Charity because it was more than 50 percent damaged by Katrina. It is expected the balance of funding will be provided through the debt markets.

The proposed hospital will serve as an important training center for Louisiana's medical students, post-graduate residents and other health care professionals. The approved governance structure will allow the new center to compete nationally for the best residents, faculty and researchers; and invest in new equipment and technology, new lines of service and cutting-edge research.

We have begun the process of preparing to build this hospital, but cannot complete the funding until we know the result of the dispute with FEMA. The issue is currently in arbitration, and the results of that are critical to the potential success or failure of our ability to finance this hospital.

Mr. Chairman and members of the committee, state government and hundreds of community-based, health care and nonprofit organizations have made tremendous progress in the recovery over the last few years. But, we face some unparalleled and seemingly insurmountable challenges. We stand ready to work with you and be helpful in every way possible to address these challenges head on. Thank you for inviting me to speak today and I look forward to answering any questions you may have.