

**Summary of Testimony of Donald R. Smithburg, CEO**  
**Louisiana State University Health Care Services Division**  
**March 13, 2007**

LSU Health Care Services Division has taken numerous interim steps to restore health care services in the New Orleans region. Despite these efforts, five key areas of concern require immediate attention: 1) medical education (with the closure of Charity Hospital, many of our medical residency programs are in jeopardy, thereby threatening the future supply of physicians and allied health professionals in the state); 2) Medicaid reimbursement (CMS limitations on the use of funds for physician services and its proposed rule limiting public providers to cost, as well as state-imposed disparities in payments to public and private providers); 3) mental health (significant loss of capacity that is unable to meet growing needs); 4) primary care delivery system (insufficient capacity is causing emergency room overcrowding, delays in treatment, and higher costs); and 5) workforce (severe shortages of medical professionals are hampering health care delivery).

Proposed solutions include a combination of federal and state financial assistance to expand and strengthen community health clinics and aid in faculty, medical student and workforce recruitment; commitment to a new academic medical center in New Orleans; changes in state and federal regulatory requirements; and a “summit” of stakeholders to develop long-term solutions to reimbursement and medical education problems.

The key to meeting our challenges is the ability to marshal the intellectual capital of the entire health care community in New Orleans to arrive at sensible solutions that transcend parochial interests.

**Testimony of Donald R. Smithburg**  
**CEO, Louisiana State University Health Care Services Division**

**Before the House Energy and Commerce Committee**  
**Subcommittee on Oversight and Investigations**

**“Post Katrina Health Care: Continuing Concerns and Immediate Needs**  
**in the New Orleans Region”**

**March 13, 2007**

**Testimony of**  
**Donald R. Smithburg, CEO,**  
**Louisiana State University Health Care Services Division**

**Introduction**

Chairman Stupak, Ranking Member Whitfield, members of the Subcommittee, I represent the LSU Health Care Services Division, which comprises most of the state public hospitals and clinics that have traditionally served as the public-teaching system in Louisiana. I must begin by expressing my sincere gratitude for the time and attention that you and your colleagues have devoted to understanding our plight in New Orleans and extending your support and assistance. Many members of this subcommittee, as well as a delegation led by Rep. Clyburn, took time out of their hectic schedules to travel to New Orleans to survey the suffering and devastation. These were fact-finding missions. They also were gestures of goodwill. But to those of us on the front lines of providing health care to the city's residents, these visits were much more. They reassured us that we will not have to go it alone and reinforced Congress' commitment to helping us stabilize and strengthen the health care delivery system. Today's hearing is one manifestation of that commitment. We are grateful for this opportunity and pledge to partner with you and with others testifying today to meet our obligations.

My testimony will briefly outline steps we have taken since Katrina to stand up some semblance of a health care delivery system. I then will add to the chorus of voices

describing the current status of health care in New Orleans. In most respects, words are insufficient, but I will attempt to provide some clarity by concentrating on five key issues. I will offer suggestions for addressing the challenges we face in the short term. Some solutions require federal action. Others simply require dialogue and partnership at the state and local levels. With oversight, guidance, and support from Congress, steps we take in the short term can provide a solid foundation for successful efforts well into the future.

### **Interim Steps**

Immediately after Katrina, LSU Health Care Services Division established limited clinic and urgent care services in tent hospitals created in partnership with the U.S. military and the U.S. Public Health Service. We operated a “Spirit of Charity” clinic in the vacated Lord and Taylor department store next to the SuperDome. In November 2006, we reopened part of University Hospital as the “LSU Interim Hospital.” FEMA provided \$64 million in federal funds for this renovation provided the facility would be operated on a temporary basis. The Interim Hospital offers all of the services that were available at Charity and University Hospitals before the storm, with the exception of psychiatry and inpatient rehabilitation. It has approximately 180 beds today – about 31% of its pre-storm capacity.

The Interim Hospital now operates 20 clinics in three buildings, which is in stark contrast to the 160 clinics that existed before Katrina. LSU plans to open seven neighborhood clinics in the New Orleans area as soon as zoning variances are in place

and the necessary permits are finally granted by the city.

With the destruction and closure of Charity, the region lost its only level I trauma center. For months, trauma patients had to be transported hundreds of miles away to Shreveport and Houston. LSU leased space at the suburban Elmwood facility and began providing trauma services there in April 2006. Those services were moved to the Interim Hospital in February 2007.

LSU has entered into a collaboration with the Department of Veterans Affairs for construction of joint facility to replace the neighboring LSU and VA hospitals that were destroyed. While this innovative and cost-saving project will not be realized for as long as five years, the partnership and the promise of a new, state-of-the-art academic health center does have a positive impact on helping us resolve some of our short-term challenges, such as attracting and retaining faculty and researchers.

### **Five Key Areas of Concern**

#### **1. Medical education**

Pre-Katrina statistics indicate that nearly 70 percent of practicing medical professionals in Louisiana completed all or part of their residency requirements at LSU and Tulane University. Prior to Katrina, the Medical Center of Louisiana at New Orleans (MCLNO) housed the anchor inpatient facilities for graduate medical education in Louisiana, hosting residency programs for both LSU and Tulane. LSU

has temporarily repositioned its residency programs in other facilities throughout the state; however, this situation is inconsistent with the standards of ACGME and unattractive to academically superior medical students seeking residency slots in top-quality teaching hospitals. Thus, it is, at best, a temporary solution and is not sustainable in the long term.

Many of our training programs already are in jeopardy. LSU lost its radiology program, and this impacts other programs that require direct interaction with radiology for purposes of proper diagnosis and treatment. We are operating with a drastically reduced number of orthopedic surgeons. We have no trainees in oncology or rheumatology. LSU's urology and ENT programs are still relocated out of town. General surgeons are under increased strain because of the manpower shortages and the enormous trauma demands. Because the entities that accredit residency programs have certain volume and case complexity requirements which cannot be achieved when residents are dispersed among a multitude of smaller, private institutions, nearly all programs are in some degree of trouble.

Possible solutions to this crisis include:

1. Commitment to a new academic health center which will restore a core facility requirement for both LSU and Tulane medical training programs;
2. Authority to hire and obtain reimbursement for private physicians to alleviate the shortage of in-house academic medical faculty;

3. Funding for recruitment and retention of students, residents, and faculty;
4. A summit of all stakeholders in the medical education field in order to devise longer-term solutions.

## **2. Reimbursement**

LSU safety net hospitals rely heavily on the Medicaid Disproportionate Share program. This source of revenues is critical to the system, but at the same time, CMS limitations on the use of funds for physician services and state-imposed disparities in the payment methodology for public and private providers diminishes our ability to fulfill our mission to provide care to the uninsured.

Unallowable Costs. CMS considers costs associated with payment of physicians and CRNAs to be “unallowable” under DSH. They are not regarded as “hospital” costs, and yet, like safety net systems across the nation, physician services in clinics are a critical component of service to the uninsured. This CMS policy is especially deleterious to the capacity to expand primary care and ultimately is more costly in terms of resulting inpatient utilization.

As a safety net system, especially one heavily involved in graduate medical education, LSU must support a massive base of physicians to provide care in the hospitals and clinics. The unreimbursable status of these major costs represents an exceedingly significant issue for any safety net health care system. For the LSU system of hospitals, which depends on the uncompensated care program for

the uninsured or on direct state funding for nearly 60 percent of its revenues, the lack of a funding stream for physicians and CRNAs has created a gaping hole that must be filled by diverting revenues from reinvestment in infrastructure or by tapping short-term or one-time internal funding sources. The necessity of employing such strategies has done significant long-term damage to our facilities and has diminished their capacity to perform their health care and medical education missions.

Disparity of Payment Methodologies. The Legislature limits the authorized Medicaid revenues of the LSU hospitals but does not limit the Medicaid revenues of any other individual public or private facilities.

State funds appropriated in the DHH Budget for state match for Medicaid hospital services are divided between the categories of “**public**” (10 state public hospitals) and “**private**” (approximately 120 nonstate hospitals).<sup>1</sup> Since the LSU hospitals are the only acute care facilities in the “public” group, they are effectively “capped” with respect to the amount of Medicaid revenues they can earn, and hence the amount of costs they can incur in delivering services to Medicaid patients.<sup>2</sup> At the same time, individual community hospitals are not limited with respect to payments for any services they provide to Medicaid patients. While

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<sup>1</sup>For FY 05 the appropriated amounts of *state* funds for public and private hospital categories for services to Medicaid recipients were approximately **\$192.9 million** and **\$1.02 billion** respectively.

<sup>2</sup>While the appropriation bill does not identify the maximum Medicaid revenues for *individual* LSU facilities, that detail is specified in effectively binding documentation associated with it and communicated by DHH, which manages the Medicaid budget.

there is a fixed amount of state funding in the Department of Health and Hospitals budget for Medicaid match for the broad category of “private” hospitals, no maximum dollar amount of Medicaid revenues is communicated to nonstate facilities as it is to the LSU hospitals.

These differences have significant consequences as they play out in the operation of state and nonstate hospitals:

*State Public Hospitals.* The LSU hospitals in recent years have experienced a demand for services by Medicaid eligible patients at a level that has exceeded their appropriated Medicaid revenue limits. In this situation, if a hospital were to serve all the Medicaid patients projected to utilize it, the facility would incur costs that Medicaid would not reimburse once the cap were reached. Unlike community hospitals, the LSU hospitals do not have a sufficient base of patients with third party payers to whom they can shift unreimbursed costs, even if desired, and strategies are required to avoid incurring these costs at all.

Specifically, with an appropriated Medicaid revenue limit below the level of actual demand, administrators have faced the necessity of implementing early-in-the-year steps to reduce services to Medicaid eligibles.<sup>3</sup> Control of the

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<sup>3</sup>In practice in some years, budget adjustments have been made through the year-end BA-7 process to increase Medicaid spending authority when the hospitals were generating Medicaid volume above the appropriated level. If this course of action were routinely followed, it would solve the problems described above, but it would also demonstrate that the cap was unnecessary in the first place. A BA-7 is optional, however. It cannot be presumed that matching funds will be available or that the legislature will

volume of Medicaid services, however, requires control of the volume of all services. Since it is not possible to target Medicaid patients only, such general steps as closing beds and curtailing clinic and Emergency Department hours are required. These actions do reduce Medicaid volume, but they also reduce the number of patients in all other payer categories as well. The result is (1) loss of revenues from other sources, (2) reduction of care to the uninsured, and (3) the reduction of service volumes upon which training programs depend.<sup>4</sup>

*Nonstate Hospitals.* Since the total appropriation to private facilities does not function as a cap on individual facilities, community hospital administrators are not faced with the same service adjustment decisions required of their LSU counterparts. Community hospital administrators can and do treat Medicaid as a payer source like private insurance that can be depended upon to pay the agreed upon rate for whatever volume of patients is encountered.<sup>5</sup>

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agree to a budget change, and the hospitals must proceed to implement service reductions when faced with a projected Medicaid revenue shortfall.

<sup>4</sup>The reduction in care available to the uninsured occurs as both a direct and indirect result of curtailing Medicaid revenues and services. The direct effect is through the general reductions in service to all patients, as indicated. In addition, however, an indirect effect on the uninsured results from the lost opportunity to spread overhead costs more broadly over a larger group of Medicaid patients. When such a payer class as Medicaid (and also Medicare and private insurance) is enlarged, there is *less* overhead that must be covered by the UCC payments for the uninsured. Consequently, a larger share of the total cost of services to these uninsured patients consists of payments for direct patient services. The implication of this is that to the extent that the state public hospitals can increase its mix of patients with third party payers, it can deliver more care to the uninsured with no additional cost to the state.

<sup>5</sup>If the State were to face a mid-year budget problem necessitating cuts in Medicaid payments to private hospitals, it is possible to adjust the rates paid for services.

The practice of legislating separate limits on Medicaid payments to public and private hospitals – and especially requiring **only** the state hospitals to remain below an arbitrary cap – serves no good purpose for the State. It adds no assurance beyond the total appropriation of state funds for match to DHH that Medicaid program expenditures will be constrained within the appropriated level. In fact, since Medicaid is an entitlement program and a recipient unable to access the state public hospitals is free to utilize other providers, the public cap could increase per recipient costs as those with a Medicaid entitlement are driven away from the LSU hospitals and into higher cost systems for services.

Another Medicaid financing issue that could adversely impact our ability to fulfill our safety net mission is CMS' proposed Medicaid cost limit regulation. On January 18, 2007, CMS issued a proposed rule that would: 1) cap Medicaid reimbursement to public providers at the provider's cost of delivering Medicaid-covered services to eligible recipients; 2) greatly restrict the sources of state match funding through intergovernmental transfers (IGTs) and certified public expenditures (CPEs) obtain through public providers; and 3) require public providers to receive and retain the full amount of Medicaid payments earned. The rule adopts a more restrictive definition of "public provider" than what exists in current law. While the Administration contends that the rule would cut \$3.87 billion from the Medicaid program over five years, survey information from public hospitals across the country indicates that the initial impact will be far greater.

The fact that many nonstate hospitals that currently make IGTs would no longer be permitted to do so under the rule will leave a gaping hole in the State's Medicaid budget. This will lead to lower reimbursements and reductions in services.

As important as what the proposed rule specifies is what it leaves open-ended. The rule does not define "costs." There is a real threat that graduate medical education costs will not be included or allowed. This could mean a loss of more than \$50 million per year to LSU alone.

Possible solutions to these reimbursement problems include:

1. Require CMS to allow public hospitals to claim physician and CRNA costs as allowable costs under DSH;
2. Ask the Administration to withdraw the proposed Medicaid regulation;
3. Organize a "summit" on hospital reimbursement in Louisiana to develop equitable and realistic solutions that ensure proper reimbursement to all providers without destabilizing the safety net.

### **3. Mental health**

There has been a significant loss of capacity in the mental health system as a result of Katrina. It is a system that already was under stress before the storm, and inpatients

from the region, especially those without funding, were being transferred across the state to any available facility.

Post-Katrina, the city lost over 400 mental health beds -- 100 at our Charity Hospital facility and only about 40 of these have been restored in New Orleans. The Crisis Intervention unit at that public hospital was closed, along with all the services of the entire safety net facility.

The crisis we continue to face is manifested in multiple ways. At the clinical level, there is an exponential increase in mental illness. Emergency Departments have been impacted and are under strain because of the volume of patients whose symptoms require special handling, facilities, and expertise not currently available. A practice of rotation of behavioral health patients among EDs in both Orleans and Jefferson parishes has been implemented, and these patients and the type of care they require have contributed to ED overcrowding in the area. Emergency Departments were not designed to accommodate the special needs of these patients, and certainly not in the volume now experienced. According to one press report, police, who reportedly answer an average of 185 mental health calls each month, often are unable to find a hospital able and willing to accept mentally distressed citizens. They can and do book many of these mentally ill people into jail, but that does not guarantee proper treatment. One prison spokesperson reported that the jail spends \$10,000 to \$12,000 per month – 21 percent of its total pharmaceutical budget – on psychiatric medicine. However, the jail has only one full-time, board-certified psychiatrist and

two part-time psychiatrists to treat 2,000 inmates. It is no place to treat the seriously and persistently mentally ill. Just this past Thursday, a mentally ill patient who was roaming the New Orleans streets at night with a rusty BB gun was shot by a patrolling National Guardsman.

Potential solutions to the mental health crisis include:

1 *Funding to open additional inpatient mental health beds.* LSU is working to establish 30-40 behavioral beds at a vacated hospital on a lease basis. Renovation of the space will be necessary, as will support from FEMA. But more capacity is needed in the region.

2 *Funding for long-term care beds.* More efficient use of short-term inpatient beds requires the ability to transfer appropriate patients to a long-term setting.

3 *Funding for outpatient facilities.* Improving the availability of outpatient services will provide alternatives to inpatient and ED admissions and overall reduce the stress on hospitals.

4 *Funding for telepsychiatry.* This technology would enable the state to extend the reach of limited psychiatric resources.

5 *Incentives and funding for recruitment and retention of mental health professionals.* The cadre of mental health professionals was decimated by Katrina. Proper staffing is essential to restoring both inpatient and outpatient clinical capacity.

#### **4. Primary care delivery system**

Emergency Department overcrowding existed prior to Katrina, but it has been severely exacerbated post-Katrina, particularly in light of reduced primary care

capacity. Many patients present to the ED for minor ailments that are more appropriately addressed in an outpatient primary care setting. This reliance on the ED stresses limited resources, is inefficient and costly, and does not provide the patient with a coordinated, holistic approach to care. A recent article in *The Times-Picayune* reported on the crisis in New Orleans EDs. Hospitals in Orleans and Jefferson parishes have run out of space in their emergency rooms and are lacking sufficient numbers of acute care beds. “There is not a bed available anywhere in the city,” said Jack Finn, president of the Metropolitan Hospital Council. The waiting time in EDs is now seven to eight hours -- approximately the time required to drive to Dallas or Atlanta. Patients remain inside ambulances or wait in hallways on gurneys until they can be seen. Physicians believe that lack of swift access to primary care is part of the problem.

Insufficient primary care capacity causes other patients to delay seeking care until their condition worsens and becomes severe and very expensive to treat. The likelihood of a poor outcome only increases.

LSU is committed to a model of health care delivery that emphasizes primary care clinics located closer to where patients live. Primary care clinics are well-positioned to encourage better patient access, facilitate care coordination, and provide patient education. In a multi-specialty clinic environment with a vigorous disease management program, it is much easier to consider and treat the patient in a holistic context. The popularity of the “Medical Home” concept for health care reform is

based on an understanding of these principles. As envisioned by the Louisiana Health Care Redesign Collaborative, the Medical Home Model calls for improved communication, information exchange, and care coordination (guided by evidence-based protocols). Such a model holds significant promise for improving care, increasing patient satisfaction, and controlling costs.

LSU strongly endorses the Medical Home concept. LSU's chronic care and disease management initiatives are consistent with the model and have produced demonstrable results in reducing the incidence of care in expensive settings and improving quality. We must now expand and strengthen the network of community health centers and neighborhood clinics in New Orleans in order to build upon these successes and optimize the benefits of the Medical Home model of care.

LSU already has offered to devote resources to community clinics, including a mobile ophthalmology unit made possible by a \$300,000 donation from Pfizer and New York Hospital Association. AstraZeneca donated \$1 million for a telemedicine project to be located in clinics that will facilitate diagnosis and specialty consultations. CLIQ is a data repository that allows sharing of laboratory and radiology information and is in operation at MCLNO and in PATH clinics. We have offered to implement a clinic referral system that will assign patients presenting at our hospitals to a community clinic for primary care services and follow-up based on the patient's zip code. All of these efforts demonstrate our resolve to bolster primary care clinics and better integrate them into the state's health care delivery system. Contrary to some fears

that may exist, we have absolutely no interest in driving community health centers and clinics out of business. There is no upside to such a shallow strategy. We firmly believe that our success in delivering quality health care is dependent upon a strong and vibrant network of community clinics. We pledge to do all we can to support primary care clinics in the state and continue a productive collaboration with the coalition in greater New Orleans that is evolving.

Obviously, the availability of additional funding is central to our ability to increase primary care capacity through community clinics and implement the Medical Home approach. Funding should be directed in the following areas:

1. *Physician and other related medical services.* As described in detail below, the Centers for Medicare and Medicaid Services (CMS) does not allow us to claim physician, certified registered nurse anesthetist, and other “non-hospital” costs under DSH. Rendering these very real and critical costs “unallowable” suppresses the ability of the safety net to provide the extent of timely clinic and other physician services that a Medical Home model requires. It is not possible to both implement a Medical Home structure and go unpaid for some of the most basic services that patients require. If CMS is not willing to change its policy, additional funding is needed to compensate for these services.
2. *Infrastructure.* A significant expansion of the network of community health centers and clinics requires an infusion of funds to acquire the necessary zoning changes and permits, build new facilities, lease space where appropriate, and

provide increased staffing levels.

3. *Information technology.* The Medical Home model requires the ability to share patient medical information throughout the health care network. Thus, funding to develop electronic medical records and ensure interoperability is essential.

## **5. Workforce**

There has been an exodus of physicians and other medical personnel from New Orleans post-Katrina. Physician specialists are in short supply, particularly orthopedists, neurosurgeons, ENTs, interventional and other radiologists, anesthesiologists, and ophthalmologists. We also are experiencing a shortage of registered nurses and medical laboratory technicians. According to Louisiana Department of Health and Hospitals officials, there are currently about 450 primary care physicians in the New Orleans area, down from about 1,500 prior to Katrina. There simply are not enough mental health professionals to meet the growing need. The nursing shortage is so severe that annual wage and benefit costs have topped \$120,000 in some cases. We also have had difficulty filling administrative/managerial slots, as well as openings for maintenance workers, electricians, and carpenters.

The reasons for the workforce shortage include hospital closures, the slow and uncertain recovery of the region, lack of affordable housing, and deficiencies in basic public services, such as schools and police protection. With the closure of Charity Hospital, medical faculty are being lured to academic health centers in other states,

and this has had a serious adverse impact on our ability to attract and retain medical students and residents and maintain robust medical education programs.

Possible solutions include:

1. State and federal funding that will enable hospitals to offer financial incentives to meet workforce needs;
2. Federal housing assistance; and
3. Commitment to a new LSU academic health center. While this facility will not be built immediately, the political wrangling and attempts by some to halt the process are exacerbating an already uncertain environment that threatens to choke off supply of future medical professionals in the state. Widespread community support for a new facility will allay concerns and help all hospitals recruit physicians, nurses, and other medical staff.

## **Conclusion**

As you know, our challenges are great. But they are not insurmountable as long as political infighting and self-interest are set aside in favor of the interests of patients. I think we all agree on the problems. Our task is to marshal the intellectual capital of the entire health care community in New Orleans to arrive at sensible solutions that transcend parochial interests. If we do that, we will be well on our way to recovery. However, we cannot accomplish our mission without additional federal assistance in the form of increased funding and regulatory changes as outlined above. It is my

hope that the interest, attention, and influence of this subcommittee can help facilitate a productive dialogue and produce positive change for the citizens of New Orleans.