Safeguarding the Health of Katrina's Victims
September 12, 2005

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RICHARD CARMONA, M.D., M.P.H.: …water is not existent, everything becomes contaminated, petroleum products are being spilled as well as anything else that gets swept up by the water into this milieu which, as some have said, become a toxic soup. Surprisingly, we have seen very little problems acutely from these exposures. We have seen some rashes; we have seen some diarrheal disease outbreaks, but they have all been contained because of the superb efforts of the local evacuee centers, which have dealt with these populations. But make no mistake that these public health needs are going to be very, very large and they are going to go on for some time, as we attempt to begin to provide an infrastructure for the communities that have been affected.

The other side of the equation here that's often missed in large disasters is mental health. Whereas we can do pretty well in acute medicine and as Dr. Frist being a surgeon and myself being a trauma surgeon, we can fix people up when you come in with wounds. We can do what has to be done surgically, but we also recognize that the wounds that are supratentorial, the psychological wounds are the ones that really go on for a lifetime sometimes and devastate people and affect their ability to reintegrate into society.

The literature is clear after disasters of a much smaller magnitude that once people get back on their feet

physically, divorce rates go up, suicide rates go up, a police officer has already committed suicide in the area. And these type of situational disorders that arise; depression, suicide, divorce rates and so on are to be expected, but part of our challenge is to integrate into the communities quickly and try and build resilience into the communities as we are providing the acute care, but also bring some hope and stability to those communities so that we can avert some of the expected outcomes from the mental health consequences that occur with just about any disaster of this magnitude.

The social needs are immense, and within days, Secretary Levitt at HHS brought us all together and said, we need to figure out a way to be able to accelerate social services where there is no infrastructure. So you will hear more about that today but we have moved ahead very aggressively recognizing that as we transition from acute care to a constant temple of public health needs behind the scenes, the big increase in need is going to be in social services. And so we are working with our partners within the federal government to figure out ways to better deliver benefits more quickly; to break down barriers with Medicare and Medicaid to ensure that health facilities and doctors' practices and health professional's practices get stoop up again as quickly as possible. Those of us have directed our efforts after the acuteness to do just that.

I want to make a few comments about the response. What I saw when I visited on the two occasions I have been down there was nothing short of miraculous. The local officials both in the acutely affected areas and in the evacuee centers have accomplished the impossible. In New Orleans, I found 18 police officers who refused to leave and stayed living in a house that should have been condemned, but slept a few hours a day and continued to go out and police everyday to try and quell the civil unrest. I saw EMT's and paramedics in the area sleeping in the streets and sleeping in trees and on roofs just so that they could be around to provide their emergency services.

The Health Director Dr. Kevin Stevens stayed within the affected areas and worked tirelessly 24 hours a day to ensure that the best public health would be delivered to its citizens. All of the medical centers in the area came together and provided emergency care and shelters. The major medical centers, the large ones, Charity and Tulane and others were closed down; yet Auctioneer, East Jefferson and West Jefferson continued to function. Although on a shoestring initially because of problems with power and contaminated water they came back and they not only provided healthcare, but they provided a logistical support base for the community. They provided beds for those who needed them and they reached out in the community to do the best they could.

And what we really saw was the best of Americanism. We saw some terrific people coming together in unanticipated ways and putting together, cobbling together, a system where none now existed because of the destruction of the infrastructure and all of a sudden the people had something. And then as I visited the evacuation sites and I visited convention centers, very huge massive complexes, that were standing empty and within 24 hours they became tertiary care medical centers for the entire infrastructure in Houston and San Antonio and Dallas came together to accept the evacuees and they had a seamless system. By the time we got there they were already operating and they had triage and infectious disease screening, they had immunizations, they had a pediatric center; so what we really saw from this country was an unprecedented response to an unprecedented challenge. And as hundreds and thousands of those people who were evacuees were displaced they were received with open arms by faith-based community, by the evacuee centers.

The private sector stepped up and when the medical leadership in the large evacuee centers said we need clothes; we need pharmaceuticals; we need other items, food companies literally backed up trucks to these evacuation centers and downloaded food. Wal-Mart and Walgreen's and others came in, and CVS Pharmacy backed up their pharmacy trucks and just gave everything and setup freestanding pharmacies to support the

evacuees. Clothing stores brought clothes. Water companies sent truckloads of water both to New Orleans and to the evacuee sites.

Once again, caring for our own people we have demonstrated what we have done so much over the years and caring for the rest of the world people during tragedy as we saw in the Tsunami when our officers in the public health service and DOD officers went over with USAID with the Peace Corps., and now we had to protect our own and we did so. So what I saw – and Senator Frist will comment on because we have spoken – is truly the American spirit resilience that we have as Americans. We refuse to give up. We came together where there we no systems we put them together. The federal government stepped in and where there were gaps we continue to provide those services.

We have moved forward over a thousand public health service Commission Corps Officers with varying disciplines doing epidemiologic studies, doing clinical care, mental health professionals who helped those communities to provide the infrastructure that was lost because of it. We have supplemented the evacuee centers and for the first time in the history of our country, we have a database with hundreds of thousands of volunteers and thousands of corporate volunteers, which we have already started to rotate into needed areas on two-week rotations to backfill our public health service

officers and our HHS teams that are there, our DOD teams who are there, volunteerism has become very, very big.

As you all know, the president is very much an advocate of volunteerism and we learned after 9-11 that one of the deficiencies we had was not being able to harness the energy of volunteers. We have a mechanism now. We have a database. We have a Web site. We have an 800 number where people can call in and they have been calling in and responding, so in short I think we should all be proud of the truly tremendous response that our country electively has moved to to support the evacuees. This couldn't have been done without the military either because DOD are the supreme logisticians in the world. There is nobody that moved hundreds of thousands of people in short with planes, trains, boats and so on; and yet if you look throughout this response, the Department of Defense is very well represented with active duty officers, enlisted men, guard forces, reserve forces, everything from doing rescues to setting up mobile field hospitals. And once again, all of us who have the privilege to serve recognize without the supreme logistical support and the extra deeds of DOD, we couldn't accomplish most of what we have accomplished right now.

The status report as of today is that we have stood up centers in Mississippi, in Louisiana Baton Rouge and New Orleans, and evacuee centers in San Antonia, Houston, and Dallas Texas. We are now demobilizing many of the sites in

Louisiana and Mississippi because the evacuees have been moved from there and we are redeploying our officers to other locations where the evacuees need assistance. This morning I was on the phone with the state Health Director in Tennessee where they have over 20,000 evacuees. New Mexico is getting evacuees, California, Michigan other states, so we recognize that this is not a sprint. It's going to be a fast moving marathon. We are going to be in this thing for a long, long time as we transition into agencies that have to replace infrastructure and provide benefits with an ongoing lower key tempo of needs of public health being met and an even lower tempo of just everyday acute care needs of a population that is now evacuated and requires some ongoing medical care.

In short, that's the status of where we are and where we came from, so I will go back over to Ed now. I would be happy to answer some questions later. Thank you.

ED HOWARD: Thank you very much Dr. Carmona. Much of the burden as the Surgeon General has described it has fallen on the states and we are very pleased, therefore, to hear and have with us today Ray Scheppach who is the Executive Director of the National Governor's Association for more than 22 years. That means I guess it's up to the association executive to diplomat, as I understand not all governors agree on everything. And perhaps above all else, he is someone who is sensitive to the bipartisanship science his party changes every

year. So he happens also to be a budget expert, which has some relevance today having served in senior position at CBO before coming to the National Governor's Association synonymous by training. Thanks for being here.

RAY SCHEPPACH: Thank you, Ed. I am just going to make a few comments of how we should think about this issue. Please understand that these do not represent any official positions of the Governor's Association [Inaudible]. I think the first thing, obviously, is you have to differentiate between the three states that have been severely impacted from those states that are basically taking the evacuees for the short run. I am not sure of the total numbers, but I suspect in terms of total people displaced is somewhat over a million maybe 1.1, 1.2. It seems to be somewhere between 400,000 and 600,000 of those are actually in other states that they have been moved from the impacted states to a number of other states.

For the three severely impacted, I think I would just second some of the previous comments which are basically we have got to go in and almost rebuild an infrastructure, a health infrastructure in that particular area because not only are the impacted people at risk and so only but given the devastation the unemployment and so on, that number really from a healthcare standpoint can increase quite dramatically. In terms of the other states, I did have the opportunity – it just so happened I was out in Arizona meeting with the governor and

key staff when the healthcare person at one of the meetings said would you like to go over to one of the shelters that have accepted 500 evacuees? And so we spent about three hours over there trying to get a sense of how they were handling it, but the first question I asked the Chief of Staff was, have you done executive orders to waive state residency requirements and everything and he kind of looked at me and then he looked at his healthcare person and asked her whether they had done anything, at which time she said no, we just went and did it.

So what I found essentially there is that they were in a government building in four, five rooms. The Red Cross had done all of the intake and as people came in there was in fact a quick assessment of the needs that went from health to education right down the line and already established in the particular building were other tables set up for job fair. They had doctors on site for a clinic to do a preliminary evaluation of healthcare. They were singing up kids for education, and what you saw was a combination of sort of local/state government with charities with the private sector. The good news was that they expect to actually close this down as temporary a shelter within the next three weeks because they really believe these 500 people will essentially be moved within the community to much more permanent housing and they are rounding that out.

The important piece of this, however, is that I can't

stress enough and I assume that we found in Arizona is true of other places, this is a very at risk, very vulnerable population. Significant numbers were elderly; I would put in the category of frail elderly. The number of wheelchairs, the number of oxygen being carried and so on was quite large, so I would say as much as 50 percent of that population really falls into this very chronic definition. A lot of the risk, actually my sense would be, will be integrated back into the economy there relatively quickly.

In terms of the federal response, I really sort of break it into two categories. One is the Medicaid and the SCHIP related programs, and I do think they are for the evacuee states some enhanced match from – and I think HHS has already moved on presumptive eligibility and so on – so they have already sort of cleared the way to get these people healthcare, and it's a matter of financing. On all of the other sort of needs which I would include such things as food stamps, welfare, child nutrition, childcare, all of the rest including education, I just questions whether we don't sort of create some additional money on a per evacuee basis for some period of time for 6 months of what have you, and get that money out either in a block grant or some additional money social services block grant as opposed to going through a bunch of legislative changes for all of the other programs because in all honesty, I would suspect that the states for these evacuees

are halfway through the process already because they have been basically required to provide the services very, very quickly.

The only other thing I would say is that even though we look at this one broader category of evacuees, it does differ within that. There are several states such as Texas, Tennessee, Arkansas that have taken in very large numbers, which I think is going to be more difficult to integrate in, and particularly, the chronic care of those individuals. We don't know yet how many are going to begin to move back, but clearly I think our role is to make them as comfortable, get them the services they need, and quickly. I assume they are going to be there for the long run. I think our response needs to focus on this first 6 months and get the services to the individuals. Thank you.

ED HOWARD: Thanks very much, Ray. Finally, we hear from Jim Tallon whose day job is President of United Hospital Fund of New York. He also serves on a variety of connected, non-profits that you see represented here. Four years ago yesterday, Jim in that New York City based organization he heads, was faced with the tragic aftermath of the 9/11 attacks and in the wake of that, he helped cobble together an initiative to make Medicaid and the care that it brings a whole lot more accessible to the folks in the affected jurisdictions. I have asked him to try to sketch some of the implications of that for us this morning.

JAMES TALLON: Ed and colleagues on the panel, thank you for the opportunity to be here. The circumstances in New York in the days, weeks, months following September 11, 2001 obviously differ in many respects from the experiences with Hurricane Katrina, but there are some underlying similarities in dealing with this kind of situation that I would like to bring to your attention today. There is background material presented in the packet, a *Health Affairs* piece authored by Katherine Hesslinger [misspelled?] at United Hospital Fund. A *Focus Group Report* sponsored by the Kaiser Commission and the United Hospital Fund but with Michael Perry authored that tells much of this story in the voice of the people who were directly affected. I would urge you to take a quick look.

I would just note I am the president of United Hospital Fund in New York City; it is a small and independent philanthropy and analytical organization. I am not the spokesperson for hospitals in New York City in any of these conversations, and as Ed indicated, I chair the Kaiser Commission. I am the Secretary Treasurer of the Alliance of Health Reform. These are my opinions.

Let me just take you to September 2001 in New York. Communications were immediately impaired throughout the city even though the physical effect of the attack was at the World Trade Center area. Our capacity to communicate was the thing that most immediately broke down, specifically in terms of

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healthcare and Medicaid. The telephone lines, particularly the telephones switching stations concentrated in lower Manhattan were destroyed, and therefore access to the computer bases of both state government and the ability of local government and many of the other organizations to use electronic communication were compromised immediately. Nothing in the city was business as usual in those weeks.

Interestingly, while the attack was concentrated in lower Manhattan the physical effects of the attack were in lower Manhattan, we immediately felt impact throughout the entirety of the city's 8 million residents and the metropolitan region beyond doubles that number. The impacts that were felt were throughout the entirety. We did not lose the healthcare infrastructure in the city that is very different. There was some effect at one or two hospitals but for the most part, the healthcare infrastructure of the city stayed intact. Emergency decision-making took place. There was a good deal of Adhock [misspelled?] decision making by the leaders of both the state and the city overseen and in consultation with federal authorities.

To remind everyone, though, we recognized the fourth anniversary yesterday of 9-11, but to take you to the fall of 2001 recall that four or five weeks later, we were faced throughout the nation and specifically in New York with the threat of Anthrax or the threat and fear of biological agents.

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In fact, from a personal sense probably with the exception of 9-11 itself, the worst day of the fall was when we received the news about five weeks later that a healthcare worker in one of the hospitals in the city had died of Anthrax and the enormous fear that a second wave of attack was going on. There was fear and uncertainty throughout the community during this period. Governor Pataki, Mayor Giuliani and in consultation with the administration here in Washington and particularly Secretary Thompson and of course the representation and leadership in the Congress, created among the responses and this on September 19th the disaster relief Medicaid program and it was implemented just five days later. It was a one-page application for Medicaid. There was self-attestation of income. There was no asset test, and it provided for eight months of fee for service coverage in the Medicaid program.

At the time, and understanding some of the differences here, it encompassed some broader policy changes. New York had requested an 1115 waiver expanding eligibility for adults in the Medicaid program up to 100 percent for a childless single and couples and 150 percent of poverty for parents. That waiver had been approved – not yet implemented in the city – and was implemented as part of DRM. The states highest court in New York, the Court of Appeals, had ruled that pursuant to the New York Constitution, New York had to make Medicaid available to any legal resident in New York State. Obviously,

notwithstanding the 1996 date that reflected for arrival in the United States for federal participation but coverage for all legal residents was ordered by the New York Courts had been ordered in June of '01 and was implemented as part of DRM. And the normal certification, re-certification processes that were with the computers inaccessible were shut down and people who were already on Medicaid were retained on the program for an extended period of time. Some 342,000 New Yorkers enrolled in the disaster relief Medicaid program between the startup date in late September and the closeout date at the end of January. They stayed on the program for about eight months because when we came up to the end of January, the enrollment period ceased, but then as people were transitioned into the opportunity to apply for a regular Medicaid benefits, the transition occurred as people were called in for interviews and that were stretched out over the spring and on into the summer of 2002.

The material in the packets cites a number of the characteristics. I will just highlight a couple of them. A number of individuals with whom we spoke enrolled in the program because they perceived that they had a need for healthcare services or for healthcare attention. I think that is part of this. There really as a heightened awareness of health of symptoms of the like probably because we were implementing this court decision regarding immigrants. A fairly large number of folks did not speak English as their

primary language obviously meant that we were working in multiple languages. There are some hundred languages or so spoken in New York City, but there are probably a dozen languages in which a substantial number of people in the population would normally converse, although obviously English is the primary language in the city. Ninety-seven percent of the people produced a social security number, which gave us an indication that we were reaching a group of people who were otherwise attached to the workforce. There was no systematic and detailed audit because you were really tracking down a paper trail here, but the fact is that as we looked at people and talk to people on the application lines and the like, these were people who were resident in the city, who were potentially legally eligible for Medicaid who probably had an attachment to the workforce prior to 9-11.

And even though United Hospital Fund with the support of Robert Wood Johnson, the Kaiser Foundation and with the enormous help of literally dozens if not hundreds of community-based organizations in New York City developed a communications mechanism to get the information out. There was also a very substantial word of mouth transmission that went on. We would even say despite all the work that we put out on billboards and spots and television spots and things like that, the word of mouth really became a very, very important communications tool. There was really a radical change that occurred here. When we

talked to the enrollees, many had tried to apply for Medicaid previously, had been dissuaded by some of the complexities of documentation and process, removing the asset test was in fact a significant characteristic here because modest savings was otherwise precluded people for being eligible for Medicaid. And the immediacy of the decision-making, what actually happened here is that people went to the 22 Medicaid offices that are run by city government in New York, eventually that was expanded a little bit to get some of the health plans involved and community organization, but people went. They on occasion stood for some lengthy periods of time hours on line, but with the simplified application process, at the end of the line almost all of them who provided adequate documentation of identity and the self attestations of income that were required actually received a temporary Medicaid card as part of that transaction.

Let me just conclude with a series of final comments about the success that we had with the program. One was this immediate eligibility determination. The immediacy of peoples' interaction really became very critical. It shows up in the *Focus Group Discussions* we did with the help of the Service Employer's Union, the Greater New York Hospital Association were able to make use of an existing 800 number for information about disaster relief Medicaid. One of the very important things was the communication that was targeted to beneficiaries

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and to providers. We really found that actually building the network of people and organizations who could explain what was going on to individuals who were potentially affected was very, very critical. And then, and I think this is relevant to what is going on with Katrina, thinking about the transition and trying to do an orderly transition as we worked at the 4-month mark, they 6-month mark, the 8-month mark to try to bring people back into their eligibility for ongoing benefits became very, very important issues.

The summary points, fear and dislocation, and Dr. Frist and the Surgeon General reported that being in the area have seen this upfront, the fear and dislocation, not simply those affected directly in New York at the disaster at the World Trade Center, but the entire community was a lesson that had to be remembered. It was so critically important to actually get explanations to individuals in terms that they could understand. The ability and particularly I guess when faced with fear for us to put various programmatic initiatives in place, the need to reach out and explain, and in our case, using a number of community-based organizations to do that was critical. The simplification of the process to the extent possible was enormously helpful, and the fact that while the events really focused on 9/11 in the weeks, immediate weeks, after that and the concern about Anthrax a little bit later in the fall, we were still very much dealing with these issues, 6

and 8 months out.

There was almost sort of a second wave of people dealing with the immediacy of the thing and then recognizing how disrupted their lives has been the Surgeon General's comments about mental health issues is certainly something that showed up enormously in the New York data. Thank you very much for letting me be here today.

ED HOWARD: Thank you very much, Jim. As we mentioned, we have our Vice Chairman with us today. He's not only as he pointed out somebody whose been a volunteer on the ground on the gulf coast, but harkening back to the days of 9-11, he was I think it's pretty clear to say, one of the most important calming voices, reassuring voices, for the American people in the weeks following the World Trade Center disaster. And with respect to Anthrax, I still ought to have your copy of Senator Frist's book, which was issued not long after that, a sort of how-to guide for American families, how to cope with and prepare for future disasters. So we are pleased to have both an official from the Alliance and expert in the subject and a public opinion leader with us today.

SEN. WILLIAM FRIST, M.D.: Ed, thank you. And again I thank the Alliance. It's exactly what J. Rockefeller and I as the chairman want the Alliance to do which you do so well with the help of strong supporters and all the participants here. Jim, I think as he talked, I listened to a number of the

parallels in the words, the two words that he closed with; fear and dislocation. It does take me back to nine days ago now that when I went into the airport at New Orleans, it was very, very, very chaotic at that point in time, but the fear and the dislocation wouldn't disappear totally, but by those hands that would go out by those volunteers and touched the people coming through the doors saying you are going to be okay after they had three days before lost everything. Not knowing in five minutes what door they would go through or where they would be or where their children were or whether their pets were shows what Dr. Carmona said, the great compassion of volunteers for pulling together on the ground. And it was heroic; it was heroic. It's the greatest thing, I too, have ever seen. Jim mentioned that Anthrax came five weeks after, and I think about five weeks, it was October and it was two or three weeks afterward that again, panic and paralysis was throughout this nation.

That leads me just to say we've got to respond; we've got to respond aggressively because we don't know what's going to hit in three weeks or five weeks whether it's a natural catastrophe, the Asian flu, or it's a bioterrorism attack. But knowing what we have observed that things didn't go as well as we wanted them to or absolutely must have them do in the future. That brings the immediacy; why we hold these sessions today, why we need to move ahead aggressively at the level of

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the federal government [Inaudible] and the state government and the local government with partisanship aside, hit where the problems are and fix them the best way we possible can. [Inaudible] after 9-11 we thought those radios between first responders would work.

The medical unit that I was with in the airport and the security guard across the way and there was a security problem. A nurse got stabbed and the doctor ran over to the security guard across the room and said can you call for help and he said I have no radio. Now the reason for that is we had a flood, infrastructures were torn out. The batteries were exhausted. There was no electricity. It can't happen again. A couple of observations: What did we see on the ground? Great volunteer spirit and in addition to that, people coming in again this was Saturday, Sunday, after the hurricane, we saw dehydration, lack of potable water. So most people knew not to drink the water around them but they came in dehydrated; separated from their medicine, hadn't been giving themselves insulin. If they were hypertensive would come in with blood pressures sky high.

What was apparent to me there was what everybody has touched upon and that is the chronicity of preexisting disability, frailty, and age, and in part because the people got off these helicopters and go through at the airport just being evacuated, they would go through one door if they needed

special needs, and if they didn't need special needs they go through another door. Lined up helicopter after helicopter coming in on the baggage carriage carts, really very innovative use and it really worked pretty well, but you'd notice for every two people going through the door, you could walk out and there would be maybe 1,000 people waiting to get on the airplanes. You know, frowns and hot and terrible, but out of every two going through that door, there would be one going through the door that needed special help, and as I saw that, I said, you know the population [Inaudible] had to be very different.

The communication, I mentioned. The lack of direction because of the lack of communication, you had small commanding structures which worked beautiful. You had a doctor coming in from Kentucky, meeting doctors coming in from DMAP unit coming out of Florida, meeting some medical students that came out of the University of Texas who happen to come down there, and all of a sudden they would build their own little triage unit there. They would have 25 or 30 stretchers lined up and I said why are you doing this, and they said, well, you know we really can't communicate with anybody else so we just have to set up our own unit; and it worked beautifully. It worked beautifully over Saturday, and I said what are you going to do with all these patients? And they said we have no earthly idea because we can't communicate with the airplanes coming in. All we know

is that we are getting hundreds and hundreds and hundreds and we just hope the airplanes are coming in. We don't know if they are coming in eight hours from now, 1 hour from now, or 30 minutes or 10 minutes from now; and nobody could answer that. And again, these are things we can fix and we need to fix early on.

The immediate needs of survivors the displaced persons right now, the chronicity in terms of public health needs to be addressed. We need to continue to quickly evaluate and prioritize and treat patients who have been separated from their regular source of care. We need to address the longer-term issues of healthcare coverage and insurance coverage. We mentioned we were talking about at one point one million people displaced, over a half a million of which are displaced out of the three affected states and those individuals need healthcare by much of the population that we saw. And how are we going to provide that care and it comes down to [Inaudible].

We need to address this issue of mental health which we have all mentioned and we'll come back to it and discuss it in the question and answer discussion to really underscore that those mental health illnesses are being dealt with and the psychological impact in the acute period, but also in the mid to long-term and in the long term period as well. We need to make sure that we support the hundreds of volunteers of health providers. Many of them are putting themselves and have put

themselves at risk. We know the other search and rescue men and women right now have healthcare problems and exposure that we need to be very sensitive to.

Very soon we have got to begin to focus on lessons learned. First, we need to make sure that Medicaid and SCHIP programs are more flexible during the periods of public emergency whether it's manmade or a natural disaster. We have to address this issue of evacuation, of one state to another state the 30 to 40,000 people who are in Tennessee now. As Diane said, of the children, a third — or 40 percent — of which are under the poverty level. How do we plug them into programs right now, and how do we handle that particular reimbursement.

An issue that Dr. Carmona and I have talked a lot about since day one – as soon as the hurricane hit – is how best to mobilize our volunteer medical and health personnel in a way that covers the issues of licensing which haven't been addressed. We need to make sure we are doing that proactively. How can we continue to rapidly bring in and utilize, not just we have their names, but utilize those medical and health volunteers [Inaudible] liability. We need to address these emergency situations.

I mentioned healthcare in terms of the displaced and I will just throw out a bit on electronic health records and our move towards information technology in healthcare. This is just yet another example, we've got 1.1 million pole who have

no healthcare records today; they are gone. They are wiped out today, and likely will be. It only makes sense that we would have those recorded electronically somewhere where they can be retrieved on time, in time, to treat appropriately.

The shortcomings we will be addressing in terms of our federal response and I'll be very, very quick, it is important for the American people to know that the Congress is acting. I wouldn't be here now if I didn't want to learn, go back, and act. The past, as you know, 10.5 billion dollars in an emergency session. We called people back in now about two and a half weeks ago; a week later we passed another 51.8 billion dollars to over 62 billion dollars that we have directed for emergency relief spending.

As senate committee chairman I have been instructed to deliver to us working in a bipartisan way those pieces of legislation that we need to implement now in order to respond to this natural disaster we have all witnessed. We have announced the formation of a joint committee between the House and the Senate. It is a bipartisan, bicameral to go in and look to see what happened; what worked and what did not work so that we will be prepared in the event of another natural disaster or manmade disaster. With that, again, I thank the Alliance and I look forward to your questions and answers and I thank the other panelists who have come forward today. Thank you.

ED HOWARD: Thank you very much, Senator Frist. You probably don't have any questions, right? But if you do there are microphones which you can go to state your question and you have green question cards you can fill out and hold up and someone will bring it forward. Let me ask you to keep your questions as brief as you can so that we can get as many covered as we possibly can in the time that we have, and that you identify yourself when you ask your question. Alan? It was working earlier. There we go.

ALAN GLASS: Yeah, Alan Glass [Inaudible]. This is a question for Mr. Scheppach, how well are the states like Tennessee, Arkansas and Texas that are accepting large numbers of these chronically ill and disabled evacuees who may be there for extended periods of time if not permanently, how well are the Medicaid provider networks going to be to provide for the care of these people given the fact that in many places the Medicaid provider network is already under a huge amount of pressure and the physicians that have been displaced from the evacuation from the impacted areas may not be in the same places where the evacuees are. So how are you going to expand the Medicaid provider networks to take care of all these people?

RAY SCHEPPACH: Well it's hard; I mean in those states that are taking a large number of people into the system are being very, very much strained. And again, I don't think it's

so much the women and kids because I think those are getting the care; again, it's the frail and elderly that may not have nursing homes and so on. I think unfortunately you are going to have some temporary systems in those states as we go forward. The rest of the states, those that have taken sort of I think below 2,000 I am not particularly concerned about. I think they can be brought into the system in general and do fairly well, but it's the three or four states that have taken a significantly higher percentage.

ED HOWARD: Yes, go ahead.

KIM MUSHANELL: Kim Mushanell, Association of University Centers on Disabilities, and mine was a similar question or concern and that is that you have found that a lot of the people in these shelters are people with special needs and people with disabilities and one of our biggest concerns is a lot of these folks get community-based services and support and that they are not helping people with dishabilles especially with primary disabilities are not now just put into institutional type settings. We hope that some of the support that you consider the legislation that you are developing will consider somehow boosting provider networks, you know, making sure that there is housing systems such as Section 8 housing vouchers and that these folks get some case management services that they desperately need. Thank you so much for this panel.

RICHARD CARMONA, M.D., M.P.H.: Yes, thanks for that

question. I wanted to let you know that Secretary Levitt has been deemed the number of our senior leadership as well as some of the other federal agencies to deal with the issue of the special needs population, especially the elderly and disabled. There are multiple agencies within HHS, SAMSA, ACF as well as AOA our Agency on Aging have been looking at this issue for the same reasons that you have just mentioned to make sure that we can have an infrastructure in place to continue services. How we are doing that on the acute is partnering with the local and state health departments who have received the evacuees and what we have been doing is supplement their services with U.S. Public Health Service Commission Corps. Officers who we send forward and the disciplines needed to support the evacuee population. As we move along in attempt to move the infrastructure, on the CMS side, Mark McClellan has been working with the regional directors and commonly their state leaders to break down the barriers to access to all of the CMS services and pretty much make every evacuee more or less a universal citizen that wherever they show up, they have immediate access to services that they need and we cut through all the red tape. So all of those things are going on as we speak right now, but we are very sensitive to those issues and they are ones that are quite challenging when such a large population is evacuated.

ED HOWARD: Yes, go right ahead.

JOHN RING: John Ring, Robert Wood Johnson Health Policy fellow; a question for Mr. Tallon. Mr. Tallon, you presented very clearly a New York State approach that's very Nike like to this sort of problem, just do it. Did you identify difficulties with that at the time? Have you subsequently identified difficulties that would – or benefits that would affect bringing that type of approach forward into the future?

JAMES TALLON: I think the fact that New York had a comprehensive Medicaid program and we were simplifying access to that Medicaid program is a unique characteristic here. The fact that we had in process a waiver approved 1115 waiver that gave us children with SCHIP up to 250 of poverty and as I said, childless adults to 100 and then parents to 150. We then implemented access to that program in an accelerated fashion. If we had a less comprehensive Medicaid program, we would have faced a different circumstance. Having said that, though, Medicaid proved to be a very flexible vehicle, particularly as we worked over time with the product. We hoped at the time that this simplification would open a door to letting us think about how to much more radically simplify access and overcome some enrollment issues in Medicaid in New York. In the short term, it really succeeded, in the long term we made some incremental improvements, but I would state we still struggle in New York with a large number of people by our count about

1.3 million people statewide eligible for Medicaid, but who are not enrolled in the program because of some of the program complexities and because of some of the other issues too. So we took the circumstance that we had and I guess as I said, you know, the things that I learned in the long run were this issue of the fear and dislocation, what it's like to be in this and I personally wasn't victimized by it, the need for communication to really get to a level of understanding that people can understand who are using the program. And then the fact that you do have the long-term transition questions in which these issue stay with you for some time.

SEN. WILLIAM FRIST, M.D.: Ed, we are shuffling around a little bit because we have got so many cards, but a number of cards and questions do center – and appropriately – on Medicaid, on healthcare services for this population. It's predominantly going to be Medicaid, every state to which these evacuees are displaced persons have arrived – just about in every state – Medicaid as we all know can be a fragile program from the finance side of it. Therefore, it is a big focus for us in the Congress and for the governors, so a couple of comments. One question, can you comment on proposals about 100 percent federal funding for states like Texas and Tennessee to provide Medicaid services for the large numbers of evacuees.

Congress quickly passed legislation to provide insurance to evacuee states and healthcare providers for some

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period of time, six, 12 months. The whole idea of Congress acting quickly to join federal state program of Medicaid which is predominantly funded by the federal government [Inaudible] that we are all familiar with. Just a quick sort of update where we are, as of Friday, so I don't know whether it's going to occur today or the early part of this week, but the administration plans to release a Medicaid waiver template for states to use and seeking of very broad waivers for periods of time to Katrina to displaced persons. Also and again, I am not sure if it's going to be today or in the next several days, there will be a broad waiver for Texas. Something very similar to what happened – I was just asking Jim – something very similar to what happened with post 9-11 this would be a formal waiver, which I guess is just a little bit different for the city. I would think that we are going to still have to legislate. The waivers are built in to flexibility and the response in this acute phase, but I would think that we are going to have to legislate as so many people have suggested in terms of the various match and no decisions have been made. We've got to look very carefully at what the federal government can do to assist states in terms of the match in terms of making more federal funding available. I just have the portability of funding and increasing, but the decision hasn't been made, but it is certainly being looked at. Diane, I guess has some Medicaid points if you are aware of other things.

DIANE ROWLAND, Sc.D.: Well, certainly, one of the big issues here is the individual states that are left in the affected states as well as those who have been evacuated, and when you look at the situation you have both people currently on Medicaid, you have large numbers of people who have been previously uninsured [Inaudible] evacuation. Jim was talking about [Inaudible] extending Medicaid to childless adults that were not previously eligible for Medicaid as well as other individuals. If you think about the income standard of eligibility to the states that are affected, children are covered in most of those states up to 200 percent poverty, but adults were only covered at about 13 [Inaudible] poverty. Then you have large numbers of adults who have been affected by this who are very low income [Inaudible] as to how you provide assistance for those already on Medicaid at the state of the hurricane. And what do you do about uninsured and the previously privately insured who are now income less and just by general standards now qualify for Medicaid [Inaudible] complex issue, and Ray can probably speak more directly to.

RAY SCHEPPACH: Not only the percentage of poverty of course in all those state reimbursements are so low that a lot of times you are going to have the doctors coming forward [Inaudible] and enroll in Medicaid, so for those three impacted states really very, very difficult problems and it [Inaudible]. You are going to have huge unemployment and it's going to be

fairly six months, 12 months, with no healthcare as well. So we have got to not only go back in and build up that infrastructure but at the same time the state revenue is going to go down significantly due to unemployment. So I do think some national focus maybe even across the board on income is necessary in those three states, which again, I think differs dramatically from [Inaudible].

ED HOWARD: I should say that we have just a flood of green cards up here, so if you want to make sure that your question is going to get addressed; you have get to one of them. Yes?

AGNES CARY: Agnes Cary with Congressional Quarterly. I had a question for Senator Frist and Mr. Scheppach. There's been a discussion here about long-range health [Inaudible]. So is this the right time to try to reduce the growth in Medicaid spending, although I am sure you are going to have a lot of demand for this program.

SEN. WILLIAM FRIST, M.D.: Good question because it's a question that aims at the heart of overall financing for Medicaid and how can we best get dollars down to where it will have an impact, whether as Ray suggested, paying providers enough so they will participate in programs, can participate in the program. The increase of Medicaid funding about 7.4 percent a year what our budget did, we took Medicaid down to 7.1 percent growth. That's about 7.4 to 7.1, is about what

that reduction in growth that has been proposed to be in our budget. A billion dollar figure is sort of the figure that's been floating out, although that hasn't been designated to be Medicaid in terms of reduction and growth. I think the appropriate answer is not cutting Medicaid and the purpose of it and it hasn't been mashed up with policy yet, but we have to see appropriations process, that was just the budget, but if it's directed in making Medicaid more efficient by stripping out the waste, of stripping out the fraud, of stripping out the abuse in the program. If it's coupled with reform that makes the program more effective, more efficient, I think it will be strongly supported. If that reduction in spending over time in some way is leaning in terms of real terms cutting back on care, not allowing increased care but in fact cutting back on care for individuals would be absolutely the wrong thing to do. And so as we see it play out legislatively over the next several weeks, you will see members of the Finance Committee who make the ultimate decision, very specially say, how can we make the program better. How we can get more providers in? How can we take care of more people? How can we increase the quality of care, increase access to care, and the best way to do that is better organize the program and cut out the waste and cut out the fraud and cut out the abuse.

RAY SCHEPPACH: This is where representing a bipartisan organization can get one in trouble. Do I upset the

republicans or the democrats with my answer? We have approached this whole Medicaid thing really from a good public policy standpoint and we are really not trying to hit any budget number; although, we did oppose anything that had federal savings with no state savings. We actually put four major components on the table from a policy standpoint. One was changing the way drugs are priced and rebated. Second, more restriction on sort of asset transfers; the third component as cost sharing; and the fourth which really talked about things for some populations more than SCHIP benefit packages. I think I could probably argue that they differ. A lot of the savings on the drug side probably would not impact individuals on this program. We can question whether asset transfers would work. Clearly some people might make a stronger argument than some of the cost sharing, but again, I think our position has been we really came at this from a public policy standpoint. I could see some combination of some kind of reconciliation actually, Bill that has been discussed, SMAP for the impacted states [Inaudible].

This question is with regard to some of the long-term implications of this disaster. Is there any discussion about the establishment of a registry tracking individuals over time that might have had an environmental exposure, water or other toxic medians? Is there any attempt here to begin to build in some sort of a long-term health affect study?

RICHARD CARMONA, M.D., M.P.H.: In fact, there is. We have an Environmental Health Office in D.C. working with the local and state public health officials who are beginning to track all of the contacts. We just set up a new command center and hospital a few days ago when I was down there. And already, the state health director, city health director of New Orleans and the U.S. Public Health Service is still locating are beginning to reach out into the community [Inaudible] to develop a database contact goal of the individuals who might be at risk for any and all problems. In addition, there are a number of databases that are being generated just in general for evacuees. The Red Cross has one and there are other agencies that are generating their own databases, and certainly connectivity will be important as we move forward with those databases and to add on to what Senator Frist said earlier, this really does give a lot of credence to moving forward aggressively with the electronic medical records digitalizing all of our data.

MALE SPEAKER: [Inaudible] with the Center on Budget Priorities. I have a question for Senator Frist, or maybe Ray Scheppach, or maybe another or whoever wants to comment. I guess I have heard some people discuss, you know, the response to some of the funding issues and the Medicaid issues. In a sense of a state by state response, so that's things like waivers that are negotiated with individual states or Ray was

mentioning, you know, there are certain states that are taking in a lot of evacuees and the rest don't matter so much. I guess part of my question is it seems to me that it's not clear that where people went first is where they are going to stay. I mean I would imagine that there are bunch of people in the first, in the immediate crisis who were moved from New Orleans to the Astro Dome, but maybe after a couple weeks after a month, they will decide they would rather go stay with relatives in Oregon and Tennessee, South Carolina, wherever they end up, and then actually six months from there they may decide they want to go back to Louisiana, back to Mississippi to try and rebuild their home. All during that time, they are still unemployed, they still need health insurance, they are still going to need healthcare, but they are going to be moving, and so you can't be sure exactly what state they really are in, and that's where you need some kind of a national response like legislation that will provide, you know, fuller Medicaid coverage for the funding no matter where they are; so it might follow the individual.

RICHARD CARMONA, M.D., M.P.H.: That's a great question, it's one that at HHS Secretary Levitt and our team has been struggling with and also working with Social Security and others in the government who provide benefits as to how to develop this universal citizen concept so that no matter where the evacuee goes, they have access. Now fortunately, within

CMS and within many of the other beneficiary companies, the federal government that provide benefits, there is a digitalized record. So portability is fairly simple from community to community, and really – correct me if I am wrong Senator – but I think this can be done administratively rather than legislatively if you just allow for the portability of the benefits between offices. If somebody moves from region seven to six or five or moves several times, as long as they are identified as an evacuee they will get preferred status and will have access to benefits wherever they go.

SEN. WILLIAM FRIST, M.D.: I will simply add, I am concerned about only because it's so untested. What is going to be incumbent on all of us – by all of us I mean government broadly – is to recognize this massive displacement of 1.1 million people is ongoing, is continual, is waive by waive. The price of healthcare that we are talking about today is also education. Children K through 12 and then higher education who we don't know whether they are going to be three months from now, we don't know in higher education. Universities have opened up broadly and in admirable ways going through that whole debate [Inaudible] so K through 12. The idea of portability a word I used earlier in my comments and the questioner used is important, I think that we address. It takes some flexibility, we have to work outside of the box; we have to work outside of a lot of the statutes and regulations.

It may well require legislation to build in portability so that the sources go to the jobs which were also mentioned, unemployment insurance. But portability for this massive stay away appropriately from the word refugee, because of certain connotations, but it's not just in evacuee that goes out to one place, it's not just somebody displaces from their home. It is somebody for a while is going to have to search and reestablish that home; geographically, economically, and from a health basic node. None of that has been determined as to the flexibility that we got to have.

DIANE ROWLAND, Sc.D.: The question here is how can the federal government [Inaudible] healthcare infrastructure in any community or for health professionals [Inaudible]

RICHARD CARMONA, M.D., M.P.H.: We are currently meeting with areas that have directly been affected, Mississippi and Louisiana relates to reestablishing a healthcare infrastructure in the community. The first step obviously is a needs assessment to sew what's left and then we have to begin to rebuild. Like I said earlier, in a gap analysis we have provided public health service officers to be deployed to those areas to provide at least a flexible, mobile infrastructure to provide for the needs whether they are administrative or clinical to those communities at this time. As we move forward, discussion have already begun last week when I was in New Orleans with Sen. Stevens and Dr. Schirisse

we spoke of if we are going to rebuild, is this an opportunity to look at rebuilding the healthcare delivery systems in a much more advanced thinking way, using the best practices, making sure everything is digitalized, making sure that we have the appropriate balance of outpatients versus inpatients. Let's not automatically just rebuild a hospital because it had a certain amount of beds; let's look at the true need in the community and where the resources need to be. So what I am seeing is that many of the leadership are leaning forward as we say and looking at the opportunity to bring back and infrastructure that is more advanced, more to the needs of the people than what was present even at the time of the hurricane.

SUE ELLEN GALBERT: Sue Ellen Galbert with Anchor. We are national providers of support for services to people with mental retardation and other disabilities. As I stood here, each of my questions have already sort of been addressed in one way or the other, but to pull things back to the immediacy of Medicaid and that response and separate it from what other Medicaid reforms we are going to be looking at just to push again for the need for immediacy of those individuals who are in the affected states as well as those states where – an example providers in our organization are lending a hand for the evacuees. In Louisiana one of our providers that has 17 – 70 homes in Louisiana evacuated everybody by Saturday in 48 of the homes, and luckily so, 36 of the homes were completely

destroyed. They now have a more I guess med-term approach for about 180 of the 240 individuals, but one of the invisible things, and I think many of you have touched on it is certainly the infrastructure as it was and in the future. And the workforce and an invisible workforce that maybe was not seen on television, but those direct support workers who provide long-term supports to people in their own home or for the six-person group home as I just mentioned 38, if one of our organization lost, they were already low-wage earners, some of whom who were really entitled to Medicaid services. So to come back to Diane's point, we have to look at those who were not just victims immediately, but those who lost their jobs or who are going to be temporarily unemployed, and we didn't have the infrastructure there to begin with, and now we are even further behind.

DIANE ROWLAND, Sc.D.: I think one of the points that came out to us as we talked to some of the individuals in Louisiana after all this, that many of the frail elderly that you are now seeing were being informally supported [Inaudible] family structure for many of them is gone, so I think the crisis is even larger than what we would have anticipated if we just looked at those currently with [Inaudible].

RAY SCHEPPACH: Let me just make another point which is that one of the problems we have to face with three levels of government workers who [Inaudible] and with the [Inaudible]

think that what happened is some of the community glue is in a sense gone. I think what we have got to do with the disaster [Inaudible] is to try to get working groups together and represent all of the state [Inaudible] so states can begin to put that community back together, and if the federal government is [Inaudible] cause all of the other charitable groups are going to be part of it because in all honesty we are running out of resources, and the question is we are not using those resources sufficiently and then I think we've got to talk about [Inaudible] at the table in those cities to build it back.

DIANE ROWLAND, Sc.D.: The people who enrolled in disaster relief Medicaid after 9-11 stayed on Medicaid coverage.

JIM TALLON: The data seemed to reflect our experience in the boarder population. In New York at the 12-month recertification period, we did about a 47 percent drop-off rate, and then in the months following a large number of those people come back on as they have healthcare needs. As best we could tell, the numbers looked pretty similar in the disaster relief Medicaid group. So we didn't manage to really fundamentally change the enrollment process, but the folks who were on an emergency basis tended to look like everyone else. So I think one of the specific problems we had again, communication, communication, communication. People who had a temporary disaster relief Medicaid card, had a very difficult

time grasping that we were doing a recertification process and they needed another card for permanent Medicaid, but they really reverted to the mean and looked like the rest of the population, which actually gave us some sense of assurance that we really were reaching out to a group of people who had significant needs in New York and were eligible for the Medicaid program.

DIANE ROWLAND, Sc.D.: Is there enough supply and does the stockpile includes medications to treat chronic illnesses, if not, should there be?

RICAHRD CARMONA, M.D., M.P.H.: Good question. The second time in the history of the country that the national stockpile was sent forward for emergency relief. Many of the chronic medications that would be needed are not included in the national stockpile as are many of the immunizations, childhood immunizations and as we mobilize hundreds of thousands of children of evacuees; it became apparent that these routine immunizations were going to be a big challenge as well. So a separate group is working, my colleague Julie at CDC as well as the vaccine group we have put together for all vaccine issues has been looking at this issue to see how do we meet the needs of a moving mobile population as it relates to the routine vacations that need to be met. The issues of medications that are not within the strategic national stockpile are being dealt with primarily through the evacuation

centers and the pharmacies that have been set up as contingent pharmacies at those evacuation sites.

ED HOWARD: We have time to take the people who I think have been patient enough to stand and including the workers when they sat down. If you would ask your questions briefly.

JANET WELLS: Janet Wells with the National Citizen's Coalition for Nursing Home Reform. I think some of the many tragic images that came out of the last two weeks; one was the St. Rita's Nursing Home where 32 residents died within days after the hurricane because they weren't rescued. We heard of another facility were all the bodies were found this weekend. We have been told about still a third facility where people were fleeing for buses to come and evacuate them and buses to come and they never came. I think, you know, of all the many things we need to do in the coming weeks and coming year is to look backward, not to blame anyone for what happened, but to really understand why the infrastructure was so poor to get people who are completely helpless out of the nursing facilities and other kinds of care facilities and to not just get them to some kind of shelter, but to get them to a shelter where they could receive the kinds of services they needed. Providers – many of the providers just have done a wonderful job of getting people out in time and relocating them in other facilities for people who have really worked hard and over time to get them resettled. But the infrastructure itself really

failed, and we hope that we will be addressed. And we feel very strongly there needs to be an Independent Commission to take that look at what happened and what we need to do in the future.

ED HOWARD: Yes?

DOMINICK KANE: My question was just asked almost. I had a question for Senator Frist and now he's gone. My name is Dominick Kane, by the way. I just had a very general public question as to why an Independent Committee wasn't formed a bipartisan committee was formed for Hurricane Katrina for the rescue effort?

SEN. WILLIAM FRIST, M.D.: I don't have an answer to that question.

ED HOWARD: Yes?

JOSLYN GYER: Joslyn Gyer with Georgetown University's Health Policy [Inaudible]. Before Katrina hit, one of the major issues facing our seniors and people with disabilities was they were slated to lose the Medicaid coverage and the Medicare drug coverage first. Obviously, less of a pressing problem in light of the daily fight for their lives they have been going through, but I am curious at this point given that that already seemed like a difficult position, are we – is there discussion about revisiting whether it's appropriate to have Katrina survivors going through that kind of transition just a couple months from now, particularly given that it may

be quite difficult to reach them and do all the logistics needed in switching their drug coverage.

ED HOWARD: I don't know if that came up in any discussion.

RAY SCHEPPACH: Yeah, we have had a lot of different discussion about it, but we really have not come to any conclusion.

ED HOWARD: It's going to leave us hanging on that note. Clearly we have a range of questions [Inaudible] most likely to fall through the crack. I would like to give our panelists about 30 seconds to say what they would like. Jim?

JAMES TALLON: I will take the opportunity because we were originally scheduled today to have a conversation and maybe we will reschedule it and do it about the boarder questions in Medicaid reform, and I was looking forward to participating in it. It is important to note that we have to have that conversation, and we have to have that conversation beyond debate about the reconciliation process. That's a very important debate and one in which I have a view, but as with the 9/11 experience in New York and now again with the Katrina experience, we have to once again sort of get a reality check of the dilemmas that exist in the lives of low income Americans, particularly when faced with threat or crisis and honestly, and for many people, not in a large group, but they experience threat and crisis individually everyday. And so, I

just hope as we come back to the broader discussion and that we come back to it that we will think about how our experience her affects the policy choices and how we can better continue to reshape the Medicaid program in a way that meets all of the conflicting demands, but I simply hope that we add to that conversation a thoughtful understanding of just once again, what are the reminders that come from the experiences that millions of our fellow citizens have experienced.

RAY SCHEPPACH: Yeah, the only comment I would make is we have focus primarily on Medicaid and from the state prospective, although that is poor program; it needs to be integrated into more of a full service because there are lots of other social services [Inaudible]. That's one of my concerns on portability and so on [Inaudible] reconcile all the programs. We are really talking about a menu of services here.

RICHARD CARMONA, M.D., M.P.H.: I think we need immediate response [Inaudible] two questions alluded to that we need to evaluate [Inaudible] and I can tell you that a lifelong area you always have lessons learned after the fact. It is important to have very objective inspections, ask tough questions, and generate the appropriate after action. Once all of the information and once all of the anecdotes can be evaluated, and then look at very crucially how we perform at a local at a state and at a federal level and move forward with instituting and institutionalizing practices that will work

better in the future. This is not uncommon. After every disaster and having been through many, many in my life that we sit down and go through sometimes a very painful discussion afterwards whether we had deficiencies that nobody saw, prospectives where there were no reasonable way that somebody could have anticipated certain events even in the mock scenarios that you plan for and ask the what if question in the worse case scenario. I think all of those things will have time and whether it's an Independent commission or whether it's individuals, this has to occur so that we can become better and stronger in the future, and I have every confidence that it will occur because it always has in the past.

DIANE ROWLAND, Sc.D.: I just want to thank Ed and the Alliance to be willing to shift the topic today to this topic. I think it's a very important one for us to engage in and I know we will continue to engage in over the long run because I think it's not an issue that is going to be settled in the next week or the next two weeks. I want to thank all of you for coming and we're trying to keep abreast of what's going on with Hurricane Katrina recovery and on our Web site kff.org we will be covering many of the statistics and many of the events that are going on around this, and I want to call your attention to an audio tape that is now on our Web site from a briefing on Friday involving the Deputy Director of the Medicaid program in Louisiana Barbara Edwards from the State of Ohio Medicaid

program and Jane Lapert talking really about some of the Medicaid issues and challenges that are being faced, and I will work with Ed and other to keep this conversation going, and I want to thank all of our panelists on behalf of Kaiser Family foundation.

ED HOWARD: I second that, and let me just say one last time to fill out these blue evaluation forms. I appreciate that. I want to thank the Kaiser Commission for thinking big enough and quickly enough to be able to get this program in front of you. Just a foot note by the way [Inaudible] when you get back an announcement of a briefing of Health Affairs journal with our health is this Friday to talk about David Graler and some colleagues Information Technology issues including electronic health records. Would you join me in thanking the panel members for a great discussion?

[Applause]

[END RECORDING]

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