

The State of Mental Health Care in Post-Katrina New Orleans

“Laws that are ambiguous prevent agencies from acting rapidly and decisively in an emergency.”¹

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I. INTRODUCTION

Hurricane Katrina devastated every aspect of life in New Orleans—notably, health care. While all fields of health care remain in crisis more than two years after the storm, particularly startling is the crippled state of mental health care in New Orleans. The problem with recovery of the mental health care system in New Orleans presents itself in three prongs: (1) the surge of mental illness resulting from the devastation; (2) the delay in acquiring health insurance following the storm; and (3) the general breakdown of the New Orleans mental health care infrastructure. In addition to the listed hurdles, any attempt to remedy the problem has been marked by incongruity among the state, federal, and local

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1. Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 J. AM. MED. ASS'N 622, 624 (2002).

governments and entities. Before and after Katrina, this incongruity manifested itself in an overwhelming bureaucracy in Louisiana's health care system and has created a culture of reactivity and shortsightedness in all areas of health care, including mental health care.

This problem demonstrates the need to streamline the administration of mental health care in a manner that can address all possible issues concerning mental health, rather than force disjointed agencies to manage with a fragmented set of statutes and regulations. In discussing the need for such a comprehensive, direct law, a medical scholar stated, "Laws that are ambiguous prevent agencies from acting rapidly and decisively in an emergency."² The Louisiana Health Emergency Powers Act (LHEPA),³ which has adapted provisions of the Model State Emergency Health Powers Act (MSEHPA),⁴ seems like a plausible prototype for such a project, as it addresses response to medical emergencies. However, the LHEPA and the MSEHPA primarily focus on health emergencies resulting from biological terrorism, which is not the concern of this Comment.⁵ Instead, Louisiana and New Orleans are faced with a different type of terror—a mental health pandemic. However, the LHEPA, with the supplementation of various existing statutes and regulations, and the continued supplementation of the MSEHPA, can be tailored to address the current and future mental health care needs of the state.

This Comment will address the state of mental health care in New Orleans before and after Katrina, with an emphasis on weaknesses exacerbated by the storm. Part II of the Comment addresses the overall state of health care before Katrina, focusing

2. *Id.*

3. LA. REV. STAT. ANN. §§ 29:760–772 (2007).

4. The Model State Emergency Health Powers Act states that: "A 'public health emergency' is an occurrence or imminent threat of illness or health condition that . . . is believed to be caused by . . . [a natural disaster] . . . and poses a high probability of any of the following harms: (i) a large number of deaths in the affected population; (ii) a large number of serious or long-term disabilities in the affected population; or (iii) widespread exposure to an infectious or toxic agent . . ." MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Revised Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>. The brackets here were included by the drafters to imply that a state legislature may include such a provision if applicable to its state.

5. The Preamble to the Model Act states that: "Though comprehensive, the scope of the Act is limited in [that the] Act does not cover some distinct areas of law despite their strong public health relevance. For example, the law relating to mental health [and] alcohol and substance abuse . . . [is] not specifically addressed." MODEL STATE EMERGENCY HEALTH POWERS ACT pmb. (Revised Draft 2003).

on the deficiencies in mental health care. The remainder of the Comment illustrates specific issues in mental health care that have arisen since the storm.

Part III discusses the rise in psychological illness since the storm demonstrating the urgency for resolution of the problem. Part IV addresses the difficulties in acquiring insurance immediately following the storm and how these difficulties contributed to the failing mental health of the New Orleans area population. Part V describes the current failing condition of the mental health infrastructure, with a comment on how Governor Bobby Jindal plans to address the problem. Each section includes background information specific to the issue; an explication of any federal, state, or local response to the issue after the storm; and an analysis of the strengths and weaknesses of the law affecting the issue. Part VI proposes consolidating the law of mental health care in order to more efficiently administer care. Specifically, Part VI proposes streamlining a statutory response to mental health care emergencies within the provisions of the LHEPA in a manner that directly addresses the flaws that were exposed in the response to Katrina. Finally, Part VII provides concluding thoughts on the magnitude of this problem as well as general recommendations.

II. BACKGROUND: HEALTH CARE IN LOUISIANA AND NEW ORLEANS BEFORE HURRICANE KATRINA

Hurricane Katrina amplified the flaws of an already failing health care system.⁶ In 2004, the year before the storm, Louisiana ranked fiftieth overall in the United Health Foundation's assessment of the adequacy of state health care systems.⁷ One of the factors that led to this ranking was the extremely low rate of insurance coverage among Louisiana citizens,⁸ which left about 20% of the population uninsured.⁹ Medicare coverage apparently accomplished little in ameliorating insurance problems; in 2003, Louisiana was last in the national rankings for overall Medicare quality, even though the state ranked first in overall Medicare

6. See Press Release, La. Dep't of Health & Hosps., State Health Rankings Published: United Health Foundation Ranks Louisiana 50 (Nov. 8, 2004), <http://www.dhh.louisiana.gov/news.asp?ID=1&Detail=386&Arch=2004> [hereinafter Rankings Release]. See also Deborah Gesensway, *How a Legendary New Orleans Hospital Is Struggling to Finally Change its Ways*, INTERNIST (Am. College of Physicians), Apr. 1999, <http://www.acponline.org/journals/news/apr99/orleans.htm>.

7. Rankings Release, *supra* note 6, at 50.

8. See Gesensway, *supra* note 6.

9. John Pope, *Blanco Demands Answers on Health Care; No Easy Solution to 1 in 5 Uninsured*, TIMES-PICAYUNE (New Orleans), Dec. 17, 2004, at B1.

expenditure per capita.¹⁰ Governor Kathleen Blanco recognized the lack of health insurance as the “core” of Louisiana’s health care problems.¹¹

While lack of insurance may be at the root of the problem, the outward manifestation of Louisiana’s health care problems has been a culture of reactive medicine that developed throughout Louisiana, creating a dependence on inpatient and emergency care, rather than less expensive outpatient and preventive care.¹² Particularly, there has been a dependence on the State’s Charity Hospital System, especially for the mentally ill.¹³ However, in the years before the storm, the efficiency of the Charity System fell under scrutiny.¹⁴ First, the majority of patients who sought care in the charity hospitals often had no insurance, rather than just insufficient insurance.¹⁵ As a result, the charity hospitals regularly received no reimbursement for the expensive emergency care that they provided from resources such as Medicare and Medicaid.¹⁶ As Louisiana has been ranked among the highest in the nation in emergency room visits, dependence on this emergency care created a serious financial problem.¹⁷ The dilapidated state of the Charity Hospital System in New Orleans and the threats of removing its status as a level I trauma center evidenced this under-funding.¹⁸ In an effort to improve the management of the hospitals, the legislature transferred the authority of the Charity Hospital System from the State to the Louisiana State University (LSU) System in 1997.¹⁹

10. *Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region: Hearing Before Subcomm. on Oversight and Investment of H.R. Comm. on Energy and Commerce, 110th Cong. 2 (2007)* (testimony of Frederick Cerise, Sec’y of La. Dept. of Health & Hosps.) [hereinafter Cerise Testimony].

11. Pope, *supra* note 9.

12. Gesensway, *supra* note 6. See also Cerise Testimony, *supra* note 10.

13. Gesensway, *supra* note 6. See generally Russell McCulley, *Another Breakdown in New Orleans*, TIME, May 15, 2007, <http://www.time.com/time/printout/0,8816,1621482,00.html>.

14. Gesensway, *supra* note 6.

15. *Id.*; Cerise Testimony, *supra* note 10.

16. See Gesensway, *supra* note 6.

17. Cerise Testimony, *supra* note 10, at 2.

18. Patrick C. Breaux, Editorial, *Health of Charity Hospital Important to Us All*, TIMES-PICAYUNE (New Orleans), July 1, 2005, at B6.

19. See Gesensway, *supra* note 6. The author cites that a motivation for this transfer was to remove Louisiana politics from the equation. For a critique of LSU’s control of the Charity System, see Jan Moller, *Senator Blasts Care at Charity Hospitals; He Says LSU System Neglecting Indigents*, TIMES-PICAYUNE (New Orleans), June 3, 2005, at A4.

While there is a remedy to this funding problem, in reality it only contributes to the culture of reactive health care in Louisiana by perpetuating dependence on charity hospitals. The system is called “disproportionate share hospital” funding (DSH) and is Louisiana’s means of paying for the health care of its uninsured.²⁰ Under this mechanism, for every thirty cents that the state invests in facilities like Charity Hospital New Orleans, the federal government will “match” the dollar. Accordingly, for every three dollars that the state invests, the federal government will invest seven. The benefits of this program are potentially great, as about \$1.5 billion was allocated for Louisiana DSH funding in 2007. However, Frederick Cerise, Secretary of the Louisiana Department of Health and Hospitals (DHH), expressed his concerns about the program to United States Congress. He critiqued the program for only allowing DSH contributions for hospitals and not providing for preventive, clinic-based services. So, this DSH mechanism fosters the more expensive hospital-based care and therefore the culture of reaction rather than prevention.²¹

In the months before Katrina, problems specific to mental healthcare in Louisiana were also coming to the forefront. On July 1, 2005, about two months before the storm, Governor Blanco convened a panel to discuss improving Louisiana health care. On the topic of mental health, the panel noted that “nearly 900,000 Louisianans—about one person in five—suffer from a mental disorder, but there is no coherent state-run system for treating them.”²² Specifically, several agencies had been charged with the administration of mental health care, yet no clear division of responsibilities existed among them. Furthermore, the agencies did not communicate with each other in the provision of mental health care.²³ Perhaps this unclear delegation of authority can be blamed for a cut to mental health care funding one month before the storm. When the DHH noticed an increase in the number of mentally ill patients being treated at state facilities, it attributed the patient increase to a lack of oversight. More specifically, the department blamed the increase on failure to note patient improvement and to encourage releases, the supposed result of insufficient and

20. STEPHEN ZUCKERMAN & JACK HADLEY, KAISER COMM’N ON MEDICAID & THE UNINSURED, LOUISIANA’S PROPOSED SECTION 1115 MEDICAID DEMONSTRATION PROJECT: ESTIMATING THE NUMBERS OF UNINSURED AND PROJECTED MEDICAID COSTS 1 (2007), <http://kff.org/uninsured/7669.cfm>.

21. Cerise Testimony, *supra* note 10, at 3.

22. John Pope, *State’s Mental Health Programs Need to Be Integrated, Panel Told Education Required to Raise Awareness*, TIMES-PICAYUNE (New Orleans), July 1, 2005, at A2.

23. *Id.*

infrequent patient evaluations. For this reason, the Department cut funding to the facilities.²⁴

III. THE RISE IN MENTAL ILLNESS SINCE HURRICANE KATRINA

Since Hurricane Katrina, the incidence of psychological illness has increased. Just after the storm, it was estimated that Hurricane Katrina “[would] cause a 30 to 40 percent increase in the number of Louisianans needing mental health treatment . . . ,”²⁵ and it was “estimated [that] 380,000 Louisianans [would] develop post-traumatic stress disorder.” These predictions have proved to be an underestimation. A recent study by the Department of Psychology at the University of New Orleans has concluded that cases of mental illness have actually doubled since the storm.²⁶

There are several factors contributing to this effect. Because of evacuation and prolonged relocation, many mentally ill patients did not have access to their physicians or their medication for an extended period of time²⁷ and were separated from their needed social support groups and families.²⁸ The relocation has also greatly impacted the mental health of children residing both inside and outside of the state. Aside from the general stress of surviving the storm and relocating, the aftermath of Katrina has also put pressure on schools throughout the nation to accommodate New Orleans students. The resulting “cultural clashes” have placed undue stress on many young children.²⁹

24. Jan Moller, *State Establishes New Rules for Mental Health Program: Move Trims Costs; Improves Oversight*, TIMES-PICAYUNE (New Orleans), July 29, 2005, at A2.

25. LA. PUB. MENTAL HEALTH REVIEW COMM’N, PAY NOW OR PAY LATER: MENTAL HEALTH RESOURCES HAVE NEVER BEEN MORE NEEDED (2006), <http://www.dhh.louisiana.gov/offices/publications/pubs-62/LPMHR%20COMMISSION%201.pdf>. This publication notes a disclaimer stating that it should be used for informational purposes only.

26. *Hurricane Katrina Victims’ Mental Health Worsens* (Nat’l Pub. Radio broadcast Nov. 1, 2007), available at 2007 WLNR 21542965 (summarizing Weems, *infra* note 28).

27. LA. RECOVERY AUTH. SUPPORT FOUND., REPORT ON LOUISIANA HEALTHCARE DELIVERY AND FINANCING SYSTEM 71 (Pricewaterhouse Coopers 2006), <http://lra.louisiana.gov/assets/docs/searchable/reports/PwHealthcarereport427061.pdf> [hereinafter PWC REPORT]. This report notes that it is intended for the use and benefit of the Louisiana Recovery Support Foundation only and not intended for reliance by any other party.

28. See Carl F. Weems et al., *The Psychosocial Impact of Hurricane Katrina: Contextual Differences in Psychosocial Symptoms, Social Support, and Discrimination*, 45 BEHAV. RES. & THERAPY 2295 (2007).

29. LA. DEP’T OF HEALTH & HOSPS., A ROADMAP FOR CHANGE: BRINGING THE HOPE OF RECOVERY TO LOUISIANANS WITH MENTAL HEALTH CONDITIONS 52

Concern about suicide since the storm also has increased. Recent coroner records have shown that the suicide rate in post-Katrina New Orleans is three times what it was before the storm.³⁰ However, the magnitude of the problem is unclear. One report prepared for the Louisiana DHH has noted the possibility that the true impact of Hurricane Katrina on the suicide rate of Louisianans may never be known.³¹ The report cites two reasons for this proposition. First, there is an inclination of coroners to falsify the cause of death when the cause is actually suicide in order to hide the truth from the public. Second, after the prolonged relocation of many citizens, it is has become difficult to maintain the records, including causes of death, for Louisiana citizens outside of Louisiana.³² These factors lend to the possibility of gross underestimation of true effects, especially once and if those dispersed mentally ill return home. However, relying on the coroner reports demonstrates the true urgency of the situation.

Additionally, in the aftermath of the storm, sociologists have noted the cyclical phenomenon apparent in the social maladies of homelessness, drug abuse, and psychological disorders.³³ Specifically, the mentally ill and the addicted, especially those who cannot maintain employment, are prone to homelessness. The despair of homelessness in turn often leads to substance abuse and an increase in mental illness often for lack of treatment. This creation or aggravation of mental illness then decreases the probability of acquiring housing. Thus, homelessness is perpetuated, creating a cycle.³⁴

This trend casts a bleak shadow on the future of mental health in New Orleans. It is possible that the increase in homelessness since the hurricane will only lead to a further increase in mental illness and fuel the aforementioned cycle.³⁵ A realization of this connection between mental illness, addiction, and homelessness has prompted Senator Mary Landrieu to support the Gulf Coast

(June 2007), <http://www.dhh.louisiana.gov/publications.asp?ID=297&Detail=1326&Arch=2006> [hereinafter ROADMAP FOR CHANGE]. This report was prepared by groups in Virginia and Massachusetts.

30. *Sen. Landrieu Chairs Hearing on Post-Hurricane Mental Health*, U.S. FED. NEWS, Oct. 31, 2007, available at 2007 WLNR 21625179 [hereinafter *Sen. Landrieu Chairs Hearing*].

31. ROADMAP FOR CHANGE, *supra* note 29, at 49.

32. *Id.*

33. *Id.* at 70–71. See also Mordecai Potash, Editorial, *Psychiatrists and the Homeless*, TIMES-PICAYUNE (New Orleans), Aug. 6, 2007, at B6.

34. *Id.*

35. *See id.*

Housing Recovery Act of 2007,³⁶ which would provide for the rebuilding of low-income housing destroyed in the flood.³⁷ In her justification of this legislation, the Senator summarized the nature of the problem: “Housing is so critical It’s just not feasible to stabilize [the mentally ill] when they’re . . . living on the street or in a car.”³⁸ For this reason, and because the incidence of mental illness in the New Orleans area has the potential to continue increasing, the need for a concerted effort to address the problem is evident.

IV. THE DIFFICULTY IN ACQUIRING INSURANCE AFTER THE STORM³⁹

One factor compounding the increase in psychological and mental illness after Hurricane Katrina was the difficulty that Louisianans, including those already mentally ill, encountered in acquiring or maintaining insurance coverage. Several factors that left many previously diagnosed mentally ill without needed medication and healthcare arose immediately after the storm. The population of New Orleans and much of Southeast Louisiana was dispersed all over the nation without insurance cards and financial records.⁴⁰ There was a problem even for those who were covered by Medicaid and were in possession of their cards, as some states would not accept out-of-state cards.⁴¹ Another issue that surfaced for Medicaid “insureds” was that individual states are allowed to define their own Medicaid eligibility requirements and scope of coverage.⁴² So, it was not uncommon for an evacuee’s “host

36. S. 1668, 110th Cong. (2007).

37. *Sen. Landrieu Chairs Hearing, supra* note 30.

38. *Id.*

39. The issues surrounding insurance coverage in the aftermath of the disaster are undoubtedly common to all insurance providers. However, this Comment will narrow its scope to Medicaid for several reasons. First of all, the Medicaid programs implemented after the storm are a primary example of the federal and state response. Second, the actions involving Medicaid typify the interrelation between federal and state systems in implementing a response plan. Third, one of the goals of the Medicaid plans was to waive certain Medicaid requirements, thus covering more people than would have been covered before the storm. Last, because of the dramatic financial losses to much of the Louisiana population as a result of the storm, the number of Louisiana citizens eligible for Medicaid increased, even under non-waived requirements.

40. EVELYNE BAUMRUCKER ET AL., CONG. RESEARCH SERV., HURRICANE KATRINA: MEDICAID ISSUES 2 (2005).

41. *Id.* at 10 n.12.

42. *Id.* at 1. Several states have recommended a Medicaid Emergency Response Plan to increase communication among the states in future disasters. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS. & CTR. FOR MEDICAID & STATE OPERATIONS, A SUMMARY OF STATE REPORTS FOR MEDICAID AND THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM HURRICANE KATRINA

state”⁴³ to offer a range of coverage different from that available in the evacuee’s home state.⁴⁴ The Congressional Research Service (CRS) summarized the nature of the problem in a hypothetical: “For example, if a 16-year-old Medicaid recipient from Louisiana relocates to Texas because of Hurricane Katrina and needs inpatient psychiatric services, will he be able to obtain this care given that the Texas Medicaid Program does not cover this benefit while Louisiana’s Medicaid program does?”⁴⁵

A method of circumventing the disparities in Medicaid requirements and regulations became obviously necessary, particularly since the number of people eligible for Medicaid increased after the storm with the massive loss of jobs, homes, and property.⁴⁶ Immediately after Katrina’s landfall, state and federal governments began taking measures to ensure that victims of the storm would receive necessary health care, namely through a “waiver” that permitted dispensing of certain Medicaid requirements in order to ease the acquisition of needed health care.⁴⁷ While these actions seemed to be a massive movement toward achieving this goal, the measures were rendered largely ineffective due to lack of timeliness, short-sightedness in scope, and over-regulation.

The first action was September 4, 2005, when the Secretary of United States Department of Health and Human Services (HHS)

SECTION 1115 DEMONSTRATIONS (2007), <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Hurricane%20Katrina%20Final%20Summary%20Report.pdf> [hereinafter SUMMARY OF STATE REPORTS].

43. “Host-state” is the term used in the documentation to refer to the state to which an evacuee relocated. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS 5 (2005) (on file with author) [hereinafter SPECIAL TERMS AND CONDITIONS].

44. BAUMRUCKER, *supra* note 40, at 6.

45. *Id.*

46. *Id.* at 2.

47. The Congressional Research Service looked immediately to New York’s response after the terrorist attacks of September 11, 2001, when all Medicaid records were destroyed in the collapse of the World Trade Center. This program was called Disaster Relief Medicaid. *See Olson v. Wing*, 281 F. Supp. 2d 476 (E.D.N.Y. 2003). Similar to the Katrina situation, Medicaid records were lost in the World Trade Center collapse. A class action initiated suit for recovery of benefits that had been terminated after September 11th. The court ordered an injunction against stopping benefits while a fair hearing was pending, “even though the state was unable to process any new applications.” *Id.* at 479. So, the federal government approved “presumptive eligibility” under 42 U.S.C § 1315. This presents a state dealing with a similar issue in a different way. Perhaps this approach should be examined in Louisiana.

declared an “1135 waiver” for all Katrina states.⁴⁸ This type of waiver, available only to those “geographic areas directly impacted by the emergency,”⁴⁹ refers to Section 1135 of the Social Security Act (SSA). This section of the SSA delineates a procedure for waiver of certain Medicaid requirements that are imposed on health care providers, such as licensing, certification, and referral procedures.⁵⁰ Other requirements that were waived included “pre-

48. BAUMRUCKER, *supra* note 40, at 17.

49. *Id.* at 16.

50. *Id.* at 17. The Social Security Act states, in pertinent part:

(a) Purpose. The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1) of this section)—

(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under subchapters XVIII, XIX, and XXI of this chapter; and

(2) that health care providers (as defined in subsection (g)(2) of this section) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b) of this section, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) Secretarial authority. To the extent necessary to accomplish the purpose specified in subsection (a) of this section, the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX, or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations thereunder, insofar as they relate to subchapters XVIII, XIX, or XXI), pertaining to—

(1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers,

(B) program participation and similar requirements for an individual health care provider or types of providers, and

(C) pre-approval requirements;

(2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

(3) actions under section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for—

(A) a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period; or

approval requirements,” in-state licenses, enrollment deadlines, Emergency Medical Treatment and Labor Act (EMTALA) prohibitions on turning patients away (provided that such action is in accordance with some emergency plan), and certain Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, but only for the first seventy-two hours of the emergency.⁵¹ However, such requirements were waived

only to the extent necessary to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Medicare, Medicaid, and SCHIP [State Children’s Health Insurance Programs] . . . and to ensure that health care providers that furnish such items in

(B) the direction or relocation of an individual to receive medical screening in an alternative location—

(i) pursuant to an appropriate State emergency preparedness plan; or

(ii) in the case of a public health emergency described in subsection (g)(1)(B) of this section that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;

(4) sanctions under section 1395nn(g) of this title (relating to limitations on physician referral);

(5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived;

(6) limitations on payments under section 1395w-21(i) of this title for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan; and

(7) sanctions and penalties that arise from noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2)—

(A) section 164.510 of title 45, Code of Federal Regulations, relating to—

(i) requirements to obtain a patient’s agreement to speak with family members or friends; and

(ii) the requirement to honor a request to opt out of the facility directory;

(B) section 164.520 of title 45, Code of Federal Regulations, relating to the requirement to distribute a notice; or

(C) section 164.522 of title 45, Code of Federal Regulations, relating to—

(i) the patient's right to request privacy restrictions; and

(ii) the patient's right to request confidential communications.

42 U.S.C. § 1320b-5(a)–(b) (Supp. V 2005).

51. BAUMRUCKER, *supra* note 40, at 16; Press Release, U.S. Dep’t of Health & Human Servs., HHS Declares Public Health Emergency for Hurricane Katrina (Sept. 4, 2005), <http://www.hhs.gov/katrina/ssawaiver.html>.

good faith, but are unable to comply with one or more of these requirements as a result of Hurricane Katrina, may be reimbursed for such items and services and exempted from sanctions for such noncompliance.

Second, on November 10, 2005, a “1115 waiver”⁵² was awarded specifically to the Louisiana Department of Medicaid.⁵³ This included a proposal for a temporary eligibility allowance for Medicaid and SCHIP to expire five months from the date of application,⁵⁴ the cost of which would be repaid to the state with federal funding.⁵⁵ This proposal had serious shortcomings, however—so serious that Louisiana opted not to implement the plan. First, to qualify for this temporary eligibility, the person had to have been an “evacuee.” “Evacuee” was defined in the waiver as “an individual who is a resident of the emergency area . . . and *has been displaced from his or her home by the emergency . . . and meets the definition of eligible population . . .*”⁵⁶ States other than Louisiana were the primary recipients of the eligible “evacuees.”⁵⁷ So, the waiver was inapplicable to Louisiana’s in-state concerns, as it was available only to Louisiana citizens outside Louisiana.⁵⁸ In other words, the program proposed to waive Louisiana Medicaid requirements when what the evacuees needed was a waiver of the

52. The Social Security Act states, in pertinent part:

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or, XIX, or part A or D of subchapter IV, in a State or States . . . the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a . . . , as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the state which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

42 U.S.C. § 1315(a)(1), (e)(2) (2000).

53. SPECIAL TERMS AND CONDITIONS, *supra* note 43, at 5; Letter from Mark B. McLellan, Administrator, U.S. Dep’t of Health & Human Servs., to Jerry Phillips, Acting Director, La. Medicaid Agency (Mar. 24, 2006) (on file with author).

54. SPECIAL TERMS AND CONDITIONS, *supra* note 43, at 4–5.

55. BAUMRUCKER, *supra* note 40, at 14.

56. SPECIAL TERMS AND CONDITIONS, *supra* note 43, at 4 (emphasis added).

57. Letter from Jerry Phillips, Director, La. Medicaid Agency, to Donna Schmidt, Ctr. for Medicare & Medicaid Servs. & Ctr. for Medicaid & State Operations (Dec. 29, 2006) (on file with author).

58. *Id.* See also SUMMARY OF STATE REPORTS, *supra* note 42.

requirements of the state to which they relocated.⁵⁹ Also detracting from the appeal of the waiver was the condition that Louisiana must “track each evacuee” in order to maintain compliance and minimize abuse⁶⁰ and a lack of timeliness; the 1115 waiver was not granted until November 10, 2005,⁶¹ two months after the storm.

In addition to the proposed waivers, an Uncompensated Care Pool (UCCP)⁶² was initiated by the Centers for Medicare and Medicaid Services (CMS) to reimburse Louisiana health care providers who cared for evacuees.⁶³ Aware of the immediate risk to mentally ill patients who were not receiving care or medication, CMS classified mental health clinic services and inpatient psychiatric services as reimbursable under the plan.⁶⁴ However, this pool was highly regulated. To obtain this reimbursement, the health care provider was required to ensure that the care was “medically necessary” and that the patient had no other available insurance coverage. The provider had to submit a detailed description of each specific treatment performed on the patient.⁶⁵ The health care provider also was required to have been a Medicaid provider as of four days before the storm, further limiting the scope of the reimbursement plan.⁶⁶ Additionally, it was stipulated that services rendered on and after February 1, 2006, were not considered eligible for reimbursement.⁶⁷

Perhaps most demonstrative of the kind of restrictions on the use of the fund is the language of federal officials in correspondence with state officials regarding the implementation of the plan. The UCCP policymakers termed it “the payer of last resort” in order to “ensure the integrity” of the fund.⁶⁸ In correspondence, Mark McClellan, a HHS administrator, wrote to the acting director of the Louisiana Medicaid Agency: “No payments may be made under the UCCP for an item or service that an evacuee or affected individual has received from an individual or organization as part of a public or private hurricane relief

59. BAUMRUCKER, *supra* note 40, at 16.

60. Letter from Mark B. McClellan, Administrator, U.S. Dep’t of Health & Human Servs., to Ben Bearden, Director, La. Medicaid Agency (Nov. 10, 2005) (on file with author).

61. *Id.*

62. Some sources have referred to this as UCC or UCP. *See* Letter from Jerry Phillips to Donna Schmidt, *supra* note 57.

63. CTRS. FOR MEDICARE & MEDICAID, LOUISIANA HURRICANE RELIEF UNCOMPENSATED CARE POOL PLAN 1 (2005) (on file with author).

64. *Id.* at 2.

65. *Id.* at 3.

66. *Id.* at 1.

67. *Id.* at 6.

68. Letter from Mark McLellan to Jerry Phillips, *supra* note 53.

effort.”⁶⁹ While it is understandable that the HHS sought to save this money for legitimate claims and for those who were in need of it the most, it seems counterproductive to the relief effort to have precluded those who had obtained assistance from volunteers and other relief workers from obtaining reimbursable care.

Aside from strict regulation, timeliness also was a problem in implementing the UCCP Plan. The plan was proposed on November 1, 2005,⁷⁰ but was not approved by the HHS until March 24, 2006. This left a little over two months following the storm during which health care providers were totally unsure of the prospect of reimbursement and another six months before they knew whether the plan would be approved. As stated by the Director of the Louisiana Medicaid Agency in correspondence on the matter, “It would have been helpful if we could have received timely CMS responses to our . . . questions This would have provided clarification to the providers as well as the staff that worked on this project thus minimizing frustration and unnecessary work on both sides.”⁷¹

Additionally, similar to the drafting of the Section 1115 waiver, the potential effectiveness of the UCCP was undercut by its intended scope. First, as the 1115 waiver was available only to Louisiana evacuees who were outside the state, the PCCF was available only to Louisiana health care providers. The PCCF was not available to out-of-state health care providers who treated otherwise ineligible Louisiana evacuees.⁷² In other words, no action was taken for Louisianans in or returning to Louisiana. Second, the UCCP was meant to exist for only six months.⁷³ These factors show the short-sightedness of the response, especially with regard to the mentally ill. The fact that the incidence of mental

69. *Id.*

70. *Id.*

71. Letter from Jerry Phillips to Donna Schmidt, *supra* note 57.

72. Though the 1115 waiver did apply to the majority of Louisiana evacuees, not all were eligible under the waiver. The waiver conditions stated that, “[e]vacuee status will be limited to parents, pregnant women, children under age 19, individuals with disabilities, low-income Medicare recipients, and low-income individuals in need of long-term care Evacuee status can be established by self-attestation of displacement [and] income” See U.S. DEP’T OF HEALTH & HUMAN SERVS., MULTI-STATE SECTION 1115 DEMONSTRATION TEMPLATE, MEDICAID AND SCHIP COVERAGE FOR EVACUEES OF HURRICANE KATRINA (2007) (on file with author). See also Letter from Mark McClellan to Ben Bearden, *supra* note 60.

73. U.S. DEP’T OF HEALTH & HUMAN SERVS., SUMMARY OF FEDERAL PAYMENTS AVAILABLE FOR PROVIDING HEALTH CARE SERVICES TO HURRICANE EVACUEES AND REBUILDING HEALTH CARE INFRASTRUCTURE (2006) (on file with author).

illness in New Orleans continues to increase more than three years after the storm shows that mentally ill patients need long-term care.⁷⁴

The shortcomings of the response with regard to insurance aggravated the effects that the storm would have on the mental health of New Orleans citizens. One survey revealed that about two-thirds of the population lost insurance coverage as a result of the storm.⁷⁵ This number is staggering. For a mentally ill patient who could not access much needed medication or care as a result of the delay or loss of insurance, the consequences were potentially severe. As one psychologist has written, “there is evidence that delays in treatment can lead to increased morbidity and mortality, including the development of various [secondary] psychiatric and physical [conditions] and the adoption of life-threatening and life-altering self-treatments [such as] licit and illicit substance abuse”⁷⁶

V. THE CONDITION OF THE MENTAL HEALTH INFRASTRUCTURE IN NEW ORLEANS

The condition of the New Orleans mental healthcare infrastructure, namely its incapacity to treat its ill, is the byproduct of the state of the health care system before the storm, psychological stress resulting from the trauma of the disaster, as well as aggravation resulting from a delay of care. These issues are discussed in Parts II, III, and IV, respectively.

The primary challenge currently facing the mental health care infrastructure in New Orleans is the lack of “beds”⁷⁷ for psychiatric patients. Before Katrina, most mental health patients sought care at LSU Charity Hospital, commonly called “Charity,” generally in the emergency department. Charity had ninety-seven psychiatric inpatient beds and provided care to about half of all mental health or addiction patients in the New Orleans area.⁷⁸ However, Charity

74. See generally McCulley, *supra* note 13; John Pope, *Poll: Mental Health a Victim of the Storm, Half Report Having Recurring Problems*, TIMES-PICAYUNE (New Orleans), Jan. 21, 2006, at 1; Potash, *supra* note 33; *All Things Considered: New Orleans Suffers Crisis in Mental Health Care* (Nat’l Pub. Radio broadcast Aug. 29, 2007) [hereinafter *All Things Considered*].

75. Pope, *supra* note 74.

76. Catherine G. McLaughlin, *Delays in Treatment for Mental Disorders and Health Insurance Coverage*, HEALTH SERVS. RES., Apr. 2004, at 221.

77. “Bed” is a term used in medical literature to denote an inpatient bed, whether in a hospital or clinic. In other words, a “bed” is a place for the ill to go when they cannot care for themselves, or be cared for at home. See MERRIAM-WEBSTER MEDICAL DICTIONARY ONLINE (2008), <http://medical.merriam-webster.com/medical/bed>.

78. PWC REPORT, *supra* note 27, at 70.

was damaged in the storm and has not reopened.⁷⁹ Thus, Katrina left the city without its primary institution for caring for the mentally ill.⁸⁰

The impact of the loss of Charity has been felt throughout the New Orleans Metropolitan area, as well as throughout other parts of the State. For example, Earl K. Long Charity Hospital in Baton Rouge has experienced a doubling of mental health patients since the storm.⁸¹ However, the tales of impact on the city of New Orleans itself are much more gruesome. Mentally ill patients, some severely ill, seek care at local emergency rooms only to find that there is no space, no “beds” for them. To keep the severely ill from roaming the street, some city officials have resorted to sending patients to jail.⁸² But jail is not the appropriate place for the severely mentally ill. One judge recounts the story of a schizophrenic man who was taken to jail because there was no available “bed” at any local hospital. Apparently confused about his surroundings, he urinated on an inmate, and as a result, he was beaten so badly that a piece of his skull had to be removed from his brain.⁸³

The interest of the patient, though, must be weighed against the interest of the public. A second harrowing account tells of another schizophrenic man who was turned away from a hospital, only to return home to stab his mother seventeen times.⁸⁴ One judge has admitted that, to prevent such incidents, officials in the criminal justice system have advised family members of the mentally ill to falsely report that the patient has committed a crime so that he or

79. See McCulley, *supra* note 13.

80. The operational health care facilities as of June 2006 in the New Orleans Metropolitan Human Services District were Chartres Pontchartrain Mental Health Center and Central City Mental Health in New Orleans, St. Bernard Mental Health Center in St. Bernard Parish, and Algiers Outreach Clinic in Algiers. New Orleans Mental Health Center and Desire Florida Mental Health Clinic were closed. In the Jefferson Parish Human Services Authority, East Jefferson Mental Health Center in Metairie and West Jefferson Mental Health Center in Marrero were open. In the Florida Parishes Human Services Authority, Lurline Smith Mental Health Center in Mandeville and two other facilities not in the general travel area from New Orleans were open. Operational Louisiana Mental Hospitals were Central Louisiana State Hospital in Pineville, Eastern Louisiana Mental Health System (with one location in Greenwell Springs and two in Jackson), New Orleans Adolescent Hospital, and Southeast Louisiana Hospital in Mandeville. DEP'T OF HEALTH & HOSPS. OFFICE OF MENTAL HEALTH, COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION FISCAL YEAR 2007, SECTION TWO 50–51 tbl. (2006).

81. PWC REPORT, *supra* note 27, at 70.

82. McCulley, *supra* note 13.

83. *All Things Considered*, *supra* note 74.

84. *Id.*

she may be arrested and receive the “care” of the criminal justice system.⁸⁵

Other than the lack of beds,⁸⁶ another crisis is the lack of mental health care professionals in the New Orleans area, particularly primary care providers.⁸⁷ One year after the storm, only twenty-two of 196 psychiatrists had returned to the city.⁸⁸ A Government Accountability Office (GAO) report asserts that this is the biggest problem facing New Orleans and that it can be attributed to the insufficient amount of available and affordable housing to accommodate the necessary health care workforce. Furthermore, there is much competition from other sectors, with newly comparable pay offers. For example, many fast-food chains offered signing bonuses and dramatic wage increases in an effort to reopen business in New Orleans.⁸⁹ Overall, the support staff necessary to sustain an adequate mental health care infrastructure has not returned to the healthcare workforce.

Compounding these problems, and perhaps posing the most significant hurdle, is that so many varying agencies govern mental health services in the New Orleans area. It is difficult to determine the function and accountability, and thus the propriety, of each of their responses to the problem.⁹⁰

The federal, state, and local responses to the problem of infrastructure have been varied. The federal government has primarily responded to this concern with general funding. Under the Stafford Act:

85. *Id.*

86. One remaining New Orleans area mental health care facility, the New Orleans Adolescent Hospital, has fourteen mental health beds in Central City. In response to the need for adult care, the facility also has opened another unit, which it calls the New Orleans Adolescent Hospital Adult Acute Services. Here, twenty adult psychiatric beds are available, but only for stabilization purposes. So, at this facility, care for adults (18 and over) expires after two weeks. Health Department: New Orleans Adolescent Hospital, <http://www.cityofno.com/Portals/Portal48/portal.aspx?portal=48&tabid=29> (last visited Jan. 24, 2009). See also Press Release, DHH Reopens New Orleans Psychiatric Hospital: Beds at NOAH to Address Critical Mental Health Needs (Aug. 11, 2006), <http://www.dhh.louisiana.gov/news.asp?Detail=921>.

87. Cerise Testimony, *supra* note 10, at 17.

88. Russell McCulley, *Is New Orleans Having a Mental Health Breakdown?*, TIME, Aug. 1, 2006, <http://www.time.com/time/printout/0,8816,1221982,00.html>.

89. U.S. GOV'T ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL COMMITTEES—HURRICANE KATRINA: STATUS OF HOSPITAL INPATIENT AND EMERGENCY DEPARTMENTS IN THE GREATER NEW ORLEANS AREA (2006), <http://www.gao.gov/new.items/d061003.pdf> [hereinafter GAO REPORT].

90. ROADMAP FOR CHANGE, *supra* note 29, at 22.

The President is authorized to provide professional counseling services, including financial assistance to state and local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.⁹¹

91. 42 U.S.C. § 5183 (2000). The federal regulations promulgated in accordance with this statute describe in detail how the federal government should implement such a response:

Assistance; procedures, limitations.

(a) *Application*. In order to obtain assistance under this part, the Governor or his State Coordinating Officer must, not later than 60 days following a major disaster declaration by the President, file with the appropriate Regional Director a request which includes:

(1) An estimate of the number of disaster victims who may need professional mental health crisis counseling services and of the number of disaster workers who may need training in the provision of such services;

(2) Identification of the geographical areas in which the need exists;

(3) An estimate of the period during which assistance under this part will be required and of the total funds which will be required to provide such assistance;

(4) A description of the types of mental health problems caused or aggravated by the major disaster or its aftermath; and

(5) Identification of the State and local agencies and private mental health organizations capable of providing professional mental health crisis counseling to disaster victims or training of disaster workers.

(b) *Review, approval*. The Secretary, upon notification by the Administrator of a State request for assistance under this part, will conduct a review to determine the extent to which such assistance is needed to supplement assistance programs provided by State and local governments and private organizations and, on the basis of that review, prepare and submit a recommendation and report for consideration by the Administrator. Upon approval by the Administrator and his advancement of funds for carrying out the approved assistance, the Secretary may, within the limits of the funds advanced, provide the approved services either directly or through a grant or contract.

(c) *Eligibility for services*. In order to be eligible for the professional mental health crisis counseling services available under this part an individual must:

(i) Have been located within the designated major disaster area or have been a resident of such area at the time of the major disaster or its aftermath; and

(ii) Have a mental health problem which was caused or aggravated by the major disaster or its aftermath.

(2) Disaster workers who are available on short notice to provide professional mental health crisis counseling services in a major disaster area are eligible for training under this part.

In accordance with the Act, \$2 billion was appropriated to the Disaster Relief Fund after Katrina in H.R. 2360⁹² in the Federal Deficit Reduction Act. This sum was for the benefit of all Katrina-affected states.⁹³ An account of this expenditure reports that it has been appropriated to address stress management for public workers, crisis intervention, and to provide funding for forty-five beds for “behavioral health” for the Substance and Mental Health Services Administration (SAMHSA).⁹⁴ The federal government also granted the Louisiana Department of Social Services \$80 million to address mental health care concerns. The DHH, the agency in charge of dispersing the funds, gave almost half the amount to state emergency departments to deal with what is termed “crisis intervention.” A portion of the money has also been allotted to addressing stress management for the public workers, to increase the number of services for substance abuse addition, and to initiate the “Louisiana Spirit” mobile counseling service.⁹⁵ The DHH apportioned slightly less than 10% of the funds, \$7 million, to create housing for the mentally disabled; this most likely was done to save psychiatric inpatient beds for critical patients.⁹⁶ However, the Federal Emergency Management Agency (FEMA) acted as a filter for this funding, and it has been stated that the agency “was too rigid in its rules about how states and localities can spend funds for mental health.”⁹⁷

The Louisiana response has been more specifically focused. On the state executive level, Governor Blanco issued Executive Order No. KBB 2005-16. In this order, the Governor called upon the agencies to increase the availability and efficiency of mental health care in the state. However, the only specific mandate of the order was to reinforce that the Louisiana Department of Health and

(d) *Time limitation.* Contracts and grants awarded under this part will not continue beyond 180 days after the first day services are provided pursuant to such contracts and grants, except that upon the recommendation of the Secretary (1) the Regional Director may extend the 180 day period for up to 30 days or (2) the Administrator may extend the 180 day period for more than 30 days.

42 C.F.R. § 38.3 (2007).

92. See KEITH BEA, CONG. RESEARCH SERV., FEDERAL STAFFORD ACT DISASTER ASSISTANCE: PRESIDENTIAL DECLARATIONS, ELIGIBLE ACTIVITIES AND FUNDING 20 (2005).

93. Cerise Testimony, *supra* note 10, at 11.

94. *Id.* at 13–14.

95. *Id.* at 13.

96. See PWC REPORT, *supra* note 27.

97. *Sen. Landrieu Chairs Hearing, supra* note 30.

Hospitals was to be in charge of the mission.⁹⁸ Also, in accordance with this grant of authority, the Louisiana DHH has enacted regulations to address the overall situation in New Orleans and statewide.

In February 2007, the DHH issued another rule seeking a higher reimbursement rate for private hospitals caring for psychiatric patients.⁹⁹ Also in February 2007, DHH issued a \$15 million grant to the Greater New Orleans Health Services Corporation (GNOHSC) designed to address the problems in the health care workforce.¹⁰⁰ With this grant, the GNOHSC has attempted to attract health care providers to the area by offering to reimburse them for their relocation costs and to pay medical malpractice insurance for those who pledge to work in New Orleans for three years.¹⁰¹ In March 2007, DHH issued an emergency rule¹⁰² to increase reimbursement fees¹⁰³ for psychiatric and behavioral screening.¹⁰⁴ Also, in March 2007, DHH proposed a rule that would increase funding for facilities for the mentally handicapped.¹⁰⁵ Later, in May 2007, the DHH issued another emergency rule that would increase pay to directors of facilities for the mentally handicapped.¹⁰⁶ Most recently, in July 2007, the DHH also promulgated an emergency rule titled “moratorium on mental health,” which is conspicuously unavailable in the Louisiana Register.¹⁰⁷ Overall, it is clear that in the past year, the DHH has recognized that measures must be taken to address the need for mental health facilities and mental health professionals. Specifically, the DHH has recognized the need to create incentives for institutions and professionals to make caring for the mentally ill a priority.

98. Exec. Order No. KBB-2005-16, 31 La. Reg. 1443 (June 2005), available at <http://doa.louisiana.gov/osr/other/kbb05-16.htm>. This action resulted in an extensive Department of Health and Hospitals Report titled, *The Louisiana Plan for Access to Mental Health Care*, released in 2007.

99. 33 La. Reg. 289 (Feb. 2007).

100. Cerise Testimony, *supra* note 10, at 17.

101. *Id.*

102. An “emergency rule” is defined in the Louisiana Administrative Procedure Act (LAPA) as a rule enacted “[i]f an agency finds that an imminent peril to the public health safety or welfare requires adoption of a rule on shorter notice than [typically required by the LAPA].” LA. REV. STAT. ANN. § 49:953(b)(1) (2003).

103. Reimbursement fees are the manner in which a facility is compensated for providing low-cost or no-cost medical care. See Cerise Testimony, *supra* note 10, at 17.

104. 33 La. Reg. 413 (Mar. 2007).

105. *Id.* at 461.

106. 33 La. Reg. 781 (May 2007).

107. 33 La. Reg. 1328 (July 2007).

The Louisiana Legislature has also taken its own measures, primarily to address the future of mental health care as well as overall health care in Louisiana. House Bill No. 846, which was passed in June 2006, “[a]uthorize[d] temporary registration of health care professionals during a declared state of public emergency”¹⁰⁸ in an effort to decrease the “red tape” that often arises in an emergency situation and to expedite the placement of needed health care professionals. This bill was codified in Louisiana Revised Statute section 29:769(E).¹⁰⁹ More recently, the Legislature also provided LSU and the Veterans’ Administration (VA) \$74 million under “Louisiana Recovery Authority Action Plan” to build a hospital in downtown New Orleans.¹¹⁰ Because an

108. H.B. 846, 2006 Leg., Reg. Sess. (La. 2006). This bill passed June 2, 2006. See also *CTR. FOR THE LAW & THE PUB.’S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., THE MODEL STATE EMERGENCY HEALTH POWERS ACT STATE LEGISLATIVE ACTIVITY TABLE 8 (2006)*, available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf>.

109. This provision, which is part of the Louisiana Emergency Health Powers Act, reads:

Temporary registration of health care professionals.

Any board or commission placed within the Department of Health and Hospitals by R.S. 36:259(E), (R), (EE), and (GG) may exercise during such period as the declared state of public health emergency exists, the power reasonably necessary to issue temporary registrations to health care providers licensed, certified, or registered in another jurisdiction of the United States whose licenses, certifications, or registrations are current and unrestricted and in good standing in such jurisdictions. The boards and commissions may promulgate rules creating an expedited emergency process for issuance of emergency temporary registrations. Such temporary registrations may be granted for a period of not more than sixty days at the discretion of the board or commission, with the possible extension of up to two additional sixty-day periods as determined appropriate and necessary by the board or commission. The temporary registrants shall register with the respective board or commission prior to providing professional services in this state. Rules promulgated pursuant to the provisions of this Section may, at the discretion of the board or commission, provide that the temporary registrants shall only be allowed to provide gratuitous services specified by the board or commission, or its designee for such purpose. Within thirty days after June 2, 2006, each such board or commission shall file an emergency plan with the department for processes related to registration of health care providers licensed, certified, or registered in another jurisdiction of the United States responding to the public health emergency.

LA. REV. STAT. ANN. § 29:769(E) (2007).

110. Press Release, La. State Univ. Health Care Servs. Div. of La.’s Hosp. Sys., Legislature Approves Hurricane Relief Funds for LSU Hospital Construction in New Orleans (Mar. 22, 2007), <http://www.lsuhsospitals.org/media-relations/PressReleases/2007/LegeApprovesFunds-LSU-VA.pdf> [hereinafter *LSUHCS Release*].

estimated 50% of the city's population eventually will return,¹¹¹ building more hospitals is a clear necessity.¹¹²

While planning for the future, however, the past of Louisiana and New Orleans health care must also be examined. The inevitable failure of the New Orleans mental health care infrastructure can be traced to lack of foresight and lack of substance and direction on the state level.

In the years just prior to Hurricane Katrina, action among the executive and administrative spectra of Louisiana state government evidences a move to remedy the already ailing health care system in the state. In 2003, the legislature took a step in the right direction by adopting portions of the Model State Emergency Powers Act,¹¹³ while modifying the language to fit Louisiana's specific needs.¹¹⁴ However, much like its federal counterpart, this Act fails to anticipate a failure of the overall mental health care infrastructure. Rather, this Act is included in the military chapter of the revised statutes, showing once again that the drafters of the Act did not contemplate what obviously was becoming imminent—that

111. PWC REPORT, *supra* note 27, at 5.

112. A temporary addiction facility opened in July for patients at least eighteen years old. It has twenty beds at the LSU Interim Hospital. In the fall of 2007, LSU will open thirty-three more mental health beds at DePaul. *See* Press Release, La. State Univ. Health Care Servs. Div. of La.'s Hosp. Sys., LSU Interim Hospital Opens 20-Bed Acute Detox Unit (Jun. 27, 2007), www.lsuohospitals.org/media-relations/PressReleases/2007/DetoxUnitOpening-PressRelease.v2.pdf; LSUHCS Release, *supra* note 110.

113. Adopted as the Louisiana Health Emergency Powers Act. *See* LA. REV. STAT. ANN. §§ 29:760–772.

114. Louisiana has adopted a definition of the model law that includes hurricanes. For example, the statute defines a “public health emergency” as:

[A]n occurrence or imminent threat of an illness or health condition that is believed to be caused by any of the following: (i) Bioterrorism. (ii) The appearance of a novel or previously controlled or eradicated infectious agent or biological toxin. (iii) A disaster, including but not limited to natural disasters such as hurricane, tornado, storm, flood, high winds, and other weather related events, forest and marsh fires, and man-made disasters, including but not limited to nuclear power plant incidents or nuclear attack, hazardous materials incidents, accidental release or chemical attack, oil spills, explosion, civil disturbances, public calamity, hostile military action, and other events related thereto. (b) Poses a high probability of any of the following harms: (i) A large number of deaths in the affected population. (ii) A large number of serious or long-term disabilities in the affected population. (iii) Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.

Id. § 29:762.

the New Orleans health care infrastructure would not be able to withstand a major disaster.

The growing awareness of the weakness of Louisiana's health care system among state administrators is shown in a program called "Project Legacy." The Louisiana Office of Mental Health, yet another agency, was commissioned to create "Project Legacy" in 2003 to address mental health care issues. A quote from the report on the project is telling of the effectiveness and the nature of the project:

Project Legacy is our plan that details the structural and system improvements identified to begin the transformation of the Office of Mental Health toward a system of care with an overarching goal of recovery and resilience. The Office of Mental Health is taking the first step toward creating the infrastructure necessary to transform its system of care into a system that supports emerging technology¹¹⁵

Ambiguous statements such as these are evident throughout reports pre- and post-Katrina. It is this sort of ambiguous statement that evidences knowledge of the problem's severity, yet a failure to implement a concrete plan.

The Louisiana Plan for Access to Mental Health Care, a report commissioned by Governor Blanco after Hurricane Katrina, is similarly devoid of substance.¹¹⁶ It is based much more on ends than on means. The only clear points successfully conveyed are a desire to shift (and retain) mental health care to the hands of the proverbial "community" and the recommendation of looking at other mental health care systems across the nation.¹¹⁷

Currently, when discussion of the problem with mental health care in New Orleans arises, the first question that people ask is why the state does not simply rebuild Charity Hospital. In other words, many see the problem to have a simple solution—bring back the facility where the majority of the mentally ill sought care before the storm. However, this approach overlooks the fact that the health care system was nearly in shambles before the storm, as discussed in Part II.¹¹⁸ Recognizing this fact, many independent agencies see the fall of Louisiana's mental health care infrastructure as an opportunity for much-needed change.

115. ROADMAP FOR CHANGE, *supra* note 29, at 8.

116. *Id.* at 10.

117. *Id.* at 79–80

118. Evidence of this fact is the disparity between the LSU and FEMA estimates for the anticipated cost of rebuilding Charity Hospital. LSU's estimate is considerably greater because LSU is including repairs that needed to be made before. See GAO REPORT, *supra* note 89, at 18–19.

Specifically, the Public Affairs Research Council (PAR)¹¹⁹ issued a report, emphasizing its assertion that rebuilding the Charity System would only bring back what existed before the storm—reactive emergency medicine. Instead, there is a clear opportunity now to move to a more proactive and financially sound system.¹²⁰ PAR proposes keeping only the teaching hospitals in the statewide LSU system and transferring the other seven charity hospitals to local control.¹²¹ The PAR report also proposes a transition to a voucher system, which would in effect reroute “charity” funding directly to the patient.¹²²

Governor Bobby Jindal also sees the breakdown of the health care infrastructure as a time for change. Jindal recognizes that Hurricane Katrina brought Louisiana’s health care problems to the forefront.¹²³ He also recognizes that the first step in preventing another mental health crisis is to first address the problems inherent in the system independent of a health care crisis. For this reason, he plans to create a more efficient health care system by reducing regulations on health care¹²⁴ and by promoting “preventative primary care that will improve the health of . . . citizens . . . and decrease dependence on . . . emergency rooms.”¹²⁵ Despite the goal of decreasing dependence on emergency rooms,¹²⁶ Jindal does plan to rebuild Charity Hospital in New Orleans.

119. It must be noted that William Jenkins, former LSU System President, alleges that PAR accepted donations from private health care interests, and is thus biased. Marsha Shuler, *LSU, PAR Debate Report, Group Wants to End Charity Hospitals*, THE ADVOCATE (Baton Rouge), Mar. 1, 2007, at A1.

120. Bill Stewart, Editorial, *Preventive Care Saves Money*, TIMES-PICAYUNE (New Orleans), May 10, 2007, at 6.

121. Jan Moller, *Group: Shut Rural Charity Hospitals: Fund Private and Community Centers*, TIMES-PICAYUNE (New Orleans), Mar. 7, 2007, at 2. Lake Charles representatives submitted a resolution to remove W.O. Moss Hospital, citing the fact that other states have locally controlled hospitals. Letter from Frederick Cerise, Sec’y, La. Dep’t of Health & Hosps., to Sen. Joe McPherson, Chairman, La. Senate Health & Welfare Comm. (Aug. 20, 2007) (on file with author). *A Roadmap for Change* suggests that dividing the states into mental health districts would make implementing an improved system more manageable, with the primary goal of “provid[ing] a clear locus of responsibility,” perhaps to combat the ambiguity and confusion of roles found in statewide administration of health care policy. The major metropolitan areas of New Orleans and Baton Rouge have already done so. ROADMAP FOR CHANGE, *supra* note 29, at 20.

122. Moller, *supra* note 121, at 2.

123. BOBBY JINDAL, GOVERNOR OF LA., FRESH START FOR LOUISIANA, HEALTH CARE REFORM: CREATING A SUSTAINABLE SYSTEM OF QUALITY HEALTHCARE 2 (2007), http://www.bobbyjindal.com/downloads/Jindal_Healthcare.pdf.

124. *Id.* at 6.

125. *Id.*

126. *Id.* at 10.

Also, in order attract more health care professionals to the State, Jindal plans to decrease medical school tuition. If more students come to Louisiana for medical training, then more will attend residency in Louisiana and likely remain in Louisiana for their careers.¹²⁷

However, in implementing this plan, Jindal also should consider consolidating the mental health agencies in Louisiana and working with the legislature to provide a more clear delegation of authority and jurisdiction with regard to the administration of mental health care. The absence of this was noticed as a problem in the years before Katrina and was certainly a problem in the response to Katrina.

VI. PROPOSAL: A MORE STREAMLINED RESPONSE STATUTE

Aside from streamlining the Louisiana mental health agencies, the State also needs a streamlined, comprehensive plan in the form of a statute to prevent such a post-disaster mental health crisis in the future. This statute must address all the possible health care problems that, as Hurricane Katrina demonstrated, might emerge from a natural disaster—a drastic increase in the number of mentally ill as a result of the psychological stress of the disaster and the delay in obtaining insurance or health care, as well as a breakdown in infrastructure. The enactment of such a comprehensive statute would also assist in remedying the weaknesses in the Louisiana response that Katrina exposed, such as overregulation and inconsistent regulation that can lead to tardiness in action.

The Model State Emergency Health Powers Act (MSEHPA) is a plausible prototype for such a statute. In fact, Louisiana already has adopted several provisions of the Model Act in the Louisiana Emergency Health Powers Act (LEHPA).¹²⁸ However, the LEHPA as it currently stands does not sufficiently address Louisiana's specific mental health care needs. In spite of this shortcoming, the LEHPA can provide the backbone of a comprehensive health care emergency act, which would adequately address mental health and the needs of Louisiana. By supplementing the LEHPA with state and federal statutes and regulations and by adopting other provisions of the Model Act, the LEHPA could be broadened to sufficiently anticipate the obstacles that Katrina showed would result from a mental health emergency.

127. *Id.* at 9.

128. LA. REV. STAT. ANN §§ 29:760–772 (2007).

The first topic that needs to be addressed within the LEHPA itself is that it does not specifically address mental health “outbreak” as a potential manifestation of a “health emergency.” Specifically, in the only substantive provision that refers to mental health, the LEHPA states that “[d]uring a declaration of a state of public health emergency, the secretary of the Department of Health and Hospitals or his designee shall provide information about and referrals to mental health support personnel to address *psychological responses to the public health emergency*.”¹²⁹ In other words, the LEHPA only anticipates that the public will endure stress as a result of an emergency situation, which the aftermath of Katrina has certainly proved true. However, the LEHPA does not contemplate that mental illness can be the core of a public health emergency.

Second, the LEHPA is geared toward addressing a health emergency resulting from terrorism and biological warfare, rather than another natural disaster such as Katrina. The MSEHPA defines a “public health emergency” as “an occurrence or imminent threat of an illness or health condition that . . . is believed to be caused by . . . bioterrorism . . . [or] the appearance of . . . [a] biological toxin.”¹³⁰ The MSEHPA leaves natural disaster as an option for a state to adopt.¹³¹ While the Louisiana legislature has tailored the statute to its needs by adopting this provision and including the natural disaster option,¹³² this is insufficient in extending the scope of the Act to a mental health crisis. In order to be considered a public health emergency, the Act requires that there be “a high probability of . . . (i) a large number of deaths in the affected population; (ii) a large number of serious or long-term disabilities in the affected population, or (iii) widespread exposure to an infectious or toxic agent”¹³³ These stipulations seem to coincide more with biological terrorism than with natural disasters and the mental illness that can result. So, to more specifically address Louisiana’s needs, the provision should be expanded to state “a large number of serious or long-term *mental or physical* disabilities” This amendment would address Louisiana’s needs by more clearly delineating that mental illness is intended to fall within the scope of the LEHPA.

129. *Id.* § 29:764(B)(1) (emphasis added).

130. MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Revised Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

131. “Natural disaster” is designated as an option by its placement in brackets. *See id.*

132. LA. REV. STAT. ANN. § 29:762(12)(a)(iii).

133. *Id.* § 29:762(12)(b)(i)–(iii).

Streamlining a mental health care statute in the LEHPA would also aid in more efficiently anticipating the increase in the number of mentally ill and the breakdown of infrastructure. Although these are separate issues, the effect of the increase in mental illness and the failure of infrastructure after a natural disaster is one in the same—the inability to care for the mentally ill. As discussed in Parts III and IV, inefficiencies in Louisiana’s response to this matter can be attributed to short-sightedness of scope in already existing statutes and bureaucracy. The enactment of a streamlined statute can address these hurdles by compensating for what the present emergency statutes lack.

First, while the Stafford Act,¹³⁴ the federal government’s primary tool in responding to emergency situations, recognized that natural disasters and emergencies can have a grave effect on mental illness, it did not contemplate the overall breakdown of the mental health care infrastructure that followed Katrina. Louisiana’s counterpart, the Louisiana Homeland Security and Disaster Act (LHSDA),¹³⁵ has the same shortcomings. The LEHPA does address such infrastructural issues.¹³⁶ Thus, in supplementing the Stafford Act and the LHSDA, the LEHPA could serve as guide to Louisiana in responding to another mental health crisis.

Increasing the scope of the LEHPA would reduce bureaucracy and overregulation as well. First, the very enactment of a streamlined health emergency act would centralize statutory authority in the case that a mental health emergency arises. The Louisiana Legislature has moved toward this goal by enacting a provision of the LEHPA that entrusts authority in the governor, who will delegate authority to the DHH as the central agency.¹³⁷ Thus, a clear extension of the LEHPA to mental health emergencies would extend this benefit of clear delegation to mental health emergencies. Furthermore, in order to establish the proposed statute as the sole authority in health emergencies, the Louisiana Legislature should also adopt the preemption provision of the MSEHPA. Section 809(b) of the Model Act states, “In the event of a conflict between this Act and other State or local laws or regulations concerning public health powers, the provisions of this Act apply.”¹³⁸ This would eliminate any uncertainty as to authority in an emergency situation. In securing this end, the Louisiana

134. 42 U.S.C. § 5183 (2000).

135. LA. REV. STAT. ANN. §§ 29:722–741.

136. See generally MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Revised Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

137. LA. REV. STAT. ANN. §§ 29:764–766.

138. MODEL STATE EMERGENCY HEALTH POWERS ACT § 809(b).

legislature should also amend the LHEPA to require consolidation of resources in the event of a mental health emergency. The Model Act provides that:

The Governor shall appoint a Public Health Emergency Planning Commission, consisting of the State directors . . . of agencies the Governor deems relevant to public health emergency preparedness . . . [which] shall deliver to the governor a plan for responding to a public health emergency, that includes provisions or guidelines . . . for central coordination of resources, manpower, and services, including coordination of responses by the state, local, . . . and federal agencies¹³⁹

Aside from infrastructural and administrative issues, the LHEPA also should be amended to include provisions that would assist in preventing the insurance problems that arose after Katrina. First, a comprehensive statute could curtail overregulation with regard to insurance matters by including standard regulation of insurance after a disaster. While it is clear that documentation of treatment is necessary, perhaps if the regulations could have been anticipated, the acquisition of insurance could have been expedited. For example, the legislature should consult with the federal and state CMS to include in the act a standard set of requirements that would be required in a waiver situation with a standardized set of forms and procedures, rather than inform state leaders of requirements as the situations arise. Perhaps this will give health care providers more time to anticipate and prepare before the onset of a crisis. Second, the LHEPA should be amended to address the inconsistencies among state Medicaid programs after the storm. In fact, some of the several states that received Louisiana evacuees have recommended “the development of a national Medicaid Disaster Plan that can be implemented immediately across multiple state programs.”¹⁴⁰

VII. CONCLUSION

Overall, the response to the mental health care crisis following Hurricane Katrina has shown that Louisiana needs to carefully examine its law with regard to emergency preparedness, as well as the administration of mental health care as a whole. As mentioned, recent statistics have demonstrated that the prevalence of mental and psychological illness has increased drastically since the storm.

139. *Id.* §§ 201–202.

140. SUMMARY OF STATE REPORTS, *supra* note 42, at 9.

If Louisiana does not find a way to efficiently care for the mentally ill, the number will continue to increase. If Louisiana does not develop a method of efficiently responding to a health emergency, the same effect will result. Since New Orleans cannot sustain rebuilding efforts when much of its population is mentally ill, scrutiny of current policy is crucial to the revitalization of New Orleans.

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