

**A SUMMARY OF STATE REPORTS
FOR MEDICAID AND THE STATE
CHILDREN'S HEALTH INSURANCE
PROGRAM
HURRICANE KATRINA SECTION
1115 DEMONSTRATIONS**

March 2007

**Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations**

**Summary of State Reports for Medicaid and the
State Children's Health Insurance Program
Hurricane Katrina Section 1115 Demonstrations
March 2007**

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) provided Federal support, through the Medicaid and State Children's Health Insurance Programs (SCHIP), to victims of Hurricane Katrina. The devastation caused by the August 25, 2005 hurricane resulted in the evacuation of thousands of citizens from one State to another. An immediate need arose to provide health care coverage to those evacuees displaced to other States. As there was no time to rely on traditional mechanisms for providing coverage, CMS developed an expedited 1115 waiver process which became known as the "Katrina Demonstrations."

Under these demonstrations, States were granted waivers of Federal requirements to allow for flexibility, administrative efficiency, and additional coverage needed to ensure that directly affected citizens received the health care services they required. Over the course of several weeks, CMS approved 32 State demonstration programs, including 8 uncompensated care pools. These pools were to be used to reimburse providers that incurred uncompensated costs for medically necessary services and supplies for evacuees who did not have other coverage or relief options. The pool could also be used to provide reimbursement for benefits not covered under titles XIX and XXI in the State.

Special terms and conditions of approved demonstration programs required States to submit final reports to CMS no later than December 31, 2006. States were required to report to CMS on the impact of the demonstration including, but not limited to, the impact on evacuees, the Host States, and the community.

The final reports document that while there were unique challenges associated with the Hurricane, overall, States received the support needed to provide services to evacuees. Specifically, States report that evacuees' needs were met even though health care needs of individuals were complex. In fact, Texas conducted a State survey in which respondents reported that the State's ability to respond to their needs during the temporary eligibility period was "excellent" or "very good." States also identified a number of challenges at both the State and Federal level that can serve as lessons learned in moving forward. Most States used the Hurricane Katrina experience as an opportunity to improve their own disaster preparedness skills and health care service delivery in a disaster-related environment. CMS will also use the information provided for future disaster planning efforts.

KATRINA DEMONSTRATION FEATURES

As a result of the Hurricane, the President of the United States declared a State of Emergency in Alabama, Louisiana, and Mississippi and the Secretary of the Department of Health and Human Services (DHHS) declared a Public Health Emergency. Secretary Michael Leavitt

granted waivers of program requirements including waivers of title XIX and title XXI to the extent necessary to ensure that sufficient health care items and services were available to meet the needs of individuals enrolled in Medicaid and SCHIP.

The States most directly affected by the storm – Alabama, Louisiana, and Mississippi (Home States) - had high numbers of Medicaid and SCHIP beneficiaries and high poverty levels. Immediate Federal assistance was needed to ensure continuation of health care coverage for these beneficiaries and to provide care for others impacted by the hurricane. On September 16, 2005, 22 days after Hurricane Katrina struck, CMS developed a State Medicaid Director’s letter announcing a section 1115 model waiver template to provide expedited health care coverage to meet the needs of low-income beneficiaries who needed health care and eliminated barriers in an effort to support evacuees (see Attachment A). CMS also established a team to provide expedited review and approval of these waivers so that care could quickly be provided to victims of Hurricane Katrina. On average, CMS approved demonstration requests within 38 days of application.

Through the demonstrations States in which Hurricane Katrina victims were residing (Host States) provided temporary eligibility for 5 months of Medicaid or SCHIP coverage to evacuees who were parents, pregnant women, children under age 19, individuals with disabilities, low-income Medicare recipients, and low-income individuals in need of long-term care, up to specified income levels. Evacuee status was established by self-attestation of displacement, income, and immigration status, but evacuees were required to cooperate in demonstrating evacuee and eligibility status. Evacuees eligible under a disability category were required to provide a physician’s statement verifying disability.

Evacuees were eligible to register for Medicaid or SCHIP without many of the traditional administrative requirements for verification and enrollment. CMS recognized that many of the evacuees’ income and resources had changed significantly because of Hurricane Katrina, and that they did not have the usual documentation. The following chart summarizes eligibility requirements.

Section 1115 Demonstration Relief From Hurricane Katrina
Evacuee Eligibility Simplification Based on Home State Eligibility Rules

Children Under Age 19	up to and including 200% FPL
Pregnant Women from Louisiana, Mississippi, and Florida	up to and including 185% FPL
Pregnant Women from Alabama	up to and including 133% FPL
Individuals with Disabilities	up to and including 300% SSI
Low-income Medicare Recipients	up to and including 100% FPL
Low-income Individuals in Need of Long-term Care	up to and including 300% SSI
Low-income Parents of Children Under Age 19	up to and including 100% FPL

States were not required to meet budget neutrality tests under these demonstration programs, as individuals participating in the waiver were presumed to be otherwise eligible for Medicaid in their respective Home State and costs to the Federal Government would have

otherwise been incurred or allowable. Additionally, Host States had the option to waive cost sharing for evacuees. If cost sharing was not waived, it had to be imposed consistent with title XIX and title XXI Federal Medicaid and SCHIP requirements. Other features of the model section 1115 template, as well as applicable sections that were waived, can be found in Attachment A.

The demonstration programs were implemented on August 24, 2005, and continued through June 30, 2006. Individuals could apply for evacuee status retroactively from August 24, 2005, until January 31, 2006. In order to continue to receive Medicaid/SCHIP at the end of the temporary eligibility period, individuals with evacuee status had to reapply for eligibility under a permanent eligibility category in the State in which they were residing.

The CMS also worked with individual States to address uncompensated care costs for needed services for evacuees by allowing States with approved uncompensated care pools to reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for Katrina evacuees who did not have other coverage for such services and supplies through insurance or other relief options. Uncompensated care pools were not offered as part of the model waiver template but were considered on an individual State-by-State basis. CMS required that in order to receive approval for the use of an uncompensated care pool a State had to have a high number of evacuees and had to be co-located or closely located to one of the affected Home States.

In addressing costs to States, CMS required that Host States submit the full cost of providing care to evacuees, including the non-Federal (State) share, when submitting their estimated expenditures to CMS as a component of their usual cost reporting for determining Federal payments. States were required to submit claims directly to CMS rather than submitting claims to Home States, as would occur under regular procedures for out-of-State evacuees.

On February 8, 2006, the President signed the Deficit Reduction Act of 2005 (DRA) in which \$2 billion in Federal funds was appropriated for Hurricane Katrina relief efforts, including the Hurricane Katrina demonstrations. Section 6201 provided authority for the provision of additional Federal payments to States under hurricane-related multi-State section 1115 demonstration projects as follows:

- Section 6201(a)(1)(A) and (C). Provides funding for the non-Federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Katrina and continue to reside in the same State) and evacuees (affected individuals who have been displaced to another State) under approved multi-state section 1115 demonstration projects (includes Medicaid, SCHIP, and premium assistance);
- Section 6201(a)(1)(B) and (D). Provides funding for the total expenditures for uncompensated care pool costs for uninsured evacuees and uninsured affected individuals;
- Section 6201(a)(2). Provides funding for the reasonable administrative costs related to such projects;

- Section 6201(a)(3). Provides funding for the non-Federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP State plans; and
- Section 6201(a)(4). Provides funding for other purposes, if approved by the Secretary, to restore access to health care in impacted communities.

DEMONSTRATION APPROVALS

The CMS approved 32 State demonstration programs. Specifically, CMS approved section 1115 Hurricane Katrina demonstrations for the following States:

Approved Section 1115 Hurricane Katrina Demonstrations

State Name	Approval Date	State Name	Approval Date
Alabama	September 22, 2005	Montana	March 20, 2006
Arizona	March 6, 2006	Nevada	November 23, 2005
Arkansas	September 28, 2005	North Carolina	February 17, 2006
California	December 7, 2005	North Dakota	March 6, 2006
Delaware	March 6, 2006	Ohio	December 7, 2005
District of Columbia	September 28, 2005	Oregon	March 6, 2006
Florida	September 23, 2005	Pennsylvania	March 6, 2006
Georgia	September 28, 2005	Puerto Rico	October 6, 2005
Idaho	September 28, 2005	Rhode Island	February 17, 2006
Indiana	October 21, 2005	South Carolina	October 21, 2005
Iowa	March 6, 2006	Tennessee	October 6, 2005
Louisiana	November 10, 2005	Texas	September 15, 2005
Maryland	November 10, 2005	Utah	March 20, 2006
Massachusetts	March 6, 2006	Virginia	March 20, 2006
Minnesota	March 20, 2006	Wisconsin	March 24, 2006
Mississippi	September 22, 2005	Wyoming	February 17, 2006

In addition, CMS approved 8 uncompensated care pools for Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, and Texas. With the exception of Texas, all State uncompensated care pools were approved by CMS on March 24, 2006. Texas' uncompensated care pool was approved by CMS on April 28, 2006.

The CMS provided for matching of expenditures under the authority of Section 1115(a)(2) for (including but not limited to): expenditures, including administrative and benefit costs of extending benefits during a temporary eligibility period to evacuees who fit into the demonstration population consisting of parents, pregnant women, children under age 19, individuals with disabilities; low-income Medicare recipients; and low-income individuals in need of long-term care with incomes up to and including the levels listed on the Simplified Eligibility Chart.

Through these demonstration programs, thousands of individuals received health care coverage. Each month States were required, as part of the terms and conditions of approved demonstration programs, to provide CMS with an enrollment report showing enrollment from individual Home States in the Host State's programs, showing end of month point in time enrollment. States were also required to provide CMS with unduplicated ever-enrolled data at the end of the demonstration period.

STATE EXPERIENCES WITH KATRINA DEMONSTRATIONS

A Final Report was required as part of the terms and conditions of approved Section 1115 projects defining the impact of the Hurricane Katrina demonstration. All States submitted a final report. Individual State final reports can be found at www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/07_KatrinaWaivers.asp.

All States reported using the Simplified Eligibility Chart provided by CMS. Most States provided evacuees with 5 months of temporary eligibility. Some States reported using a different time period as the temporary eligibility period for evacuees; however, once Federal guidelines were announced, all States revised the temporary eligibility period to be consistent with the template; i.e., 5 months of temporary eligibility. Mississippi and Alabama also provided an additional 60 days post-partum eligibility to evacuees who were pregnant.

Each State reported providing evacuees with its respective State title XIX State plan benefit package. At least seven States also reported providing evacuees with the State's title XXI State plan benefit package. Some States reported providing extra coverage to evacuees that included mental health services and home and community-based waiver services.

Most States reported imposing title XIX and title XXI allowable cost-sharing. Responsibility to collect co-payments rested with the provider. However, providers could not deny services based on the ability to pay. Most States used the fee-for-service delivery system in providing health care to evacuees because of the temporary eligibility period timeframe. Oregon provided services as a result of their Prioritized List of Health Care Services which is funded to cover a comprehensive set of services and focused on preventive care.

Final report information indicated that total actual unduplicated enrollment in the Hurricane Katrina demonstrations was lower than previously estimated; however, there are limitations in the data due to incomplete capture of data by providers caring for increased case loads or individuals receiving early health care services and supplies from the Red Cross, mobile pharmacies provided by chain pharmacies, and providers who came to shelters to provide services.

Although data on separate and distinct eligibility categories is limited, it appears that the largest eligibility groups receiving services were children under age 19, parents (caretaker relatives), and pregnant women.

Of the 32 States, 23 reported numbers of evacuees from each Home State in the final reports. States reported that individuals relocated to other States. (See Attachment B for unduplicated end of demonstration enrollment data. Total enrollment figures are not consistent with those reported as unduplicated ever enrolled included in Attachment B since only 23 States reported enrollment data by Home State distributions.)

Only a few States indicated that a large number of evacuees still remain and were determined eligible for Medicaid or SCHIP coverage in the State in which they currently are residing. Georgia reports that only a few individuals moved from a Katrina evacuee eligibility status to a regular categorical Medicaid eligibility status.¹ Florida indicates that 2,039 individuals are currently receiving Florida Medicaid² and Indiana reports that 403 remain in Indiana and continue to receive Host State Medicaid benefits³.

Use of the Uncompensated Care Pool

Eight States were approved to utilize an uncompensated care pool: Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, and Texas. Uncompensated care pools were approved to reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for evacuees who did not have other coverage for such services and supplies through insurance, or other relief options available, including title XIX and title XXI, for a 5-month period, effective August 24, 2005, through January 31, 2006. The pool could also be used to provide reimbursement for benefits not covered under titles XIX and XXI in the State.

In submitting claims for reimbursement from the uncompensated care pool, providers were required to attest:

- that evacuees had no other health care coverage on the date of service;
- the provider had received no reimbursement from any other source for the claim and/or expected to receive no reimbursement from any other source;
- the recipient was a Katrina evacuee from one of the designated counties/parishes; and
- the services and/or supplies were medically necessary and within the scope of the Hurricane Relief effort.

Alabama required providers to certify claims for services provided were for eligible individuals and were medically necessary. This established proof to receive reimbursement from the Federal emergency uncompensated care pool. Alabama did not utilize an income test to determine whether services provided to an eligible individual were to be reimbursed through the Federal emergency uncompensated care pool program. Alabama Medicaid determined such that an income test was not feasible given the emergent nature of services provided and the lack of income documentation available to both providers and Medicaid.

Louisiana did not enroll individuals into the demonstration but rather operated an uncompensated care pool. Louisiana considered the demonstration an expansion in eligibility. Louisiana reported that the most helpful element of the Hurricane Katrina demonstrations was the uncompensated care pool. This provided reimbursement for Louisiana Medicaid providers who provided medically necessary services to those people from the 31 affected parishes. Louisiana was able to reimburse approximately 960 providers for medical services delivered to approximately 215,000 uninsured residents.⁴

¹ Georgia Hurricane Katrina Final Report, January 2007, p. 4.

² Florida Hurricane Katrina Final Report, January 2007, p. 2.

³ Indiana Hurricane Katrina Final Report, January 2007, p. 3.

⁴ Louisiana Hurricane Katrina Final Report, January 2007, p. 1.

In Tennessee, payments from the pool were made to 500 providers. Providers initially anticipated that they would be reimbursed at cost but, instead, were reimbursed by a fee schedule. The evacuees, for the most part, were unaffected since the services had been provided months previously.

Texas enrolled the largest number of evacuees at 58,671. Additionally, over 251,000 individuals received services as a result of the uncompensated care pool. According to the State survey conducted by Texas in May 2006, about 64 percent of respondents believe they will reside in Texas 6 months into the future, 50 percent believe they will remain in Texas in the next year, and 40 percent believe they will still be in the State in 2 years.⁵ These percentages, according to Texas, mean that the State will continue to have individuals with no health insurance coverage, thus straining the States resources.

Preventing Fraud and Abuse

States were required to (1) verify circumstances of eligibility, (2) verify residency and citizenship of the evacuees, and (3) prevent fraud and abuse. States reported that circumstances of eligibility were verified to the greatest extent possible in order to prevent fraud and abuse. Compliance with these terms and conditions of the waivers is subject to audit. Two program examples are discussed below.

Texas implemented its program in two phases. Phase I was the Urgent Medical Care Service Delivery for Evacuees phase and provided that individuals received services from August 24, 2005, through September 30, 2005. There were no income limits for evacuees covered during this period. Evacuees did not need to complete an application or have a Texas Medicaid Identification Number to access services; however, evacuees had to be from one of the designated counties/parishes to receive services. Phase II was the Transition Health Care Coverage for Eligible Evacuees phase in which Texas enrolled eligible evacuees into this program from October 1, 2005, through January 1, 2006. Texas reports that all claims are subject to a retrospective review to ensure that services were provided and no other payments were received for services.⁶

Alabama reported that Medicaid staff queried previously paid uncompensated care claims to prevent duplicate payment for duplicate services. In addition to this, prospective queries to prevent duplicate payment, Medicaid staff will conduct retrospective reviews and initiate appropriate recoupments for inappropriate claims.⁷

Costs Reported by States

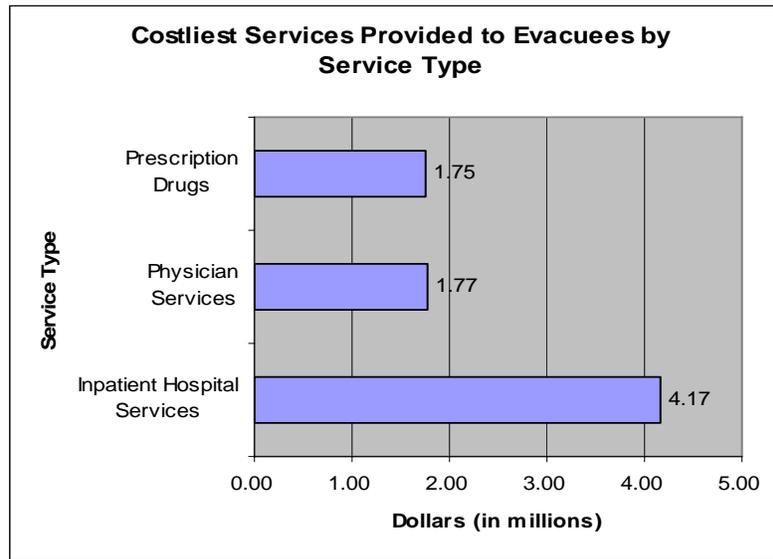
Detailed information for each State can be found in Attachment C. Final reports indicated that, of the claims data reported by States, the three most costly service categories were inpatient hospital, physician services, and prescription drugs.

⁵ Texas Hurricane Katrina Final Report, January 2007, p. 4.

⁶ Texas Hurricane Katrina Final Report, January 2007, p. 2.

⁷ Alabama Hurricane Katrina Final Report, January 2007, p. 5.

Most Significant Expenditures Reported by States by Category of Service



It should be noted that nursing facility services, dental services, and outpatient hospital services were also significant expenditures claimed by States; however, since all States did not report expenditures for these categories of services, CMS could not determine with confidence that these services were the most costly service categories for all States.

Further, expenditures reported may be different than those reported on the Medicaid Budget Expenditure System/State Children's Health Insurance Budget Expenditure System because of the timeframe of reporting of expenditures versus the timeframe of the submission of State Final Reports. Additionally, not all States reported expenditures by category of service.

Early estimates indicated that the States would be requesting reimbursement for expenditures at approximately \$1.863 billion. Two billion dollars was allocated by the DRA. Attachment C indicates that as of February 1, 2007, expenditures reimbursed from the DRA funding to States totals \$1.639 billion dollars. Specifically, States estimated that reimbursement for the non-Federal share of expenditures for health care provided to affected individuals and evacuees under the approved multi-State section 1115 demonstration projects would be \$97 million. Expenditures reported for this category were actually \$21 million, or 1 percent of the total reimbursed. Administrative costs related to the approved demonstration projects were estimated at \$5 million, while actual expenditures reimbursed account for \$1.5 million, or less than 1 percent of the total; uncompensated care estimates were \$297 million, while actual expenditures in this category account for \$192 million, or 11 percent; and administrative costs related to the uncompensated care pool were estimated at \$4.7 million, while actual expenditures were \$1.6 million, or less than 1 percent. The highest percentage of expenditures was estimated for the non-Federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP State plans to Alabama, Louisiana, and Mississippi at \$1.459 billion. Actual expenditures reported by Alabama, Louisiana, and Mississippi in this category account for \$1.423 billion, or 87 percent of the

total reimbursed to States.⁸ The expenditures reported by States indicate that large eligibility expansions were not needed by States.

Challenges and Opportunities

States reported different benefits and challenges related to the Katrina Demonstrations. The complete State reports can be found at www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/07_KatrinaWaivers.asp. The following paragraphs highlight examples of these benefits and challenges.

Benefits of the Katrina Demonstration

Iowa noted that evacuees were grateful for the fact that they were able to access Medicaid benefits immediately. Additionally, shelter and counseling services were available. This immediate help contributed to some confidence for the evacuees that their needs would be met.⁹ Florida reported that the waiver was successful in providing evacuees with access to health care, which resulted in improved quality of life and peace of mind. Florida noted that it has a long history of working closely with CMS to provide eligible individuals access to health care in response to hurricanes, which greatly contributed to the success of the Katrina demonstration project.¹⁰

Tennessee reported that overall, the demonstration allowed Tennessee to help alleviate some of the worst of the physical suffering for evacuees that came to the State, while maintaining the integrity of the Medicaid program. Tennessee noted that the lessons learned in the aftermath of Hurricane Katrina will make us better prepared in the future.¹¹ The District of Columbia reported that in the face of this tragedy, it also recognized an opportunity to use the Katrina situation as a blue print to improve its own disaster preparedness skills and health care service delivery in a disaster-related environment.¹²

Lessons Learned and Recommendations from States

Emergency Preparedness

Georgia recommends the development of a national Medicaid Disaster Plan that can be implemented immediately across multiple State programs.¹³ This was echoed by several other States.

Oregon noted that such a plan should:

- Clarify program eligibility, verification, benefit, and Federal reporting requirements as early as possible;
- Establish a mechanism to coordinate information about Federal financial relief with Congress and other Federal entities; and
- Consider a temporary period of eligibility of 6 months rather than 5.

⁸ Percentages may not total at 100 percent due to rounding.

⁹ Iowa Hurricane Katrina Final Report, January 2007, p. 1.

¹⁰ Florida Hurricane Katrina Final Report, January 2007, p. 6.

¹¹ Tennessee Hurricane Katrina Final Report, January 2007, p. 4.

¹² District of Columbia Hurricane Katrina Final Report, January 2007, p. 1.

¹³ Georgia Hurricane Katrina Final Report, January 2007, p. 5.

Rhode Island believes Federal requirements should reflect some sort of “proportional response” that considers the differential degree to which different States will be affected.

Eligibility

Arizona suggests that States responding in natural disasters and times of need should be able to transition new enrollees into the State’s programs as it does for its residents in order to ensure continuity of care and administrative ease.¹⁴ Other States indicated that the eligibility period for future demonstration programs for a natural disaster should be longer than 6 months. Oregon’s eligibility system is configured to provide for 6 or 12 months of eligibility. Since the Hurricane Katrina temporary eligibility period provided to evacuees was 5 months, Oregon State staff had to review each medical assistance case involving an evacuee on a monthly basis.

Although all States chose to use the Simplified Eligibility Chart, some States reported that implementing the Simplified Eligibility Chart provided challenges. The Simplified Eligibility Chart was provided by CMS in an effort to simplify eligibility criteria and provide some consistency for purposes of program administration. Eligibility threshold levels were developed in line with most Home State’s eligibility levels. However, in some cases, the eligibility levels in Home States could be either higher or lower than those in Host States depending upon the State to which evacuees presented. For example, Mississippi viewed the application of the chart as an expansion of eligibility and the responsibility for additional non-Federal (State) share for evacuees. Conversely, South Carolina indicated that to the extent that the Home State may have more generous benefits, the health care need may have gone unmet until (and if) evacuees returned home.¹⁵ Some States also noted that administering two sets of eligibility criteria was an administrative burden.

Indiana suggested that executive action allowing disparate programs to accommodate potentially different populations through documentation be reconciled after a 6-month period.

Coordination among Federal Agencies

Wisconsin noted that there are distinct differences in preparedness and policies for disasters under Medicaid and SCHIP, compared to the Food Stamp program. These differences created challenges in the development, communication, and implementation of application and eligibility policies and processes. For States such as Wisconsin that have an integrated service delivery system for Medicaid and SCHIP, Food Stamps, and Temporary Assistance to Needy Families, any differences in basic policies add confusion and create additional work for State agencies. For instance, while the Medicaid demonstration allowed evacuees eligibility for up to 5 months before a review must be conducted, the Food Stamp program allows only 3 months of eligibility before review. However, the Food and Nutrition Service was also able to exempt these cases from their quality control review and to allow States to loosen verification and documentation requirements for this group during the 3 month time period.

Florida identified the need for detailed instructions on disability and long term care determinations (i.e., what must be verified and what could be relaxed). There is a need for

¹⁴ Arizona Hurricane Katrina Final Report, January 2007, p. 2.

¹⁵ South Carolina Hurricane Katrina Final Report, January 2007, p. 3.

coordination among a number of agencies in the provision of benefits for the disabled and elderly.

Electronic Medical Records and Use of Technology

Alabama indicated that the lessons learned in this demonstration now, more than ever, make it obvious there is critical need for a secure electronic connection for medical information between State health and human service agencies within Alabama and the gulf coast States. Millions of medical records were disposed and left health care providers and victims without accurate medical documentation during a time when it was needed most. Access to electronic medical, pharmacy, inpatient, laboratory and diagnostic would have been invaluable during, before, and after Hurricane Katrina.¹⁶

Several States reported the need to change computer systems to track services provided to Hurricane Katrina evacuees and reported the initial start-up phase was the most problematic and provided the most impact on State programs. Delaware reported that minor systems changes were made to the Medicaid Management Information System in order to identify evacuees. Virginia also reported that computer systems changes were needed.

Funding

Virginia suggested greater availability of uncompensated care pool funds in recognition that many disaster victims do not meet Medicaid and SCHIP eligibility requirements.¹⁷ Additionally, Arizona requested approval to operate an uncompensated care pool. The State reports that when CMS was unable to approve their uncompensated care pool request, 1,140 evacuees (for a total of over \$996,000 of costs incurred) were not paid since these evacuees were not linked to traditional title XIX categories.¹⁸

Cultural Issues

Puerto Rico reported the greatest challenge in providing health care coverage to evacuees was the language barrier that presented when evacuees from the US came to Puerto Rico.

Provider Networks and Community Involvement

Arizona's most significant impact involved the need to quickly develop an appropriate provider network willing to provide immediate care to those evacuated to Arizona. Non-emergency transportation and dental services were in high demand for this new population.

Most States reported the need to involve other stakeholder groups in providing care and services to the evacuees. Such groups were comprised of the provider community, county and city governments, churches, non-profits, and private volunteers. Wisconsin indicated that it worked directly with providers and provider associations to problem solve and remove unnecessary barriers to the provision of health care services and benefits to evacuees. Wisconsin worked with the American Red Cross, local health departments, the Wisconsin

¹⁶ Alabama Hurricane Katrina Final Report, January 2007, p. 13.

¹⁷ Virginia Hurricane Katrina Final Report, January 2007, p.4.

¹⁸ Arizona Hurricane Katrina Final Report, January 2007, p. 3.

Department of Workforce Development, the Pharmacy Society of Wisconsin, the Wisconsin Hospital Association, and Area Agencies on Aging.¹⁹

CMS continues to work with States and providers to ensure that providers, including pharmacies, are reimbursed for the services they provided to Katrina evacuees. CMS has dedicated high level staff to work with the Department and the Federal Emergency Management Agency to develop procedures to engage all local pharmacies in future emergency response.

CONCLUSION

The Katrina Demonstrations proved to be invaluable to individuals in need of health care coverage in the time of a devastating natural disaster. Most States reported that, overall, providing health care to evacuees presented challenges to their health care infrastructure, but more importantly, providing health care coverage allowed States the opportunity to challenge their own disaster preparedness systems. Several States reported that the lessons learned from Hurricane Katrina demonstrations are being incorporated into States' on-going disaster preparedness activities. States valued the opportunity to forward information to CMS to inform future emergency preparedness efforts for future disasters. CMS will use the information provided in future planning activities.

¹⁹ Wisconsin Hurricane Katrina Final Report, January 2007, p. 2.

Attachment A

State Medicaid Director's Letter and Demonstration Template of September 15, 2005,
Announcing the Hurricane Katrina Section 1115 Demonstration Program

Attachment B

Final Reports require the actual unduplicated ever-enrolled end of demonstration enrollment. See information below. It should be noted that CMS did not verify enrollment data and relied upon numbers provided by States.

State Name	Final Reported Actual Demonstration Evacuee Enrollment
Alabama	4,815
Arizona	1,776
Arkansas	2,385
California	2,747
Delaware	220
District of Columbia	408
Florida	5,739
Georgia	17,544
Idaho	28
Indiana	1,037
Iowa	672
Louisiana	0
Maryland	2,458
Massachusetts	471
Minnesota	854
Mississippi	5,160
Montana	80
Nevada	1,299
North Carolina	1,680
North Dakota	37
Ohio	2,596
Oregon	309
Pennsylvania	749
Puerto Rico	34
Rhode Island	55
South Carolina	1,897
Tennessee	2,591
Texas	58,671
Utah	882
Virginia	641
Wisconsin	720
Wyoming	47
Total	118,602

Attachment C

**Section 1115 Hurricane Katrina Demonstration Deficit Reduction Act Expenditures
(as of February 1, 2007)**

State	KATRINA DRA EXPENDITURES					Tot. Katrina EXPENDITURES/(DRAWS)
	§6201(a)(1)(A)&(C) Demo Eligibles	§6201(a)(2) ADMIN related to Demo Eligibles	§6201(a)(1) (B)&(D) UCCP	§6201(a)(2) ADMIN related to UCCP	§6201(a)(3) Expenditures	
Alabama	\$2,045,741		\$1,633,195		\$236,350,742	\$240,029,678
Arizona	\$420,870	\$30,567				\$451,437
Arkansas	\$588,506		\$194,488			\$782,994
California	\$414,426	\$13,312				\$427,738
Delaware						\$0
D.C.						\$0
Florida	\$1,232,069	\$556,602				\$1,788,671
Georgia						\$0
Idaho	\$32,267	\$7,000				\$39,267
Indiana	\$93,394					\$93,394
Iowa						\$0
Louisiana	\$177		\$97,443,982	\$668,643	\$680,569,382	\$778,682,184
Maryland	\$395,007	\$66				\$395,073
Massachusetts	\$130,835					\$130,835
Minnesota	\$297,706					\$297,706
Mississippi			\$72,367,638		\$506,083,540	\$578,451,178
Montana	\$20,500	\$4,337				\$24,837
Nevada	\$240,000	\$10,000				\$250,000
N. Carolina	\$427,116	\$14,216				\$441,332
North Dakota	\$4,170					\$4,170
Ohio	\$229,829					\$229,829
Oregon	\$54,119	\$4,678				\$58,797
Pennsylvania	\$1,398,777					\$1,398,777
Puerto Rico						\$0
Rhode Island	\$4,691					\$4,691
S. Carolina	\$377,770	\$55,863	\$6,180			\$439,813
Tennessee	\$1,403,729		\$2,023,335			\$3,427,064
Texas	\$10,937,245	\$753,406	\$18,234,959	\$891,885		\$30,817,495
Utah	\$229,904	\$13,851				\$243,755
Virginia	\$126,145	\$43,000				\$169,145
Wisconsin	\$154,534					\$154,534
Wyoming						\$0
Totals	\$21,259,527	\$1,506,898	\$191,903,777	\$1,560,528	\$1,423,003,664	\$1,639,234,394