

# CRS Report for Congress

Received through the CRS Web

## Hurricane Katrina: Medicaid Issues

**September 15, 2005**

Evelyne Baumrucker, April Grady, Jean Hearne, Elicia Herz,  
Richard Rimkunas, Julie Stone, and Karen Tritz  
Domestic Social Policy Division

# Hurricane Katrina: Medicaid Issues

## Summary

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own version of the program under broad federal guidelines. The complexity of Medicaid can present an enormous challenge in meeting the needs of Hurricane Katrina's victims, especially when evacuees cross state lines. State variation in eligibility, covered services, and the reimbursement and delivery of services is the rule rather than the exception. Furthermore, although Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor.

As a federal-state program that helps to finance health care services for people with limited resources, Medicaid is an obvious avenue of quick response for support of hurricane victims in Katrina's aftermath. The program's federal budgetary status as mandatory spending means that federal funding is available to support coverage for all people who meet the program's eligibility criteria, without the need for a supplemental appropriation.

However, the ability of Medicaid to respond to this disaster — in terms of the numbers and types of people who can rely on it for health care support — may depend on a number of factors, including congressional action to modify statutory provisions (e.g., the level of federal Medicaid reimbursement offered to states), the Secretary of Health and Human Services' ability to waive certain program requirements administratively (e.g., regarding eligibility and benefits), and actions of the states (each of whom operates its own unique Medicaid program within federal guidelines).

This report, which will be updated as events warrant, discusses the following:

- Medicaid's rules on eligibility, benefits, and financing in the context of current questions and issues raised by Hurricane Katrina.
- Recent state actions in response to Medicaid issues raised by the hurricane.
- Federal Medicaid waiver authority, including information on current activity in this area and the New York Disaster Relief Medicaid waiver granted in response to the September 11 terrorist attacks.
- Current federal legislation related to Medicaid and Hurricane Katrina relief efforts.

## Contents

Overview .....	1
Medicaid Eligibility and Access .....	1
Background .....	1
Issues Raised by Hurricane Katrina .....	2
Residency .....	2
Income and Asset Documentation .....	3
Look-Back Period for Financial Eligibility .....	3
People Who Do Not Meet Current Eligibility Requirements .....	4
Medicaid Benefits .....	4
Background .....	4
Issues Raised by Hurricane Katrina .....	5
Variation in Benefit Coverage Across States .....	5
Access to Long-Term Care Services .....	7
Cost-Sharing .....	7
Payment and Financing .....	8
Background .....	8
Issues Raised by Hurricane Katrina .....	8
Increased Costs Resulting from Increased Enrollment .....	8
Payments for Out-of-State Care .....	9
State and Federal Responses .....	10
Recent State Actions .....	11
Federal Waiver Authority .....	13
Section 1115 Waiver Authority .....	13
Precedent for Emergency-Related Section 1115 Waivers: New York’s Disaster Relief Medicaid Program .....	15
Section 1135 Waiver Authority .....	16
Current Waiver Activity Related to Hurricane Katrina .....	17
Emergency Action Under Section 1115 .....	17
Section 1135 Waivers .....	18
Current Federal Legislation .....	20
House Proposals .....	20
Senate Proposals .....	21

## List of Tables

Table 1. States Covered Under Section 1135 Waivers Authorized in Response to Hurricane Katrina .....	18
---	----

# Hurricane Katrina: Medicaid Issues

## Overview

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own version of the program under broad federal guidelines. The complexity of Medicaid can present an enormous challenge in meeting the needs of Hurricane Katrina's victims, especially when evacuees cross state lines. State variation in eligibility, covered services, and the reimbursement and delivery of services is the rule rather than the exception. Furthermore, although Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor.

While some of the federal rules governing Medicaid are flexible enough to allow states to act without federal intervention in the wake of Hurricane Katrina, certain issues raised by the disaster may be addressed only through administrative or legislative action by the federal government. On the administrative front, the Centers for Medicare and Medicaid Services (CMS) is currently working with affected states to develop a voluntary Medicaid waiver program that would address some of the hurricane-related eligibility and benefit issues raised in this report.

Although states are not obligated to participate in the waiver arrangement being developed, it is likely that the promise of additional federal dollars would entice them to do so. On the legislative front, congressional action may be required if enhanced reimbursement is to be provided to states for Medicaid costs incurred as a result of Hurricane Katrina. Congress may also consider the desirability of uniform treatment of hurricane victims across states (rather than relying on voluntary participation in the waiver program developed by CMS).

This report begins with a discussion of Medicaid's rules on eligibility, benefits, and financing in the context of current questions and issues raised by Hurricane Katrina. It then discusses recent actions taken by states, provides information on federal Medicaid waiver authority, and describes current federal legislation dealing with Medicaid and hurricane relief efforts.

## Medicaid Eligibility and Access

### Background

In general, to qualify for Medicaid coverage, an individual must meet both categorical and financial eligibility requirements. Categorical eligibility requirements relate to the age or characteristics of an individual. Categories of individuals that may qualify for Medicaid generally include aged persons (65 and over), certain

persons with disabilities, children and their parents, and pregnant women. In addition, within federal guidelines, states set functional requirements for individuals seeking Medicaid covered long-term care services.

Financial requirements govern the amount of income and assets that categorically eligible individuals may have and still qualify for Medicaid, as well as how these amounts are calculated (e.g., whether a portion of earned income or the value of a car may be disregarded). The specific income and asset limitations that apply to a particular group are determined through a combination of federal requirements and state options. Consequently, different standards apply to different groups, and the standards themselves may vary considerably among states.

Individuals who do not meet categorical eligibility requirements (e.g., non-elderly adults who are not disabled and do not have children) generally cannot qualify for Medicaid coverage even if they are poor. However, as discussed later in this report, Section 1115 waivers (which allow the Secretary of Health and Human Services (HHS) to waive certain statutory Medicaid requirements for purposes of conducting research and demonstration projects) provide exceptions to these eligibility rules for states that have obtained an approved waiver.

## Issues Raised by Hurricane Katrina

People who are currently eligible for their state's Medicaid program may face difficulty accessing health care services if they have lost their Medicaid cards and other identification or have been evacuated from their home state. In addition to creating problems for those who are current Medicaid enrollees, the large losses of Hurricane Katrina's victims may also swell the numbers of people who are financially eligible for Medicaid, either in their home state or in the state to which they have been evacuated.

**Residency.** Current federal Medicaid rules governing residency help in understanding which program is the right one for evacuees to appeal to if they believe they are Medicaid eligible. State Medicaid programs are required to provide coverage to all state residents who are otherwise eligible for Medicaid. An individual is generally considered a resident of a state if he or she is living in it with the intention of remaining there permanently or indefinitely. Eligibility may not be denied because an individual has not resided in the state for a specified period or because the individual is temporarily absent from the state. A state is also prohibited from denying coverage to an individual who satisfies residency rules but who did not establish residence in the state before entering a medical institution.

For currently enrolled Medicaid recipients who have been displaced from their home state, the home state is *required* under certain circumstances to pay for covered services (i.e., covered under the home state's Medicaid program) furnished in another state to the same extent that it would pay for services furnished within its boundaries and may *opt* to pay for out-of-state services under other circumstances (see the Payment and Financing section of this report for additional information). However, the Medicaid recipient must find an out-of-state provider willing to accept Medicaid payment from the home state (as well as enroll or otherwise enter into an agreement

with the home state's Medicaid program as a condition of receiving that payment), and not all providers may be willing to do so.

Regardless of whether they are enrolled in Medicaid in their home state, displaced individuals might wish to be considered residents of the state to which they have evacuated, either to obtain Medicaid coverage (in the case of those who were not previously eligible) or to facilitate access to care (in the case of those who were eligible for Medicaid in their home state but are having difficulty finding a provider that will accept their out-of-state coverage). If an individual meets the residency requirements described above and is otherwise eligible for Medicaid in the state to which they have evacuated, coverage cannot be denied. However, it should be noted that the eligibility and benefit rules of an individual's host state may be different than the rules of his or her home state.

**Income and Asset Documentation.** In general, federal law stipulates few documentation requirements for Medicaid applicants. State policies on this issue vary based on the eligibility group, but a considerable amount of documentation may be required to determine whether an individual meets financial eligibility requirements for Medicaid.<sup>1</sup> Although states have flexibility to collect income and asset information through self-declaration alone, they also have the ability to require supporting documentation.

Federal law does require states to have an Income and Eligibility Verification System (IEVS), but states are not required to verify income and assets through the IEVS for every Medicaid recipient and may conduct these verifications after enrollment. Under these systems, state Medicaid agencies use information from a number of federal and state sources to verify financial eligibility, including state wage information maintained by the State Wage Income Collection Agency (SWICA) and information on net earnings from self employment, wages, and retirement benefits maintained by the Social Security Administration (SSA).

**Look-Back Period for Financial Eligibility.** For evacuees who may have lost their homes and other assets and are now without jobs, will requirements related to the period over which income is examined for the purpose of determining Medicaid eligibility prevent Medicaid funds from being used to meet their needs? Here again, federal laws and regulations stipulate few rules for the look-back period used to determine an individual's financial eligibility for Medicaid, leaving states with a great deal of flexibility.<sup>2</sup> For many eligibility groups, federal regulations require that states use income counting methods that are no more restrictive than method used under the most closely related cash welfare program.<sup>3</sup> Such methods can

---

<sup>1</sup> For example, individuals applying for certain Medicaid-covered long-term care services must provide financial records for up to a five-year look-back period. These requirements are outlined in Section 1917(c)(1)(A) of the Social Security Act.

<sup>2</sup> A major exception to this rule is for individuals applying for certain Medicaid-covered long-term care services, in which case up to five years of financial records may be examined.

<sup>3</sup> Traditionally, eligibility for Medicaid was linked to the receipt of cash welfare payments.  
(continued...)

be less restrictive at states' option. For certain other groups, such as the medically needy (generally people who become eligible for Medicaid in part because they spend considerable amounts of their income on medical care), the budget period can be no longer than six months. Again, states have the flexibility to shorten such budget accounting periods.

**People Who Do Not Meet Current Eligibility Requirements.** As previously noted, Medicaid eligibility is limited by two primary types of current law restrictions: financial and categorical. Individuals qualify for Medicaid by having income and assets that fall below certain thresholds and by falling into particular groups or categories of individuals. In general those categories include the elderly, people with disabilities, dependent children, parents of dependent children and pregnant women. Could exceptions to these categorical restrictions be made for people impacted by the Katrina disaster? Many states have used Section 1115 Medicaid waivers (discussed later in this report) to allow categorical eligibility requirements to be waived. Many states have also exercised options that allow them to liberalize eligibility without the use of a waiver, such as the option to disregard certain amounts of income or assets for particular groups.

## Medicaid Benefits

### Background

Medicaid's basic benefit rules require all states to provide certain mandatory services listed in federal statute. Examples of services that are mandatory for most groups of Medicaid recipients include: (1) inpatient and outpatient hospital services, (2) federally qualified health center (FQHC) services, (3) lab and X-ray services, (4) physician services, (5) certain nurse practitioner services, (6) pregnancy-related services (including postpartum care), (7) early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21, (8) nursing facility care for persons age 21 and over, and (9) home health care for persons entitled to nursing facility care.

The statute also lists additional services that are considered optional — that is, available to recipients if states choose to include them in their state Medicaid plans. Some of these optional benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined as classes of medical providers whose array of services are considered to be Medicaid covered benefits (e.g., psychologists, nursing facility care for persons under age 21, intermediate care facility services for individuals with mental retardation (ICFs/MR)). Still others include a wide range of types of medical care and services (e.g., physical therapy, prescribed drugs, personal care services, private duty nursing, hospice, clinic services, and rehabilitation).

In addition to the above general rules regarding mandatory and optional benefits, Medicaid statute specifies special benefits or special rules regarding certain benefits

---

<sup>3</sup> (...continued)

While this is no longer true for all coverage groups, many income and asset counting rules are still linked to those used under existing or former cash welfare programs.

for targeted groups of individuals. For example, for children under the age of 21, EPSDT guarantees access to all federally coverable services that are necessary to correct or ameliorate identified defects, physical and mental illnesses, and other conditions. States are required to provide otherwise optional services to a Medicaid child, even if that service is not listed in the state Medicaid plan. Thus, children in any state can receive eyeglasses through Medicaid, for example, while adults living in the same state may not have any, or limited, access to this optional benefit.

Medicaid is also an important financing mechanism for long-term care (LTC). LTC services refer to a wide range of supportive and health services generally provided on an ongoing basis for persons who have limitations in functioning because of a disability or chronic condition. Medicaid-covered nursing facility (NF) and ICF/MR services are generally categorized as “institutional” services because individuals reside in and receive health care services in a specific type of certified facility. Other Medicaid-covered LTC services (e.g., personal care, home health care) are categorized as “home and community-based” care because individuals generally receive these services in the community (e.g., in their homes or apartments).

States also have the option of requesting permission from the federal government to provide other home and community-based services for individuals who would otherwise need the level of care in an institution. These other services may be offered as a supplement to, or instead of, those optional services available through the state plan. This option is referred to as a Home and Community-Based (HCBS) waiver, authorized under Section 1915(c) of the Social Security Act. Unlike services offered as part of the state Medicaid plan, the HCBS waiver allows states to limit the number of individuals served and to offer the services on a less-than-statewide basis. These waivers include a broad range of services such as case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, respite care, home modifications, and home-delivered meals.

## Issues Raised by Hurricane Katrina

**Variation in Benefit Coverage Across States.** Because each state designs and administers its own Medicaid program under broad federal rules, coverage of benefits varies from state to state. Among the five states initially declared to have public health emergencies due to Hurricane Katrina (Alabama, Florida, Louisiana, Mississippi, and Texas), certain optional services<sup>4</sup> are covered in all of these states (e.g., hospice care, ICF/MR, prescribed drugs, prosthetic devices, and transportation). Other optional services are not covered by all of these states

---

<sup>4</sup> Information on benefit coverage is taken from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid At-A-Glance 2003*, Publication No. CMS-11024-03. (Hereafter cited as “CMS, *Medicaid At-A-Glance 2003*.”). These data are based on a review of approved state Medicaid plans and waivers as of September 30, 2003.

(e.g., physical therapy, emergency hospital services in non-certified hospitals,<sup>5</sup> care for the elderly in institutions for mental disease (IMDs), eyeglasses, and basic dental care).

In addition to choosing the menu of optional services they will provide, states define the specific parameters (e.g., amount, duration and scope) of each mandatory and optional service covered under the state Medicaid plan within broad federal guidelines. Thus, even for mandatory benefits, there will be variations in the breadth of coverage from state to state.

There has been discussion about the potentially substantial mental health needs of survivors of Hurricane Katrina in both home and host states.<sup>6</sup> A wide range of inpatient and outpatient mental health services may be provided through several mandatory and optional benefits under Medicaid. However, even among states that cover a specific benefit (e.g., psychologist services, services in mental health clinics, other mental health rehabilitation and stabilization services), there may be interstate variations in the amount, duration and scope of such covered benefits.

In the wake of Hurricane Katrina, questions have been raised about which state's benefit package will apply to individuals who have been displaced from their home state. 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?<sup>7</sup>

The answer to this question is currently unclear. As discussed in the Payment and Financing section of this report, if a Medicaid recipient is evacuated to another state, the home state is obligated under certain circumstances to pay for covered services (i.e., covered by the home state) that are provided out-of-state. However, the Medicaid recipient must find a provider who is willing to accept the home state's Medicaid coverage, which may be difficult. As discussed earlier in the Medicaid Eligibility and Access section of this report, there is also a residency question for people who have been displaced. If a Medicaid recipient or any other individual has no intention of returning to their home state, will they now be considered a resident of their host state — which may offer a different benefit package than their home state — for Medicaid purposes?

---

<sup>5</sup> Includes care that is necessary to prevent the death or serious impairment of the health of a recipient, and because of the threat to life or health necessitates the use of the most accessible hospital that is equipped to provide these services, even if that hospital does not meet the conditions of participation in Medicare, or the definition of mandatory inpatient and outpatient services under Medicaid.

<sup>6</sup> For example, HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded \$600,000 in emergency grants to four states to meet mental health assessment and crisis counseling needs. See [[http://www.samhsa.gov/news/newsreleases/050913\\_hhs.htm](http://www.samhsa.gov/news/newsreleases/050913_hhs.htm)].

<sup>7</sup> CMS, *Medicaid At-A-Glance 2003*.

**Access to Long-Term Care Services.** Individuals eligible for Medicaid-covered LTC services generally have significant physical or mental impairments that often require 24-hour supervision and assistance with activities of daily living (e.g., eating and drinking, using the toilet, getting in and out of bed). Medicaid covers long-term care services in both institutional (e.g., nursing homes and ICFs/MR) and home and community-based settings (e.g., home care, adult day care, transportation, personal attendant care) for certain individuals. Because LTC recipients are highly dependent upon paid direct care staff (also referred to as paraprofessionals), such as certified nursing assistants in nursing homes and home health aides providing a range of services to beneficiaries in their homes, access to such care will be critical in the locations to which these individuals are evacuated.

Unfortunately, many states are experiencing difficulties in attracting and retaining a sufficient supply of paraprofessionals to meet the growing demand for long-term care services in all settings, even in the absence of a disaster such as Hurricane Katrina. Furthermore, many Medicaid beneficiaries with long-term care needs obtain assistance from unpaid caregivers, such as spouses, relatives, or neighbors. Such assistance often enables these individuals to remain at home or in a community setting, helping to reduce reliance on Medicaid-covered LTC institutions. The death or displacement of paid and unpaid caregivers may lead more evacuees to go without needed assistance or to seek services from Medicaid-covered institutions in both home and host states, further straining staff-to-resident ratios in institutions.

Another factor to consider is the impact on access to home and community-based services posed by the movement of HCBS waiver recipients across states. It remains unclear whether persons enrolled in HCBS waivers in their home states will be able to enroll in similar waiver programs in their host states. First, enrollment in waiver programs is dependent upon a person having access to housing in the community. It is unclear whether community-based housing will be available to evacuees with long-term care needs. Second, many states already have waiting lists for waiver enrollment slots. As a result, host states may request federal approval to lift their enrollment caps to cover evacuees and may need to renegotiate cost neutrality agreements with the Secretary.<sup>8</sup> Third, each HCBS waiver covers a different set of services and is targeted toward a distinct population. As a result, persons eligible for waiver services in their home state may find that they are either ineligible for waiver services in their host state or that the services offered do not meet their needs. If no appropriate community-based alternatives are available, will these evacuees then be placed in host state institutions?

**Cost-Sharing.** Finally, while cost-sharing is not widely applied under Medicaid, state policies may also be an issue for Hurricane Katrina survivors who remain in their home states as well as those that relocate to other states. This issue

---

<sup>8</sup> Section 1915(c) of the Social Security Act constrains states to a budget neutrality test in defining which services they cover under the HCBS waiver program. Specifically, the statute requires that the average per capita Medicaid expenditures estimated by the state in any fiscal year for waiver enrollees can not exceed the amount Medicaid would have paid if the individuals were residing in an institution.

is particularly relevant to some of the working people with disabilities who pay substantial premiums for Medicaid coverage. Will home states continue to require cost-sharing for in-state evacuees? Will host states require out-of-state evacuees to comply with participation and point-of-service cost-sharing requirements applicable to in-state Medicaid recipients? Or will the home state cost-sharing requirements, if any, apply instead?

## Payment and Financing

### Background

The Medicaid program is jointly financed by the federal government and the states. States incur Medicaid expenditures by reimbursing providers for the covered care and services they provide to Medicaid recipients and by administering their Medicaid programs (e.g., conducting eligibility determinations, processing claims, enrolling providers) in compliance with federal requirements. Each quarter, states submit accounting statements detailing their Medicaid expenditures to the federal government and are reimbursed at the applicable federal rate.

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal reimbursement rate for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive enhanced (usually 75%) reimbursement.

### Issues Raised by Hurricane Katrina

**Increased Costs Resulting from Increased Enrollment.** States affected by Hurricane Katrina — including both those that have taken in large numbers of individuals displaced by it and those whose own population may be struggling financially in the aftermath — are concerned about the possibility of a surge in Medicaid program enrollment, and some advocate that enhanced federal reimbursement should be made available for Medicaid costs associated with serving hurricane victims. A legislative change may be required to provide such enhanced reimbursement, because the Secretary of HHS may not have the authority to waive provisions of federal Medicaid law that govern payments to states.<sup>9</sup>

---

<sup>9</sup> Section 1903 of the Social Security Act governs payments to states for Medicaid. See the discussion of federal waiver authority later in this report for more information on provisions of Medicaid law that can and cannot be waived administratively. While the Secretary does not have the authority under Section 1115 to waive rules governing payments to states, the reach of Section 1135 waiver authority is less clear. It was reported on Sept. 15 that CMS is announcing that it will pick up all costs of Medicaid care for low-income evacuees who fled to Texas. Senator Kay Bailey Hutchison reportedly received a phone call late Wednesday (Sept. 14) from CMS Administrator Mark McClellan about the forthcoming aid.

(continued...)

As described above, the FMAP is used to reimburse states for most of their Medicaid service expenditures. Current statutory exceptions to the FMAP include family planning services and supplies (reimbursed at 90%), services that are received through an Indian Health Service (IHS) facility (reimbursed at 100%), and services provided to targeted low-income children enrolled in Medicaid who qualify through State Children's Health Insurance Program (SCHIP) provisions (reimbursed at an enhanced FMAP that varies by state and may range from 65% to 85%, subject to the availability of funds from a state's federal SCHIP allotment).

In addition to experiencing an increase in expenditures for medical care, states may also see an increase in administrative costs associated with performing eligibility determinations for hurricane victims. In the past, temporary increases in federal reimbursement (separate from the permanent enhancements available for specified administrative functions, such as the 100% reimbursement provided for operating an immigration status verification system) have been authorized by Congress to assist states with administrative costs. For example, a \$500 million federal fund was made available beginning in 1997 (and continuing until exhausted) to provide states with enhanced federal reimbursement for administrative expenditures attributable to eligibility determinations that would not have been made were it not for the implementation of the Temporary Assistance for Needy Families (TANF) program.<sup>10</sup>

**Payments for Out-of-State Care.** Under federal law, regulations promulgated by the Secretary of HHS dictate the extent to which states must furnish Medicaid assistance to state residents who are absent from the state.<sup>11</sup> Under these regulations, a state must pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the state and any of the following conditions is met:

- medical services are needed because of a medical emergency;
- medical services are needed and the recipient's health would be endangered if he were required to travel to his state of residence;
- the state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
- it is general practice for recipients in a particular locality to use medical resources in another state.

The regulations also require states to establish procedures to facilitate the furnishing of medical services to individuals who are present in one state but eligible

---

<sup>9</sup> (...continued)

According to her spokesperson, state matching funds that are part of the Medicaid program will be waived for five months. See [http://www.lasvegassun.com/sunbin/stories/bw-cong/2005/sep/15/091505138.html?CFID=1704740&CFTOKEN=34e39eea2adb9e1e-A953925A-B922-DC4F-64CC442B2E4EBC26].

<sup>10</sup> Section 1931(h) of the Social Security Act.

<sup>11</sup> Section 1902(a)(16) of the Social Security Act and 42 CFR 431.52.

for Medicaid in another. In cases where a Medicaid recipient seeks out-of-state care not related to a medical emergency, the home state may typically require prior authorization of the care. The home state may also require the out-of-state provider to enroll or otherwise enter into an agreement with its Medicaid program as a condition of receiving payment. In the case of bordering states where recipients commonly cross state lines to seek care, states often have agreements in place to facilitate the provision and payment of Medicaid services.

For Medicaid recipients who were displaced from their home state by Hurricane Katrina, nothing under federal law would prevent the home state from paying for all covered services (i.e., covered under the home state's Medicaid program) that are provided to recipients while they are in another state. At minimum, the home state must pay if any of the conditions listed above are met. However, the Medicaid recipient must find an out-of-state provider willing to accept Medicaid payment from the home state, and not all providers may be willing to do so.<sup>12</sup> In addition, since an individual may be considered a resident of the state to which they have evacuated, he or she may be subject to the eligibility rules of that state's Medicaid program (see the Medicaid Eligibility and Access section of this report for more information on residency).

## State and Federal Responses

States operate their Medicaid programs in the context of federal rules. While some of these rules are flexible enough to allow states to act without federal intervention in the wake of Hurricane Katrina, certain issues raised by the disaster may be addressed only through administrative or legislative action by the federal government.

For example, although states have a great deal of flexibility in setting eligibility and benefit rules, they are generally required to apply these rules equally to all applicants and recipients to ensure that they meet federal Medicaid requirements governing statewideness and comparability of benefits. If a state wants to modify these rules substantially (e.g., by allowing coverage of childless adults who ordinarily could not qualify for Medicaid) or apply special rules to a select group of individuals (e.g., allowing Medicaid coverage for all hurricane victims who meet categorical eligibility requirements by disregarding their income), federal permission in the form of a waiver granted by the Secretary of HHS would generally be required.

Although states are not obligated to participate in the Section 1115 Medicaid waiver arrangement being developed by the federal government in response to

---

<sup>12</sup> For example, Barbara Coulter Edwards, the Ohio Medicaid director, has reportedly indicated that her agency had received calls from hurricane victims who had found shelter in Ohio but were turned away by health care providers unwilling to accept out-of-state Medicaid cards. See [\[http://www.nytimes.com/2005/09/07/national/nationalspecial/06cnd-welfare.html?ei=5070&en=247ac2ca27b8a7be&ex=1126756800&adxnnl=1&emc=eta1&adxnnlx=1126181605-mqKqPzFajORBtyFxJXs0/g\]](http://www.nytimes.com/2005/09/07/national/nationalspecial/06cnd-welfare.html?ei=5070&en=247ac2ca27b8a7be&ex=1126756800&adxnnl=1&emc=eta1&adxnnlx=1126181605-mqKqPzFajORBtyFxJXs0/g).

Hurricane Katrina (described later in this report), it is likely that the promise of additional federal dollars would entice them to do so. As discussed earlier, congressional action may be required if enhanced reimbursement is to be provided to states for Medicaid costs incurred as a result of Hurricane Katrina. Congress may also wish to consider the desirability of uniform treatment of hurricane victims across states.

## Recent State Actions

A number of states have expressed a desire for explicit federal guidance on Medicaid issues raised by Hurricane Katrina.<sup>13</sup> Although the situation is evolving at the federal level both administratively and legislatively, examples of state actions reported thus far within the confines of existing federal rules include the following:<sup>14</sup>

- Louisiana is providing temporary Medicaid cards to Medicaid recipients who lost their cards in the hurricane and allowing recipients who have left their homes because of Hurricane Katrina to access Medicaid services — without any prior authorization requirements — in or out of state from any medical provider that is willing to accept Louisiana Medicaid as payment. There is an emergency procedure in place to expedite provider enrollment for purposes of receiving Medicaid payment. The state is making Medicaid staff members available at the Family Assistance Centers being set up by the Federal Emergency Management Agency (FEMA) and at many shelters across the state to help those affected by Hurricane Katrina fill out forms to get health coverage. Because of the severe statewide impact of Hurricane Katrina, all of Louisiana Medicaid's staff is being called upon to sign up those who have been devastated by the hurricane and need health coverage — instead of doing normal redeterminations for currently eligible individuals.<sup>15</sup> In addition, Louisiana has requested permission from CMS to cancel as yet unpaid premiums for individuals enrolled in a buy-in program for working persons with disabilities through December 2005. In response, CMS has granted a waiver of these premium payments for 120 days.<sup>16</sup>

---

<sup>13</sup> For example, see Kaiser Commission on Medicaid and the Uninsured, *Reporter Teleconference Briefing on Health Coverage After Katrina* (Sept. 9, 2005), available at [<http://www.kff.org/medicaid/kcmu090905pkg.cfm>].

<sup>14</sup> Also see American Public Human Services Association, *News on State and Local Relief Efforts*, available at [<http://www.aphsa.org/katrina/news/default.asp>].

<sup>15</sup> Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, *Louisiana Medicaid Response to Hurricane Katrina*, available at [<http://www.dhh.louisiana.gov/offices/page.asp?id=92&detail=5156>].

<sup>16</sup> American Public Human Services Association, *Updated Information on Hurricane Katrina Disaster Policies and Assistance* (Sept. 9, 2005), available at [<http://www.aphsa.org/katrina/disasterpolicy9-9-05.asp>].

- The Mississippi Division of Medicaid is encouraging its medical providers and pharmacies to provide essential services for Medicaid recipients who have migrated from Louisiana as well as other parts of Mississippi. An emergency enrollment form that allows for temporary (120-day) provider enrollment in the state's Medicaid program is available. Providers may call a toll-free number to verify an individual's eligibility for Mississippi Medicaid.<sup>17</sup>
- In Alabama, the Governor signed a proclamation expediting the process of obtaining prescription drug refills for storm victims. People can go to any pharmacy and receive assistance with their medications. It is not clear how these services are being financed (e.g., through Medicaid or another means).<sup>18</sup> The state is allowing out-of-state providers not enrolled in its Medicaid program the ability to verify eligibility for Alabama Medicaid recipients via its Automated Voice Response System (AVRS).<sup>19</sup>
- The Texas Health and Human Services Commission has provided Texas pharmacies and providers with information on how to assist Louisiana, Mississippi and Alabama residents who are on Medicaid and need to fill prescriptions or obtain other services in Texas. The Texas Department of State Health Services is also assessing long- and short-term medical care needs and other special arrangements for evacuees who are hospital patients, medically fragile, injured, ill or have other special needs.<sup>20</sup>
- North Carolina's Medicaid website is suggesting that documentation requirements will be relaxed for an indeterminate period of time. "People must still be Medicaid eligible in order to take part in this program but we're not going to insist on people turning up with birth certificates or Social Security cards in the midst of an emergency," according to Department of Health and Human Services Secretary Carmen Hooker Odom.<sup>21</sup>

---

<sup>17</sup> Mississippi Division of Medicaid, *Provision of Essential Services to Medicaid Beneficiaries Displaced by Hurricane Katrina*, available at [[http://www.dom.state.ms.us/Emergency\\_Provisions\\_Due\\_To\\_Katrina.pdf](http://www.dom.state.ms.us/Emergency_Provisions_Due_To_Katrina.pdf)].

<sup>18</sup> Alabama Department of Public Health, *Alabama's health care services are not interrupted by Hurricane Katrina* (Sept. 6, 2005), available at [<http://www.adph.org/NEWSRELEASES/default.asp?TemplateNbr=0&DeptID=107&TemplateId=3914>].

<sup>19</sup> Alabama Medicaid Agency, *Hurricane Katrina Update*, available at [[http://www.medicaid.state.al.us/news/hurricane\\_update.aspx?tab=2](http://www.medicaid.state.al.us/news/hurricane_update.aspx?tab=2)].

<sup>20</sup> State of Texas, Office of the Governor, *Gov. Perry Seeks Assurance of Full Reimbursement of Health Care Expenses* (Sept. 7, 2005), available at [<http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2005-09-08.5610>].

<sup>21</sup> State of North Carolina, Department of Health and Human Services, *State offers Medicaid assistance to eligible Hurricane Katrina victims* (Sept. 2, 2005), available at [<http://www.dhhs.state.nc.us/dma/Katrina%20Medicaid.pdf>].

## Federal Waiver Authority

**Section 1115 Waiver Authority.** Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to conduct research and demonstration projects under several programs authorized in the Social Security Act. Specifically, Section 1115 authorizes the Secretary to waive certain statutory requirements for conducting demonstration projects that further the goals of Titles XIX (Medicaid) and XXI (SCHIP). Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902 (known as “freedom of choice” of provider, “comparability,” and “statewideness”).<sup>22, 23</sup> States must submit proposals outlining terms and conditions for proposed waivers to CMS for approval before implementing these programs. Whether large or small reforms, Section 1115 waiver programs have resulted in significant changes for Medicaid recipients nationwide, and serve as a precedent for federal and state officials who wish to make temporary changes to the Medicaid program in response to the unique circumstances resulting from the devastation of Hurricane Katrina.

In recent years, there has been increased interest among states and the federal government in the Section 1115 waiver authority as a means to restructure Medicaid coverage, control costs, and increase state flexibility. Under current law, states may obtain waivers that allow them to provide services to individuals not traditionally eligible for Medicaid, cover non-Medicaid services, limit benefit packages for certain groups, adapt their programs to the special needs of particular geographic areas or groups of recipients, or accomplish a policy goal such as to temporarily provide Medicaid assistance in the aftermath of a disaster, among other purposes.

Following the September 11, 2001 terrorist attacks, for example, New York requested and received approval for a Section 1115 waiver known as “Disaster Relief Medicaid” (DRM). The DRM program allowed Medicaid applicants who were residents of New York City to receive four months of coverage if they met the eligibility requirements of the Medicaid or Family Health Plus (FHP) program, and they applied for DRM between September 11, 2001, and January 31, 2002 (for more detail on this temporary waiver program see discussion below).

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations or restrictions on how a state may operate a waiver program. For example, one provision restricts states from establishing waivers that fail to provide all mandatory services to the mandatory poverty-related groups of pregnant women and children; another provision specifies

---

<sup>22</sup> “Freedom of choice” refers to a requirement that Medicaid recipients have the freedom to choose their medical care providers. “Comparability” refers to a requirement that services be comparable in amount, duration, and scope for all persons in each eligibility group. “Statewideness” refers to the requirement that states provide services on a state-wide basis, rather than in only a portion of the state.

<sup>23</sup> For SCHIP, no specific sections or requirements are cited as “waivable.” Section 2107(e)(2)(A) of SCHIP statute simply states that Section 1115 of the Social Security Act, pertaining to research and demonstration waivers, applies to Title XXI.

restrictions on cost-sharing imposed under demonstration waivers. Other features of the Section 1115 waiver authority that may be relevant in using this authority to respond to Hurricane Katrina include:

- *Federal Reimbursement for Section 1115 Demonstrations.* Approved Section 1115 waivers are deemed to be part of a state’s Medicaid state plan. Project costs associated with waiver programs are subject to that state’s FMAP.<sup>24</sup> Changes to these financing arrangements, even under a Section 1115 waiver, would require congressional action.
- *Financing and Budget Neutrality.* Unlike regular Medicaid, CMS waiver guidance specifies that costs associated with waiver programs must be *budget neutral* to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state’s existing Medicaid program under current law program requirements. As described below, an exception to this guidance on budget neutrality was made by the Secretary for the Section 1115 waiver granted to New York after September 11, 2001.
- *Financing and Allotment Neutrality.* Under the SCHIP program, a different budget neutrality standard applies. States must meet an “allotment neutrality test” where combined federal expenditures for the state’s regular SCHIP program *and* for the state’s SCHIP demonstration program are capped at the state’s individual SCHIP allotment. This policy limits federal spending to the capped allotment levels. Any additional financial resources for SCHIP would require congressional action.
- *Relationship of Medicaid/SCHIP Demonstration Waivers to Other Statutes.* Section 1115 waiver projects may interact with other program rules outside of the Social Security Act; for example, employer-sponsored health insurance as described by the Employee Retirement Income Security Act (ERISA), or alien eligibility as contained in immigration law. In cases like these, the Secretary does not have the authority to waive provisions in these other statutes.<sup>25</sup>
- *Program Guidance.* The Secretary can develop policies that influence the content of demonstration projects and prescribe approval criteria in three ways: (1) by promulgating program rules and regulations;<sup>26</sup> (2) through the publication of program guidance

---

<sup>24</sup> The same reimbursement rules apply to SCHIP, except that SCHIP Section 1115 demonstration programs are reimbursed at an enhanced rate (the same rate used for regular SCHIP programs).

<sup>25</sup> For example, states may not provide benefits to qualified aliens as a part of a Section 1115 eligibility expansion without adhering to the five-year ban on alien access to federal assistance as required by the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193).

<sup>26</sup> Program rules and regulations that meet specified rulemaking criteria are legally binding. To date, CMS has *not* shaped Section 1115 waiver-related policy through program rules and (continued...)

(e.g., the waiver program must meet a budget neutrality test);<sup>27</sup> and (3) waiver policy may also be implicitly shaped by the programs that have been approved (e.g., CMS approval of New York’s “Disaster Relief Medicaid”). Legislative action may be required if Congress chooses to further shape the Secretary’s authority over the content of the demonstration programs or dictate specific Section 1115 waiver approval criteria.

**Precedent for Emergency-Related Section 1115 Waivers: New York’s Disaster Relief Medicaid Program.** Federal and state officials have looked to New York’s Section 1115 Disaster Relief Medicaid program as precedent for the Secretary of HHS to use the authority under Section 1115 of the Social Security Act to respond to emergency situations. Details on eligibility criteria, benefit packages, provider agreements, financing arrangements, and other issues outlined in the terms and conditions of New York’s temporary waiver program provide an example of how this state used the flexibility under Section 1115 to address specific health care needs in the wake of an emergency situation.

Following the terrorist attacks on September 11, 2001, New York requested and received approval for a Section 1115 waiver known as “Disaster Relief Medicaid.” The DRM program allowed Medicaid applicants who were residents of New York City to receive four months of coverage if they met the eligibility requirements of the Medicaid or Family Health Plus program, and they applied for DRM between September 11, 2001, and January 31, 2002. The FHP program is a separate Section 1115 waiver that had been approved by CMS, and was scheduled to be implemented in October 2001. FHP significantly expanded Medicaid eligibility to certain groups; for example, the income standard for childless adults went from about 50% to 100% of the federal poverty level.<sup>28</sup>

The DRM program also extended eligibility for current Medicaid beneficiaries residing in New York City and Westchester County. These individuals were permitted to receive coverage for one year without the annual re-certification normally required by Medicaid law.<sup>29</sup>

---

<sup>26</sup> (...continued) regulations.

<sup>27</sup> Unlike program rules and regulations, program guidance is not legally binding. Rather, program guidance provides a framework for the process by which states may obtain approvals and the principles under which states may operate their programs. Program guidance contains authoritative interpretation and clarification of statutory and regulatory requirements. To date the Secretary only used guidance through public notices in the *Federal Register*, as well as technical guidance distributed to state health officials and HHS regional officers or posted on the CMS website to shape Section 1115 waiver policy.

<sup>28</sup> K. Haslanger, “Radical Simplification: Disaster Relief Medicaid in New York City,” *Health Affairs*, Jan./Feb. 2003.

<sup>29</sup> Centers for Medicare and Medicaid Services, Waiver approval letter to Dr. Antonia Novello, New York State Department of Health (Dec. 31, 2002). (Hereafter cited as “Waiver approval letter.”)

The Secretary of HHS announced tentative approval of the DRM program in a September 19, 2001 press release. Approval of the temporary modifications to New York's SCHIP program were provided via e-mail and through discussions with senior staff at CMS. On September 16, 2002, CMS articulated the agreement with New York in an award letter and terms and conditions. CMS awarded final approval for the DRM Section 1115 waiver on December 31, 2002. CMS decided not to apply its usual Medicaid cost neutrality requirements (described earlier) to the waiver because of the unusual circumstances of September 11, 2001. However, the SCHIP allotment neutrality requirements did apply.<sup>30</sup>

As a result of the September 11 attacks, the state Medicaid agency was left without a way to process Medicaid eligibility records in New York City. The presumptive eligibility process established by the DRM program was intended to facilitate enrollment of new applicants into Medicaid. New applicants were required to fill out a one-page application for the program, prove who they were, and attest to their income and resources. Individuals did not have to be direct victims of the World Trade Center attacks to receive services. The DRM program was the only Medicaid program available to New York City Medicaid applicants between September 2001 and January 2002.<sup>31</sup>

Individuals who qualified for the DRM program received a temporary Medicaid authorization form that allowed them to access Medicaid services. Services provided under the DRM program included all fee-for-service benefits except residential long-term care such as nursing facilities.

Though the waiver was scheduled to provide only four months of coverage, it actually ran from September 2001 through January 2003. The extended time frame allowed the state to schedule eligibility redetermination for individuals enrolled in the DRM program.

An estimated 342,000 beneficiaries enrolled in the DRM program, and funding for the DRM waiver was estimated at \$670 million over the waiver period.<sup>32</sup> Generally, New York receives federal reimbursement for 50% of its Medicaid service expenditures. New York requested that FEMA cover the non-federal share of Medicaid expenditures for the DRM program through the agency's public assistance funds; however, FEMA denied that request. The request is currently under appeal in FEMA.<sup>33</sup>

**Section 1135 Waiver Authority.** The Section 1135 waiver authority is a second mechanism currently available to allow the Secretary of HHS to make immediate program changes in response to an emergency situation; however, the authority is limited to geographic areas directly impacted by the emergency. Created under the Public Health Security and Bioterrorism Preparedness and Response Act

---

<sup>30</sup> Waiver approval letter.

<sup>31</sup> *Olson v. Wing*, U.S. District Court for the Eastern District of New York (Feb. 14, 2003).

<sup>32</sup> Personal communication with Betty White, NY Department of Health.

<sup>33</sup> Personal communication with Emil Slane, NY Division of the Budget.

(P.L. 107-188), Section 1135 of the Social Security Act authorizes the Secretary to temporarily waive federal conditions of participation and other certification requirements for any entity that furnishes health care items or services to Medicare, Medicaid, or SCHIP recipients in an emergency area (defined as a geographical area in which there exists an emergency or disaster declared by the President *and* a public health emergency declared by the Secretary of HHS). During such an emergency, it authorizes the Secretary to waive:

- participation, state licensing (as long as equivalent licensure from another state is held and there is no exclusion from practicing in that state or any state in the emergency area), and pre-approval requirements for physicians and other practitioners;
- sanctions for failing to meet requirements for emergency transfers between hospitals;
- sanctions for physician self-referral; and
- limitations on payments for health care and services furnished to individuals enrolled in Medicare Advantage (MA) plans when services are provided outside the plan.

In addition, P.L. 107-188 requires the Secretary to provide Congress with certification and written notice at least two days prior to exercising this waiver authority. It provides for the waiver authority to continue for 60 days, and permits the Secretary to extend the waiver period. Finally, the law requires the Secretary, within one year after the end of the emergency, to provide Congress with an evaluation of this approach and recommendations for improvements under this waiver authority.

## **Current Waiver Activity Related to Hurricane Katrina**

To date, the Secretary of HHS has announced his intent to exercise both the Section 1115 waiver authority and the Section 1135 waiver authority to make needed changes to health care programs so they are better able to accommodate the emergency health care needs of Hurricane Katrina survivors. At this point, few details are available regarding the specifics of each of these waiver actions, or how the policies under each will work together to better meet the needs of beneficiaries. Below is a brief description of the information that is currently available.

**Emergency Action Under Section 1115.** On September 9, 2005, CMS announced emergency policies they have adopted to address the health care needs of Hurricane Katrina survivors.<sup>34</sup> Specifically, President Bush announced that “special evacuee status” will be granted to individuals impacted by Hurricane Katrina. Under this special eligibility status, evacuees will be allowed to apply for several federal programs, including Medicaid and SCHIP, without having to verify their income or employment status.

---

<sup>34</sup> Centers for Medicare and Medicaid Services, *CMS Takes Emergency Steps to Ease Health Care Access to Katrina Evacuees* (Sept. 9, 2005), available at [<http://www.cms.hhs.gov/media/press/release.asp?Counter=1551>].

CMS also announced that it is working with affected states to develop an emergency Section 1115 demonstration program to provide temporary eligibility for all groups. According to the HHS press release, host states will adopt an expedited enrollment process to enroll newly eligible evacuees in existing Medicaid and SCHIP programs in the host state, and to provide temporary eligibility to current beneficiaries in their new host states. The CMS press release also says that host states will be allowed to submit their estimated expenditures for their temporary Section 1115 waiver programs to CMS for federal payments. Details regarding the specifics of the eligibility criteria or financing arrangements under these emergency waiver programs are not available.

**Section 1135 Waivers.** The Secretary of HHS invoked the Section 1135 waiver authority on each of September 1, September 4, and September 7, 2005, to waive certain requirements and program regulations under Titles XVIII, XIX, and XXI of the Social Security Act to accommodate the emergency health care needs of recipients and medical providers in the Hurricane Katrina impacted states. **Table 1** shows states that are covered under the Section 1135 waivers authorized by the Secretary of HHS as a result of meeting the following requirements: (1) the President has declared them to be major disaster or emergency areas pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act; *and* (2) the Secretary of HHS has declared them to have public health emergencies pursuant to Section 319 of the Public Health Service Act.<sup>35</sup>

**Table 1. States Covered Under Section 1135 Waivers  
Authorized in Response to Hurricane Katrina**

State	Effective date
States identified in the September 1, 2005 announcement	
Florida	8/24/05
Alabama	8/29/05
Louisiana	8/29/05
Mississippi	8/29/05
States identified in the September 4, 2005 announcement	
Texas	9/2/05
States identified in the September 7, 2005 announcement	
Arkansas	8/29/05
Colorado	8/29/05
Georgia	8/29/05
North Carolina	8/29/05

<sup>35</sup> For information on the Stafford Act, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by Keith Bea. For general information on the Public Health Services Act, see CRS Report RL31719, *An Overview of the U.S. Public Health System in the Context of Emergency Preparedness*, by Sarah A. Lister.

State	Effective date
Oklahoma	8/29/05
Tennessee	8/29/05
West Virginia	8/29/05
Utah	8/29/05

**Source:** U.S. Department of Health and Human Services, *Waiver Under Section 1135 of the Social Security Act* (Sept. 1, 2005), available at [<http://www.cms.hhs.gov/katrina/1135ssa.pdf>]; *Waiver Under Section 1135 of the Social Security Act* (Sept. 4, 2005), available at [<http://www.hhs.gov/katrina/ssawaiver.html>]; *Waiver Under Section 1135 of the Social Security Act* (Sept. 7, 2005), available at [<http://www.hhs.gov/emergency/determination2.html>].

In each of the above listed states, the following program operating rules will be loosened under the Section 1135 waiver authority to speed the provision of health care services for individuals enrolled in the Medicare, Medicaid and SCHIP programs, and to ensure that health care providers may be reimbursed for items and services rendered to program recipients:<sup>36</sup>

- Certain conditions of participation, certification requirements, program participation or similar requirements, or pre-approval requirements for individual health care providers or types of health care providers, including as applicable, a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.
- The requirement that physicians and other health care professionals hold licenses in the state in which they provide services, if they have a license from another state (and are not affirmatively barred from practice in that state or any state in the emergency area).
- Sanctions under Section 1867 of the Act (the Emergency Medical Treatment and Labor Act, or EMTALA) for the redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances.
- Limitations on payments under Section 1851(i) of the Act to permit Medicare Advantage enrollees to use out-of-network providers in an emergency situation.
- Sanctions and penalties arising from noncompliance with the following provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations: (a) the

---

<sup>36</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Waiver Under Section 1135 of the Social Security Act* (Sept. 1, 2005), available at [<http://www.cms.hhs.gov/katrina/1135ssa.pdf>]. Similar waivers covering additional states were authorized on Sept. 4 and Sept 7, available at [<http://www.hhs.gov/katrina/ssawaiver.html>] and [<http://www.hhs.gov/emergency/determination2.html>].

requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory (as set forth in 45 CFR 164.510); (b) the requirement to distribute a notice of privacy practices (as set forth in 45 CFR 164.520); or (c) the patient's right to request privacy restrictions or confidential communications (as set forth in 45 CFR 164.522).

CMS offered some additional information on the operating procedures being relaxed in a fact sheet released on September 6,<sup>37</sup> but it is still unclear what role the Section 1135 waiver authority plays in the context of a program like Medicaid whose day-to-day operations are controlled by the states — especially with regard to payment for services. For example, although CMS has stated that crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid, the agency does not specify *how* they will be paid and whether states, who normally pay providers directly for services rendered to Medicaid beneficiaries and then seek federal reimbursement, *must* pay providers in this situation.

## Current Federal Legislation

Several proposals have been introduced in 109<sup>th</sup> Congress that would affect Medicaid coverage for survivors of Hurricane Katrina. These proposals assist those states directly impacted by Hurricane Katrina and those states that have taken in Medicaid recipients who have been displaced as a result of Hurricane Katrina.

### House Proposals.

#### H.R. 3671 (Green)

This proposal would authorize the Secretary of HHS to provide 100% of the federal medical assistance percentage (FMAP) for displaced Medicaid recipients receiving medical assistance outside their state of residence due to a declared public health emergency.

#### H.R. 3698 (Dingell)

This proposal would allow states to receive 100% federal funding for the Medicaid expenditures for individuals who are Katrina survivors (as described by the proposal) and for any individual who is in a directly impacted state (i.e., Alabama, Louisiana, and Mississippi). States may also receive 100% federal funding for administrative costs related to covering Katrina survivors. States that choose to cover Katrina survivors would *not* be allowed to establish income or asset tests or state residency or other categorical requirements. States must also use a simplified application process that would allow individuals to attest that they qualify as a

---

<sup>37</sup> Centers for Medicare and Medicaid Services, *CMS ACTIONS TO HELP BENEFICIARIES, PROVIDERS IN KATRINA STRICKEN AREAS* (Sept. 6, 2005), available at [<http://www.cms.hhs.gov/media/press/release.asp?Counter=1546>].

Katrina survivor (individuals would be penalized for knowingly falsely attesting to their status as a survivor). This provision would remain in effect during the disaster relief period from August 29, 2005, through September 30, 2006.

In addition, the proposal would hold *all* states harmless for any scheduled reduction in a state's FMAP rate for FY2006. If a state's FMAP rate for FY2006 is less than it was for FY2005, the FY2005 FMAP rate shall apply.

The proposal would also affect the scheduled changes to Medicaid related to the Medicare prescription drug benefit, effective January 1, 2006. First, the proposal would suspend until January 2007, the requirement for certain states to pay the federal government a portion of what the Medicaid program would have spent on prescription drugs for those dually eligible for Medicaid and Medicare. This provision would only apply to states directly impacted by Hurricane Katrina and those states that have received a "significant influx" of Katrina survivors. The provision would also change federal law to allow state Medicaid programs to pay for prescription drugs for a Part D eligible individual who is also a Katrina survivor. These changes related to the Medicare prescription drug benefit can be ended if the Secretary determines (after consulting with the state) that individuals can be effectively transferred to Medicare for their prescription drug coverage without discontinuing an individual's drug coverage.

#### **H.R. 3708 (Johnson)**

This proposal would require HHS to dedicate 10% of any Hurricane Katrina disaster relief funds for mental health services to victims and first responders. These funds would also be available to cover the state share of Medicaid or SCHIP costs for victims of, or first responders to, Hurricane Katrina.

#### **H.R. 3735 (Davis)**

This proposal would prevent a reduction in a state's FMAP rate for FY2006. No state shall receive a lower FMAP for FY2006 than the greater of the FY2005 FMAP rate, or the computation of the FMAP formula without the retroactive application of re-benchmarked per capita income.

### **Senate Proposals.**

#### **S. 1637 (Reid)**

Similar to H.R. 3698, except that the disaster relief period is from August 29, 2005, through February 28, 2006 (though the President must extend through September 30, 2006, unless a determination is made that all Katrina survivors have sufficient access to health care).

#### **S.A. 1652 to H.R. 2862 (Lincoln)**

Similar to S. 1637.

**S.A. 1672 to H.R. 2862 (Durbin)**

This proposal allows certain health professionals to provide Medicaid services in Florida, Alabama, Louisiana, Mississippi and Texas without regard to state licensing and certification laws for 90 days following enactment of the provision.

**S. 1688 (Hutchison)**

This proposal would allow any state to receive 100% federal funding for Medicaid and SCHIP expenditures for individuals (children in the case of SCHIP) who are Katrina survivors (as described by the proposal) during the disaster period in the area of the survivor's residence (or former residence).

The disaster period for a state is determined by the date an area(s) in the state were declared a major disaster area in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act because of Hurricane Katrina. The disaster period ends on the earlier of: (1) the latest date an area of that state is designated as a major disaster area; or (2) six months following the declaration of the disaster area. The President may extend the disaster period for a state for up to an additional six months.

States that choose to cover Katrina survivors would not be allowed to establish income or asset tests or state residency or other categorical requirements. States must also use a simplified application process that would allow individuals to attest that they qualify as a Katrina survivor (individuals would be penalized for knowingly falsely attesting to their status as a survivor).

Katrina survivors would be eligible for the same range and scope of services as those who are categorically needy under the Medicaid program, or as a targeted low-income child under the SCHIP program. In addition, the state must pay for medical services (including mental health services) that are outside the scope of the state's Medicaid coverage if the item or service is medically necessary for the survivor.