THE HENRY J. KAISER FAMILY FOUNDATION

DIANE ROWLAND, Sc.D
EXECUTIVE VICE PRESIDENT

The Honorable Gene Green
US House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, DC 20515

April 13, 2007

Dear Representative Green,

I am pleased to provide you with written responses to your questions following the Subcommittee on Oversight and Investigation's March 13, 2007 hearing entitled "Post-Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Area." Thank you for your continued interest in the health needs of the New Orleans area.

Sincerely,

Diane Rowland

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Executive Director, Kaiser Commission on Medicaid and the Uninsured

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Question: *Your testimony referred to the Disaster Relief Medicaid Program for New York after the tragedy of September 11, 2001, and how a different approach—the waiver process—was utilized to address Medicaid issues as a result of Hurricane Katrina. There is no question that the federal response was more effective in New York, so I would like to explore why CMS did not build on that experience to respond more effectively to Katrina.*

In your opinion, what factors contributed to the use of a waiver approach, and did you sense a lack of political will to respond in a manner similar to the response after the attacks of September 11, 2001?

Additionally, what legislative changes would you suggest we make to ensure that the Medicaid program can effectively respond to a disaster and provide real help to Americans during a public health emergency?

Answer: On September 19th, 2001, eight days after the terrorist attacks, New York Governor George Pataki announced a program called Disaster Relief Medicaid. The state had received federal approval to implement a program to address the challenges Medicaid administrators faced as they attempted to operate with computer systems rendered defunct in the wake of the attacks. The program also addressed the health needs of New York residents by providing temporary Medicaid coverage beyond the scope of coverage available prior to September 11th. In the four months between the terrorist attacks and the end of January 2002, when New York's Disaster Relief Medicaid closed to new enrollees, over 350,000 New Yorkers signed up for the program.[1]

Included in New York's Disaster Relief Medicaid were administrative simplifications that made it easier for New Yorkers to apply for coverage and expanded eligibility levels for Medicaid, particularly for adults. The state shifted from an eight-page Medicaid application to a single page and dramatically reduced the amount of documentation applicants were required to present. Eligibility interviews lasted about fifteen minutes and determinations were made on the spot, reflecting a change in procedure that appealed to low-income residents who could leave the interview with an assurance of immediate coverage.[2] The state also increased eligibility levels for adults in New York City that had been approved but not put into operation as part of the state's Family Health Plus waiver in 1999, and it administratively implemented a New York

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[1] K. Haslanger, "Radical Simplification: Disaster Relief Medicaid in New York City," *Health Affairs* 22(1):252-8, January/February 2003.

[2] M. Perry, "New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People," Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund, pub number 4062, August 2002.

Court of Appeals decision that required Medicaid to enroll all legal immigrants in the state, regardless of whether they arrived before or after 1996.

The state and federal government quickly partnered to implement New York's Disaster Relief Medicaid, putting in place within weeks a solution for those still grappling with the health and emotional aftershocks of the terrorist attacks. Simplified documentation requirements and application materials as well as expanded eligibility enabled more individuals to apply for and enroll in public coverage. An extensive outreach campaign, aided by private philanthropy and fed by the positive experiences applicants had with New York's Disaster Relief Medicaid, helped link vulnerable residents with health coverage and services.

In their September 2006 article in the *Journal of the American Medical Association*, Jeanne Lambrew and Donna Shalala reflect upon the federal health policy response to Hurricane Katrina and provide suggestions to improve the federal response to future disasters.[3] To mitigate against future harmful delays in the federal health response to disasters, Lambrew and Shalala recommend that Congress consider enacting a permanent emergency Medicaid authority that could build upon the program's existing eligibility and payment systems to address health coverage needs after disasters. Fully-funded, temporary expansions to broad or targeted groups could be triggered by legislative criteria or an executive agency designation. Lambrew and Shalala also point out that Congress and the Executive Branch can employ budget policy to appropriate funds for public health programs, such as through the Public Health and Social Services Emergency Fund. A reserve for use in disasters could be retained in this fund, which would revert to the Treasury if unspent.

In the face of the massive destruction to the Gulf Coast, and especially the New Orleans region, in the aftermath of Katrina there was no ready mechanism to extend coverage to the displaced, uninsured population and assist the providers trying to meet their health needs. Having emergency authority to extend Medicaid coverage and provide full federal financing in disasters from a disaster reserve fund would provide an important safety net for the needy in times of crisis.

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[3] J. Lambrew and D. Shalala, "Federal Health Policy Response to Hurricane Katrina: What It Was and What It Could Have Been," *JAMA* 2006;296:1394-7.

Question: *The witnesses on the hearing's second panel shared different views about the effect of CMS' proposed rule on Medicaid financing and limitations to cost. Given that the public hospital infrastructure has been crippled due to Hurricane Katrina and the private hospitals have taken on the bulk of uncompensated care, can you address the likely effect of this proposed rule on New Orleans' ability to shoulder uncompensated care costs?*

Answer: This question seems to arise from Gary Muller's testimony stating: "as we understand the proposed rule, CMS will require states to direct federal funds back to governmentally operated healthcare providers. This certainly seems to be aligned with how the federal government intended these funds to be used in the first place. For WJMC, we believe this will result in equitable distribution of funds to our hospital."

It seems that there is a misunderstanding about how the regulation would affect hospitals and providers and some confusion with this regulation and the way the state currently distributes Medicaid disproportionate share hospital payments (DSH). DSH is the primary mechanism used to support uncompensated care in Louisiana and the majority of Medicaid DSH funds are now targeted to the Charity Hospitals. This rule does not impact or affect the distribution of DSH payments.

The proposed rule would place new restrictions on reimbursement for government providers and limit the definition of a public hospital which restricts a states' ability to use intergovernmental transfers and certified public expenditures to fund their programs.

The American Hospital Association, the National Association of Public Hospitals and the American Health Lawyers Association have all submitted comments to CMS to request that the rule not be implemented or significantly changed because of the impact of the regulations on safety-net providers and on how states fund their Medicaid programs.

Ultimately, these changes could leave states with less funding available for safety-net providers which could further hinder efforts to support uncompensated care. Because Louisiana has in the past relied on intergovernmental financing arrangements to fund the charity system more heavily than other states, the proposed rule could have a larger impact on safety-net financing in Louisiana compared to other states. If the rule is implemented, it could also limit the state's

ability to use similar financing arrangement with other public providers in considering options to restructure the health care delivery system.

For more specific comments about the regulation see the following:

http://www.aha.org/aha/letter/2007/070315-cl-cms2258p.pdf
http://www.naph.org/naph/advocacy/NAPHCommentLetter.pdf
http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/AHLA_medicaid_IGT_030907.pdf