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Report to Congressional Committees

February 2007

HURRICANE KATRINA

Allocation and Use of $2 Billion for Medicaid and Other Health Care Needs

GAO-07-67

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-07-67, a report to congressional committees

Why GAO Did This Study

In February 2006, the Deficit Reduction Act of 2005 (DRA) appropriated $2 billion for certain health care costs related to Hurricane Katrina through Medicaid and the State Children's Health Insurance Program (SCHIP). The Centers for Medicare & Medicaid Services (CMS) was charged with allocating the $2 billion in funding to states directly affected by the hurricane or that hosted evacuees.

GAO performed this work under the Comptroller General's statutory authority to conduct evaluations on his own initiative. In this report, GAO examined: (1) how CMS allocated the DRA funds to states, (2) the extent to which states have used DRA funds, and (3) whether selected states—Alabama, Louisiana, Mississippi, and Texas—anticipate the need for additional funds after DRA funds are expended. To conduct this review, GAO reviewed CMS's allocations of DRA funds to all eligible states, focusing in particular on the four selected states that had the highest initial allocation (released by CMS on March 29, 2006). GAO obtained data from Medicaid offices in the four selected states regarding their experiences enrolling individuals, providing services, and submitting claims; collected state Medicaid enrollment data; and analyzed DRA expenditure data that states submitted to CMS.

www.gao.gov/cgi-bin/getrpt?GAO-07-67.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen (202) 512-7118 or allenk@gao.gov.

What GAO Found

As of September 30, 2006, CMS allocated $1.9 billion of the $2 billion in DRA funding to states. CMS allocated funds to: Category I—the nonfederal share of expenditures for time-limited Medicaid and SCHIP services for eligible individuals affected by the hurricane (32 states); Category II—expenditures for time-limited uncompensated care services for individuals without a method of payment or insurance (8 of the 32 states); and Category III—the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries (Alabama, Louisiana, and Mississippi). CMS did not allocate funds to Category IV—for restoration of access to health care. After CMS reconciles states' expenditures with allocations, it will determine how to allocate the unallocated $136 million and unexpended funds from the $1.9 billion allocated to states.

Allocation of DRA Funds to States, as of September 30, 2006

	DRA allocations (in thousands)[a]				
State	**Category I**	**Category II**	**Category III**	**Total**	**Percentage**
Alabama	$2,377	$4,660	$241,144	$248,181	13.3
Louisiana	24	132,091	699,529	831,644	44.6
Mississippi	1,816	75,265	518,483	595,563	32.0
Texas	76,872	65,336	[b]	142,208	7.6
Subtotal	81,088	277,352	1,459,155	1,817,596	97.5
Remaining states	21,315	25,002	[b]	46,317	2.5
Total	**$102,404**	**$302,354**	**$1,459,155**	**$1,863,913**	**100.0**

Source: GAO analysis of CMS data.

Note: This table accounts for the DRA funds allocated to states as of September 30, 2006.

[a]CMS did not allocate funds to Category IV, restoring access to health care.

[b]Texas and the remaining states were not eligible for funding from this category.

Of the $1.9 billion in allocated DRA funds, almost two-thirds of the 32 states that received these funds submitted claims totaling about $1 billion as of October 2, 2006. Claims from Alabama, Louisiana, and Mississippi for Category III accounted for about 85 percent of all claims filed. These initial results are likely to change as states continue to file claims for services.

Of the four selected states, Louisiana and Texas raised concerns about their ability to meet future health care needs once the DRA funds are expended. Louisiana's concerns involved managing its Medicaid program across state borders as those who left the state remain eligible for the program. Texas was significantly affected by the number of evacuees seeking services, thus raising concerns among state officials about the state's future funding needs.

CMS, Alabama, Louisiana, and Texas commented on a draft of this report. CMS suggested the report clarify the DRA funding categories, reallocation process, and communication strategy with states, especially Louisiana. Louisiana and Texas commented on their ongoing challenges, and Alabama provided technical comments. The report was revised as appropriate.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FPL	Federal Poverty Level
HHS	Health and Human Services
MBES	Medicaid Budget and Expenditure System
SCHIP	State Children's Health Insurance Program
SSA	Social Security Act
SSI	Supplemental Security Income

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United States Government Accountability Office
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Congressional Committees

Hurricane Katrina, which made landfall along the Gulf coast of Louisiana and Mississippi on August 29, 2005, was one of the largest natural disasters in our nation's history, disrupting the lives of hundreds of thousands of individuals who suddenly lacked housing and access to basic health care services. The states most directly affected by the hurricane—Alabama, Louisiana, and Mississippi[1]—were among the poorest areas in the United States, even before Hurricane Katrina hit. Compared to the rest of the United States, higher proportions of the nonelderly populations in these directly affected states were enrolled in Medicaid, a program jointly financed by the federal government and states to provide health care coverage to certain categories of low-income individuals. The devastation caused by Hurricane Katrina compounded the health care needs of these communities, increasing the numbers of eligible beneficiaries for Medicaid and adding large numbers of uninsured individuals. Additionally, individuals displaced from their homes and jobs evacuated their home states and moved to other states, such as Texas, which strained these states' health care resources.

During the first 3 weeks after the hurricane, the Centers for Medicare & Medicaid Services (CMS), which oversees the Medicaid program, announced that states could apply for demonstration projects—to be approved by CMS—through which the federal government would fund its share of expenditures for health care services for certain individuals affected by the hurricane.[2] CMS identified two categories of services covered under these demonstration projects, both of which were subject to time limitations. The first category allowed individuals affected by the hurricane and eligible under an approved demonstration project to receive benefits under Medicaid or the State Children's Health Insurance Program

[1]Throughout this report, we refer to these three states—Alabama, Louisiana, and Mississippi—as the "directly affected" states.

[2]Under section 1115 of the Social Security Act (SSA), the Secretary of Health and Human Services (HHS) may waive certain Medicaid requirements and authorize certain Medicaid expenditures in order to demonstrate approaches that are likely to promote Medicaid program objectives. *See* SSA § 1115 (codified at 42 U.S.C. § 1315). HHS has delegated the administration of these demonstration projects to CMS.

(SCHIP) for up to 5 months.[3] The second category, known as uncompensated care, allowed states to reimburse providers rendering services from August 24, 2005, through January 31, 2006, to individuals affected by the hurricane who had no other method of payment or insurance.[4] In February 2006, the Deficit Reduction Act of 2005 (DRA) appropriated $2 billion to fund, among other purposes, these two categories of services under approved demonstration projects.[5] DRA further specified that the $2 billion could be used for two additional categories of expenditures that were not time-limited. With respect to the third category, funds were available for the nonfederal (state) share of expenditures for services provided to existing Medicaid and SCHIP beneficiaries from certain areas of the directly affected states.[6] Funds were also available for the fourth category of restoring access to health care in impacted communities.[7] DRA did not specify how the $2 billion in Hurricane Katrina relief funding would be allocated among the states; rather, CMS was responsible for determining these allocations.[8]

Because of broad congressional interest, we performed this work under the Comptroller General's statutory authority to conduct evaluations on his own initiative. This report presents results of our work examining:

[3]SCHIP is a federal-state program that provides health coverage, generally, for children living in families whose incomes exceed the eligibility limits for Medicaid. *See* SSA § 2107(e) (codified at 42 U.S.C. § 1397gg(e)) regarding the applicability of section 1115 of the SSA to the SCHIP program.

[4]For purposes of this report, the District of Columbia and insular areas (such as Puerto Rico) that were allocated or expended DRA funds will be included in our discussion of states.

[5]The Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6201, 120 Stat. 132-134 (Feb. 8, 2006). For purposes of this report, we refer to DRA funds available for the nonfederal share of expenditures associated with individuals affected by the hurricane receiving Medicaid or SCHIP benefits under an approved demonstration project as "Category I" and DRA funds available for the total expenditures associated with uncompensated care services provided to individuals affected by the hurricane who had no other method of payment or insurance as "Category II."

[6]For purposes of this report, we refer to DRA funds available for the nonfederal share of expenditures associated with services provided to existing Medicaid and SCHIP beneficiaries from certain areas of directly affected states as "Category III."

[7]For purposes of this report, we refer to DRA funds available for expenditures associated with restoring access to health care in impacted communities as "Category IV."

[8]Throughout this report, we refer to Hurricane Katrina relief funding provided through the DRA as DRA funding or DRA funds.

(1) how CMS allocated the DRA funds to states, (2) the extent to which states have used DRA funds, and (3) whether Alabama, Louisiana, Mississippi, and Texas anticipate the need for additional funds after DRA funds are expended.

To conduct this work, we obtained documentation from CMS on its allocation of DRA funds to states. We reviewed allocations for four categories, as outlined below.

- **Category I—time-limited Medicaid and SCHIP services**:[9] This category was for the nonfederal (state) share of expenditures associated with Medicaid and SCHIP services (including administrative costs) provided to individuals affected by Hurricane Katrina and eligible under an approved demonstration project.[10] Each state defined the populations eligible for its demonstration project for individuals affected by the hurricane. Funding is available through this category for services delivered through June 30, 2006.

- **Category II—time-limited uncompensated care services**:[11] This category contained funding for the total expenditures associated with services (including administrative costs) provided to individuals affected by Hurricane Katrina who did not have a method of payment or insurance.[12] Funding is available through this category for services delivered through January 31, 2006.

- **Category III—existing Medicaid and SCHIP beneficiaries**:[13] This category was designated to compensate states for the nonfederal (state) share of expenditures associated with services provided to existing Medicaid and SCHIP beneficiaries from certain areas of directly affected states. The DRA did not specify any time limits on funding for services

[9]DRA, Pub. L. No. 109-171, § 6201(a)(1)(A),(C), (a)(2), 120 Stat. 132-133.

[10]This category of DRA funding required CMS approval of a section 1115 demonstration project for Katrina-affected individuals.

[11]DRA, Pub. L. No. 109-171, § 6201(a)(1)(B),(D), (a)(2), 120 Stat. 132-133.

[12]This category of DRA funding required CMS approval of a section 1115 demonstration project for Katrina-affected individuals. In addition to individuals without a method of payment or insurance, it also included Medicaid and SCHIP-eligible individuals who did not have any coverage for certain services.

[13]DRA, Pub. L. No. 109-171, § 6201(a)(3), 120 Stat. 132-133.

delivered under this category. Funding is limited to the three directly affected states—Alabama, Louisiana, and Mississippi.

- **Category IV—restore access to health care in impacted communities**:[14] This category allowed for coverage of expenditures provided for other purposes, if approved by the Secretary of HHS, to restore access to health care in impacted communities. The DRA did not specify any time limits on funding under this category.

We focused our review on four selected states that, as of March 29, 2006, had received the highest allocations of DRA funding from CMS—Alabama, Louisiana, Mississippi, and Texas.[15] We selected March 29, 2006, because this was the date on which CMS made its initial allocation of DRA funds to states. We obtained data and information from Medicaid offices in these states regarding their experiences enrolling individuals, providing services, and submitting claims for services and administrative costs. We also collected Medicaid enrollment data from the four selected states through June 2006. In addition, we analyzed CMS data included in the Medicaid Budget and Expenditure System (MBES) on DRA funding for the states that received initial allocations as of March 29, 2006. Within the MBES, we examined data that states submitted for expenditures that qualified for DRA funding as of October 2, 2006. States submit all Medicaid data to MBES electronically and must attest to its completeness and accuracy. These data are preliminary in nature, in that they are subject to further review and are likely to be updated as states continue to submit claims for DRA funding. Nevertheless, we considered MBES data sufficiently reliable for purposes of conducting a preliminary assessment of claims submitted to date. We also contacted Medicaid officials in Arizona and Georgia to ascertain why they had not submitted claims for DRA funding. We chose Arizona and Georgia because they had not submitted claims data as of June 2006, but were the only two states that had logged into MBES and inserted placeholders for their claims data. We conducted our work from April 2006 to October 2006 in accordance with generally accepted government auditing standards.

[14]DRA, Pub. L. No. 109-171, § 6201(a)(4), 120 Stat. 132-133.

[15]Throughout this report, we refer to Alabama, Louisiana, Mississippi, and Texas as "selected states."

Results in Brief

As of September 30, 2006, CMS had allocated $1.9 billion of the $2 billion made available by DRA to states that were directly affected by Hurricane Katrina or that hosted evacuees in the aftermath of the storm. Based on states' estimates of their DRA expenditures, CMS allocated funds as follows:

- Category I—CMS allocated about $102 million to 32 states for the nonfederal share of expenditures for time-limited Medicaid and SCHIP services for individuals affected by the hurricane and eligible under an approved demonstration project.
- Category II—CMS allocated about $302 million to 8 states for expenditures for time-limited uncompensated care services provided to individuals affected by the hurricane who did not have a method of payment or insurance.
- Category III—CMS allocated approximately $1.5 billion to the 3 directly affected states (Alabama, Louisiana, and Mississippi) for the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries.
- Category IV—CMS chose not to allocate any DRA funding to this category—restoring access to health care in impacted communities—because, according to CMS, the agency viewed this category as discretionary in nature and not associated with direct services expenditures.

In allocating the $1.9 billion, CMS met 100 percent of the states' estimated expenditures in categories I, II, and III. After CMS reconciles states' expenditures with their allocations, CMS will determine how to allocate the remaining $136 million of available DRA funds and any unexpended funds from the approximately $1.9 billion in DRA funds previously allocated to states.

Of the $1.9 billion in DRA funding that CMS allocated, states had submitted claims for approximately $1 billion (54 percent) as of October 2, 2006. Approximately two-thirds of the 32 states that received DRA funding (including the 4 selected states—Alabama, Louisiana, Mississippi, and Texas), submitted claims. The amount of claims submitted for Category I, the nonfederal share of expenditures for time-limited Medicaid and SCHIP services, accounted for 20 percent of allocations; for Category II, expenditures for time-limited uncompensated care services, 42 percent; and for Category III, the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries, 58 percent.

Claims from Alabama, Louisiana, and Mississippi for the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries (Category III) accounted for about 85 percent of claims filed for all categories of funding. States are permitted up to 2 years after paying claims to seek reimbursement from CMS. According to state officials, they have not submitted claims to CMS in some instances because of problems processing providers' claims. For example, in Mississippi, uncompensated care claims had to be processed manually because the state did not have a computerized system to accommodate such claims. Although expenditures varied by state, typically claims were concentrated in nursing facility services, inpatient hospital care, and prescription drugs.

Of the four selected states, two states—Louisiana and Texas—raised concerns about their ability to meet future health care needs of those affected by the hurricane once the DRA funds are expended.

- Louisiana, a directly affected state that is therefore eligible for DRA funding for services provided beyond June 30, 2006, raised concerns that it would need additional funds to provide coverage for individuals affected by the hurricane who evacuated the state but intend to return. State officials noted that Louisiana is currently managing what they characterized as a national Medicaid program, given that many individuals enrolled in Louisiana Medicaid are temporarily residing in other states. Additionally, the state has asked CMS for direction on issues such as managing out-of-state providers, redetermining eligibility, and ensuring program integrity given the state's concern that some providers may be receiving payment from more than one state for the same service.

- Texas, which is eligible only for the time-limited DRA funds from Categories I and II, expressed concern about its future funding needs in light of the many evacuees remaining in the state. To learn more about this population, the state commissioned a survey that indicated that evacuees responding to the survey continue to have a high need for services, including health care coverage under Medicaid and SCHIP. Because the state is not eligible for DRA funding for Medicaid services provided beyond June 30, 2006, officials expressed concern that these services are being provided through evacuees' use of emergency rooms in the state or through local county facilities, thus straining resources that provide care for all Texas residents.

The remaining two selected states—Alabama and Mississippi—while also eligible for ongoing DRA funding, stated that they did not anticipate a need for funding beyond that allocated by CMS.

We received comments on a draft of this report from CMS and state officials from Alabama, Louisiana, and Texas. In commenting, CMS provided additional information on an initiative aimed at assisting Louisiana to rebuild its health care system in the aftermath of Hurricane Katrina. In response to CMS's comment that we mischaracterized the categories of DRA funding, we provided additional legal citations to better link the statutory language of DRA with the categories of funding presented in the report. Additionally, CMS noted that our description of its process for allocating unexpended funds was misleading. While the draft report did include a thorough description of this process, we clarified this process in the Highlights and Results in Brief. CMS also discussed criticism it faced in communicating with the states, particularly Louisiana, regarding program implementation, coverage for out-of-state evacuees, and other issues. In its comments, CMS identified the steps it took to work with states with approved demonstration projects. While CMS may have provided such assistance, from Louisiana's perspective, it was not sufficient to address the many issues the state is facing. Louisiana and Texas primarily provided comments about their efforts to assist those affected by the hurricane and ongoing challenges as a result of Hurricane Katrina. Alabama provided technical comments which we incorporated as appropriate, while Mississippi did not provide comments.

Background

Medicaid and SCHIP are joint federal-state programs that finance health care coverage for certain categories of low-income individuals. To qualify for Medicaid or SCHIP, individuals must meet specific eligibility requirements related to their income, assets, and other personal characteristics such as age. Each state operates its program under a CMS-approved state plan.

Almost immediately after Hurricane Katrina, CMS announced in a State Medicaid Director's letter on September 16, 2005, that states could apply for Medicaid demonstration projects authorized under section 1115 of the SSA, through which the federal government would fund its share of expenditures for health care services for certain individuals affected by the hurricane.[16] These demonstration projects provided for (1) time-limited Medicaid and SCHIP services to allow states to quickly enroll eligible

[16]See SSA § 1115 (codified at 42 U.S.C. § 1315). Throughout this report, we refer to the section 1115 demonstrations that were approved after Hurricane Katrina with the intent of providing services to individuals affected by the hurricane as "demonstration projects," or "demonstrations."

individuals who were affected by the hurricane, and (2) time-limited uncompensated care services—allowing states to pay providers rendering services for individuals affected by the hurricane who do not have an alternative method of payment or insurance. Interested states could apply to CMS to offer demonstration projects for either or both categories, and those receiving CMS approval were permitted to seek reimbursement for the federal share of allowable expenditures for covered beneficiaries under the demonstrations. To assist states in applying for these demonstration projects, CMS convened a conference call with all state Medicaid agencies to brief them on the agency's September 16, 2005, letter, discuss the application process, and provide information on other implementation issues, such as benefits for evacuees and relevant federal regulations regarding Medicaid eligibility.

For time-limited Medicaid and SCHIP services under the demonstrations, states received approval to provide Medicaid and SCHIP coverage to certain evacuees and affected individuals.[17] In establishing eligibility for this type of demonstration, states primarily used simplified eligibility criteria that CMS developed to determine if affected individuals and evacuees could enroll to receive time-limited Medicaid and SCHIP services (see table 1).

[17]Affected individuals and evacuees were individuals from certain counties or parishes of directly affected states that were declared disaster areas eligible for individual assistance under section 408 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (codified at 42 U.S.C. § 5174). Affected individuals continued to reside in the same state, while evacuees relocated to another state after the hurricane.

Table 1: CMS's Simplified Eligibility Groups for Demonstration Projects for Time-Limited Medicaid and SCHIP Services

Simplified eligibility groups	Income levels
Children under age 19	Up to and including 200 percent of the Federal Poverty Level (FPL)[a]
Pregnant women from Louisiana and Mississippi	Up to and including 185 percent FPL
Pregnant women from Alabama	Up to and including 133 percent FPL
Individuals with disabilities	Up to and including 300 percent Supplemental Security Income (SSI)[b]
Low-income Medicare recipients	Up to and including 100 percent FPL
Low-income individuals in need of long-term care	Up to and including 300 percent SSI
Low-income parents of children under age 19	Up to and including 100 percent FPL

Source: CMS.

Note: CMS approved these demonstration projects under section 1115 of the SSA.

[a]In fiscal year 2005, the Federal Poverty Level for a family of four was $19,350 in the 48 contiguous United States and the District of Columbia. Federal poverty levels are not defined for Puerto Rico and other insular areas.

[b]SSI is a means-tested income assistance program for disabled, blind, or aged individuals.

States with approved demonstrations for time-limited uncompensated care services could pay providers who delivered services to affected individuals and evacuees who either did not have any other coverage for health care services (such as private or public health insurance), or who had Medicaid or SCHIP coverage but required services beyond those covered under either program.

On February 8, 2006, the DRA appropriated $2 billion to be available until expended for four funding categories—two categories associated with the demonstration projects, and two additional categories of funding.[18] DRA applied time limits on the first two categories that were linked to the demonstration projects—that is, services must have been provided by certain dates. The DRA did not specify time limits for the two remaining funding categories. (See table 2.)

[18]DRA, Pub. L. No. 109-171, § 6201, 120 Stat. 132-134.

Table 2: DRA Funding Characteristics and Categories

Funding characteristics	Category I[a,b] Time-limited Medicaid and SCHIP services	Category II[a,c] Time-limited uncompensated care services	Category III[d] Existing Medicaid and SCHIP beneficiaries	Category IV[e] Restore access to health care
Share of funding available	Nonfederal share of expenditures[f]	Total expenditures	Nonfederal share of expenditures[f]	Total expenditures
Designated purpose of funding	To reimburse eligible states for Medicaid and SCHIP services provided to individuals affected by the hurricane who meet certain criteria and were eligible under a demonstration project	To reimburse eligible states for services associated with caring for individuals affected by the hurricane with no other source of payment or insurance	To reimburse states for Medicaid and SCHIP expenditures for affected individuals in certain areas of directly affected states	To restore access to health care in impacted communities, when approved by the Secretary of Health and Human Services
Length of availability[g]	For services provided through June 30, 2006	For services provided through January 31, 2006	No time period specified	No time period specified
Limit on individual eligibility	Up to 5 months[h]	None specified	None specified	None specified
States eligible for funding	The three directly affected states and states that accepted evacuees;[i] states must have demonstrations approved by CMS	The three directly affected states and states that accepted evacuees;[i] states must have demonstrations approved by CMS	The three directly affected states[i]	None specified

Source: GAO analysis of DRA and CMS demonstration project provisions.

[a]Category I and Category II required CMS approval of a demonstration project under section 1115 of the SSA. In addition to service expenditures, associated administrative costs are also covered under these categories.

[b]DRA, Pub. L. No. 109-171, § 6201(a)(1)(A),(C), (a)(2), 120 Stat. 132-133.

[c]DRA, Pub. L. No. 109-171, § 6201(a)(1)(B),(D), (a)(2), 120 Stat. 132-133.

[d]DRA, Pub. L. No. 109-171, § 6201(a)(3), 120 Stat. 132-133.

[e]DRA, Pub. L. No. 109-171, § 6201(a)(4), 120 Stat. 132-133.

[f]DRA funding is available for the states' share of expenditures incurred under this category. The remaining share of funding would be obtained from the federal Medicaid program; thus, the states' expenditures in these categories would be $0 until DRA funds have been expended.

[g]Although the DRA was not enacted until February 8, 2006, CMS allowed funding to be retroactive to August 24, 2005.

[h]CMS required states to limit Medicaid and SCHIP eligibility to 5 months under their demonstration projects.

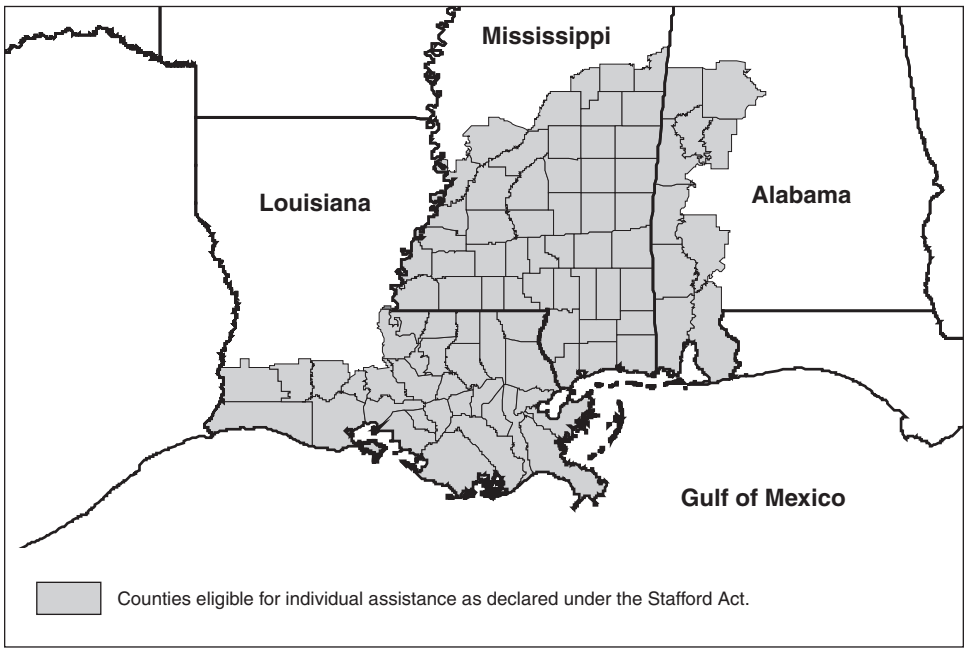
[i]The three directly affected states are Alabama, Louisiana, and Mississippi.

States could receive allocations from CMS based on certain criteria identified in the DRA, including whether they were directly affected by the hurricane or hosted evacuees. States directly affected by the hurricane—Alabama, Louisiana, and Mississippi—and states that hosted evacuees could receive DRA funding through Categories I and II, the nonfederal share of expenditures for time-limited Medicaid and SCHIP services and expenditures for time-limited uncompensated care services. In contrast, as specified by DRA, funds for Category III, the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries, were available only to certain areas in the directly affected states. These areas were counties or parishes designated under the Robert T. Stafford Disaster Relief and Emergency Assistance Act as areas eligible to receive federal disaster assistance.[19] According to a CMS official, shortly after Hurricane Katrina, 10 counties in Alabama, 31 parishes in Louisiana, and 47 counties in Mississippi were identified as eligible to receive such assistance and were declared individual assistance areas.[20] (See fig. 1.)

[19]Certain counties and parishes were declared disaster areas that are eligible for individual assistance under section 408 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (codified at 42 U.S.C. § 5174). The declaration allows for a variety of federal programs to assist in the disaster recovery effort, including housing for individuals and families. We refer to these areas as "designated areas of the directly affected states."

[20]In the aftermath of Hurricane Katrina, individuals were evacuated from individual assistance areas to other locations. Areas absorbing evacuees were within states directly affected by the hurricane or in other states entirely.

Figure 1: Affected Counties or Parishes in Louisiana, Mississippi, and Alabama



Source: GAO map using Federal Emergency Management Agency data provided by CMS.

Note: These three states were all considered directly affected by Hurricane Katrina.

States receive reimbursement for their expenditures in each of the funding categories through the submission of claims to CMS. To obtain reimbursement of claims for services, providers first submit claims to states for health care services provided to affected individuals and evacuees. States then submit claims to CMS for DRA-covered expenditures made for health care services provided to affected individuals and evacuees under each of the DRA funding categories. In addition, although the DRA was not enacted until February 8, 2006, CMS allowed funding to be retroactive to August 24, 2005.

CMS Allocated DRA Funds to Three Funding Categories

As of September 30, 2006, CMS had allocated approximately $1.9 billion of the total $2 billion in DRA funds to states that were directly affected by Hurricane Katrina or that hosted evacuees in the aftermath of the storm. CMS allocated funds to the first three categories: Category I—the nonfederal share of expenditures for time-limited Medicaid and SCHIP services; Category II—expenditures for time-limited uncompensated care services; and Category III—the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries from designated areas of the

directly affected states. CMS chose not to allocate any DRA funding to Category IV, for restoring access to health care in impacted communities. CMS allocated the majority of DRA funding (78.3 percent of the $1.9 billion allocated) to Category III, the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries, which, by law, was limited to the three directly affected states (Alabama, Louisiana, and Mississippi).[21] CMS allocated funds to states on two occasions—an initial allocation of $1.5 billion on March 29, 2006, and a subsequent allocation on September 30, 2006. Both of these allocations were based on states' estimates of their DRA expenditures. In the second allocation on September 30, 2006, no state received less funding than it received in the March 29, 2006, allocation, but allocations shifted among the DRA categories.

CMS Allocated $1.9 Billion of DRA Funds to Three DRA Categories

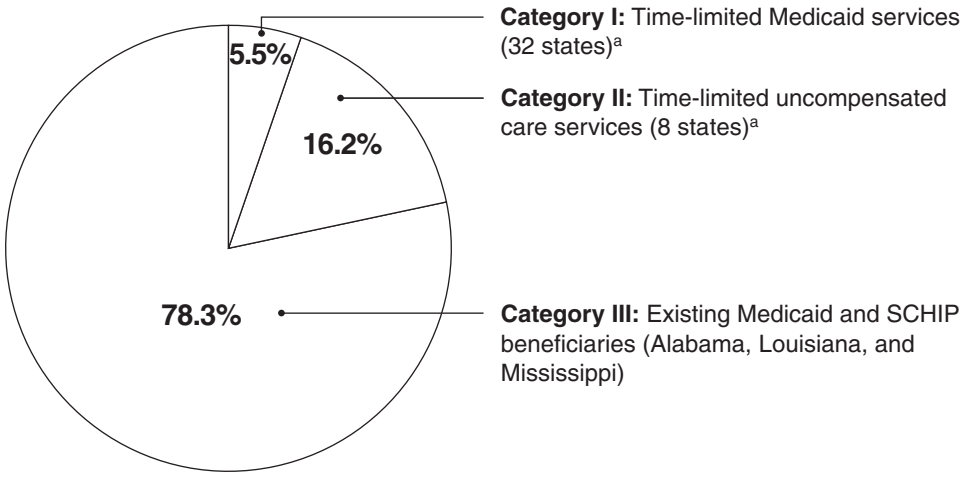
As of September 30, 2006, CMS had allocated approximately $1.9 billion of DRA funds to three DRA funding categories to 32 states. The majority of the $1.9 billion allocation—about $1.5 billion (78.3 percent)—is for Category III, existing Medicaid and SCHIP beneficiaries, which is limited to the three directly affected states (Alabama, Louisiana, and Mississippi). For Category I, time-limited Medicaid and SCHIP services, and Category II, time-limited uncompensated care services, states received about $102 million (5.5 percent of the total allocation) and about $302 million (16.2 percent of the total allocation), respectively. (See fig. 2.) With regard to Category I, 32 states received approval to extend time-limited Medicaid and SCHIP coverage to individuals affected by Hurricane Katrina; however, no states actually enrolled individuals in SCHIP. Therefore, only Medicaid services were covered through this DRA funding category.[22] Of these 32 states, 8 states also received approval for Category II to pay providers for rendering extend time-limited uncompensated care services to individuals affected by the hurricane. CMS officials stated that the

[21]DRA, Pub. L. No. 109-171, § 6201(a)(3), 120 Stat. 132-133.

[22]Because no states enrolled individuals into SCHIP, we refer to Category I as "time-limited Medicaid services" for the remainder of this report.

agency approved the majority of states' applications for demonstration projects within 45 days of the hurricane.[23]

Figure 2: Percentage of $1.9 Billion DRA Allocation by Funding Category, as of September 30, 2006



Source: GAO analysis of CMS data.

[a]Category I and Category II required CMS approval of a demonstration project under section 1115 of the SSA.

Of the 32 states that received allocations totaling $1.9 billion, Louisiana received the largest amount—44.6 percent (about $832 million) of the total allocation. Combined, the 3 directly affected states—Louisiana, Alabama, and Mississippi—received approximately 90 percent ($1.7 billion) of the $1.9 billion allocated to states. While not a directly affected state, Texas hosted a large number of evacuees and received about 7.6 percent ($142 million) of the allocation. These 4 selected states together received approximately 97.5 percent ($1.8 billion) of the $1.9 billion allocation. (See table 3.)

[23]Thirty-five states applied for the time-limited Medicaid and SCHIP category of the demonstrations, but 3 states were denied because they applied after the January 31, 2006, deadline. Although 17 states applied for the time-limited uncompensated care services category of the demonstration, 9 states were denied because of their low number of evacuees and because of their lack of proximity to the directly affected states.

Table 3: CMS's Allocation of DRA Funds to States Based on States' Estimated Expenditures, as of September 30, 2006

	DRA allocations					
State	**Category I Time-limited Medicaid services[a,b]**	**Category II Time-limited uncompensated care services[b]**	**Category III Existing Medicaid and SCHIP beneficiaries**	**Category IV Restore access to health care**	**Total allocation**	**Percentage of DRA allocation**
Alabama	$2,377,000	$4,660,000	$241,144,000	[c]	$248,181,000	13.3
Louisiana	23,811	132,091,048	699,528,807	[c]	831,643,666	44.6
Mississippi	1,815,572	75,264,730	518,482,628	[c]	595,562,930	32.0
Texas	76,872,000	65,336,000	[d]	[c]	142,208,000	7.6
Subtotal	81,088,383	277,351,778	1,459,155,435	0	1,817,595,596	97.5
Remaining states	21,315,202	25,002,000	[d]	[c]	46,317,202	2.5
Total	**$102,403,585**	**$302,353,778**	**$1,459,155,435**	[c]	**$1,863,912,798**	**100.0**

Source: GAO analysis of CMS data.

Note: This table accounts for the approximately $1.9 billion of DRA funds allocated to states as of September 30, 2006.

[a]While states applied for and received approval to extend time-limited SCHIP coverage to individuals affected by Hurricane Katrina, no states actually enrolled individuals in SCHIP.

[b]Category I and Category II required CMS approval of a demonstration project under section 1115 of the SSA. In addition to service expenditures, associated administrative costs are also included.

[c]CMS did not allocate funds to this category.

[d]State was not eligible for funding to this category.

CMS Provided Allocations to States on Two Occasions

CMS provided DRA allocations on two occasions, and both allocations were based on states' estimated DRA expenditures.[24] CMS first allocated $1.5 billion to 32 states on March 29, 2006. After the DRA was enacted in February 2006, CMS requested states' estimated fiscal year 2006 expenditures for three of the four DRA funding categories: Category I—the nonfederal share of expenditures for time-limited Medicaid services; Category II—expenditures for time-limited uncompensated care services; and Category III—for directly affected states, the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries. CMS did not

[24]When submitting estimates to CMS, states provided estimated expenditures by service, as well as any associated administrative costs for Categories I and II, time-limited Medicaid and uncompensated care services. For Category III, existing Medicaid and SCHIP beneficiaries, CMS did not ask states to provide a breakdown of service and administrative costs, but did request separate estimates for Medicaid and SCHIP.

request that the three directly affected states estimate expenditures for Category IV—restoring access to health care in impacted communities. CMS officials told us that they viewed restoring access to care as discretionary in nature and not associated with direct service expenditures. In the March 29, 2006, allocation, CMS fully funded 32 states' estimated expenditures for DRA funding for Categories I and II, and also provided the three directly affected states with allocations to approximately half of their estimated expenditures for Category III. Because allocations were based on states' estimates, CMS withheld $500 million of the $2 billion available for the initial allocation, anticipating that allocations would need to be realigned.

In July 2006, CMS requested updated estimates of DRA expenditures for fiscal year 2006 for the same three categories: the two time-limited categories for Medicaid and uncompensated care services (Categories I and II) and the existing Medicaid and SCHIP beneficiaries (Category III). On September 30, 2006, CMS allocated an additional amount of about $364 million to states, which, combined with the initial March 29, 2006, allocation of $1.5 billion, provided a total allocation of approximately $1.9 billion. This allocation was based on states' updated estimated expenditures for each of the three DRA categories for which CMS provided funding. For the second allocation, each of the three directly affected states received allocations of 100 percent of their updated estimated expenditures for all three funding categories.

While CMS did not decrease any state's allocation as a result of the July 2006 request for updated estimates, it did shift allocation amounts among DRA funding categories when necessary for the September 30, 2006, allocation. Therefore, each state received its allocation amount from March 29, 2006, plus any additional funding included in the updated estimated expenditures. As a result, some states that lowered their subsequent estimates received more than they requested. For example, Texas lowered its initial estimated expenditures from $142 million (its March 29, 2006, estimate) to approximately $36 million. CMS did not change Texas' allocation from the amount the state received on March 29, 2006; thus, Texas retained an allocation of $142 million.[25] Other states received more than they were initially allocated. For example, Alabama

[25]CMS did not decrease the amounts states received in the March 29, 2006, allocation (even if their updated estimated expenditures were less than the March 29, 2006, allocation), because when CMS fully funded states' increased estimated expenditures, the total allocation of $1.9 billion was still less than the $2 billion in DRA funds available.

requested about $181 million initially, but gave CMS an updated estimate of $248 million. CMS initially allocated Alabama approximately $97 million, but increased its allocation to $248 million on September 30, 2006. (See table 4.)

Table 4: Selected States' Initial and Updated Estimated Expenditures and CMS's Initial and Updated Allocations, as of September 30, 2006

	Initial		Updated	
State	States' estimated expenditures	March 29, 2006, allocation[a]	States' estimated expenditures[b]	September 30, 2006, allocation
Alabama	181,472,000	96,946,000	248,181,000	248,181,000
Louisiana	1,092,652,000	768,982,000	831,643,666	831,643,666
Mississippi	793,294,000	446,521,000	595,562,930	595,562,930
Texas	142,208,000	142,208,000	35,713,063	142,208,000
Total	**2,209,626,000**	**1,454,657,000**	**1,711,100,659**	**1,817,595,596**

Source: GAO analysis of CMS data.

[a]CMS's initial allocation on March 29, 2006, provided states with allocations of 100 percent of their estimated expenditures for Categories I and II. For Category III, which was available only to the directly affected states, Alabama, Louisiana, and Mississippi each received allocations of approximately half of their estimated expenditures. CMS did not allocate any funds to Category IV.

[b]Represents states' updated estimated DRA expenditures for fiscal year 2006 requested by CMS in July 2006.

As of September 30, 2006, $136 million in DRA funding remained available for allocation. CMS officials stated that, during the first quarter of fiscal year 2007, they plan to reconcile states' expenditures submitted to CMS with the allocation amounts provided to states on September 30, 2006. After this reconciliation is completed, CMS will determine how to allocate the remaining $136 million of available DRA funds and any unexpended funds of the approximately $1.9 billion previously allocated to states.

States Have Submitted Claims for About Half of Total DRA Allocations

As of October 2, 2006, states had submitted to CMS claims for services—including associated administrative costs—totaling about $1 billion (or 54 percent) of the $1.9 billion in DRA funds allocated to them. The amount of claims submitted and the number of states that submitted claims varied by DRA category. Of the 32 states that received allocations from CMS, 22 states have submitted claims, including the 3 directly affected states. Some state officials said they faced obstacles processing DRA-related claims. While DRA-related expenditures varied by state, claims were concentrated in nursing facilities, inpatient hospital care, and prescription drugs.

About Two-Thirds of Eligible States Have Submitted Claims for Reimbursement, Accounting for 54 Percent of Total Allocations

Of the 32 states that received DRA allocations, about two-thirds (22) had submitted claims for expenditures to CMS as of October 2, 2006. The submitted claims accounted for about 54 percent of CMS's $1.9 billion allocated to states. States that submitted claims for reimbursement did so for amounts that ranged from about 7 percent to approximately 96 percent of their allocations. (See table 5.) Each of the 4 selected states we reviewed—Alabama, Louisiana, Mississippi, and Texas—had submitted claims by this time.

Table 5: CMS Allocation of DRA funds and States' Claims Submitted for Reimbursement, by State, as of October 2, 2006

States	Total CMS allocation of DRA funds	States' DRA claims submitted	DRA claims submitted as percentage of state's allocation
Alabama	**$248,181,000**	**$127,161,817**	**51.2**
Arizona	713,000	445,219	62.4
Arkansas	5,370,000	661,954	12.3
Delaware	429,000	49,902	11.6
District of Columbia	80,541	72,305	89.8
Florida	2,871,000	1,788,666	62.3
Idaho	44,000	34,652	78.8
Indiana	368,332	208,314	56.6
Iowa	240,000	203,514	84.8
Louisiana	**831,643,666**	**434,790,616**	**52.3**
Maryland	701,000	326,317	46.6
Minnesota	383,581	291,759	76.1
Mississippi	**595,562,930**	**400,531,996**	**67.3**
Montana	25,000	22,002	88.0
Nevada	250,000	213,160	85.3
Ohio	404,000	301,275	74.6
South Carolina	1,212,000	408,696	33.7
Tennessee	7,528,467	487,675	6.5
Texas	**142,208,000**	**30,817,487**	**21.7**
Utah	275,000	233,935	85.1
Wisconsin	1,170,234	154,385	13.2
Wyoming	14,000	13,368	95.5
10 remaining states[a]	24,238,047	0	0.0
Totals	**$1,863,912,798**	**$999,219,014**	**53.6**

Source: GAO analysis of CMS and MBES data.

Note: This table includes the three DRA funding categories for which states received allocations: (I) time-limited Medicaid and SCHIP services, (II) time-limited uncompensated care services, and (III) existing Medicaid and SCHIP beneficiaries. The selected states—Alabama, Louisiana, Mississippi, and Texas—which received the highest allocations of DRA funding are presented in bold type.

[a]The remaining 10 states received allocations but had not submitted claims as of October 2, 2006. The remaining states are: California, Georgia, Massachusetts, North Carolina, North Dakota, Oregon, Pennsylvania, Puerto Rico, Rhode Island, and Virginia.

Of the claims submitted for the two time-limited funding categories, 22 of 32 states submitted claims for Medicaid services (Category I) and 6 of 8 states submitted claims for uncompensated care services (Category II). The claims submitted constituted approximately 20 percent of total allocations to Medicaid and about 42 percent of total allocations to uncompensated care services. Of the 4 selected states, 3 states—Alabama, Mississippi, and Texas—submitted claims for Medicaid services, while all 4 selected states submitted claims for uncompensated care services. (See table 6.)

Table 6: CMS Allocation of DRA Funds and States' Claims Submitted, by Time-limited Funding Categories, as of October 2, 2006

	Time-limited funding categories[a]					
	Category I: Medicaid services[b]			Category II: Uncompensated care services		
States	CMS allocation of DRA funds	DRA claims submitted	DRA claims submitted as a percentage of CMS allocation	CMS allocation of DRA funds	DRA claims submitted	DRA claims submitted as a percentage of CMS allocation
Alabama	**$2,377,000**	**$1,887,744**	**79.4**	**$4,660,000**	**$116,214**	**2.5**
Arizona	713,000	445,219	62.4	[c]	[c]	[c]
Arkansas	670,000	525,145	78.4	4,700,000	136,809	2.9
Delaware	429,000	49,902	11.6	[c]	[c]	[c]
District of Columbia	80,541	72,305	89.8	[c]	[c]	[c]
Florida	2,871,000	1,788,666	62.3	[c]	[c]	[c]
Idaho	44,000	34,652	78.8	[c]	[c]	[c]
Indiana	368,332	208,314	56.6	[c]	[c]	[c]
Iowa	240,000	203,514	84.8	[c]	[c]	[c]
Louisiana	**23,811**	**0**	**0.0**	**132,091,048**	**101,305,491**	**76.7**
Maryland	701,000	326,317	46.6	[c]	[c]	[c]
Minnesota	383,581	291,759	76.1	[c]	[c]	[c]
Mississippi	**1,815,572**	**1,270,965**	**70.0**	**75,264,730**	**6,940,321**	**9.2**
Montana	25,000	22,002	88.0	[c]	[c]	[c]
Nevada	250,000	213,160	85.3	[c]	[c]	[c]
Ohio	404,000	301,275	74.6	[c]	[c]	[c]
South Carolina	1,088,000	406,918	37.4	124,000	1,778	1.4
Tennessee	1,850,467	487,675	26.4	5,678,000	[d]	[d]
Texas	**76,872,000**	**11,690,643**	**15.2**	**65,336,000**	**19,126,844**	**29.3**
Utah	275,000	233,935	85.1	[c]	[c]	[c]
Wisconsin	1,170,234	154,385	13.2	[c]	[c]	[c]
Wyoming	14,000	13,368	95.5	[c]	[c]	[c]
Remaining states[d]	9,738,047	[d]	[d]	14,500,000	[d]	[d]
Totals	**$102,403,585**	**$20,627,863**	**20.1**	**$302,353,778**	**$127,627,457**	**42.2**

Source: GAO analysis of CMS and MBES data.

Note: The four selected states—Alabama, Louisiana, Mississippi, and Texas—which received the highest allocations of DRA funding are presented in bold type.

[a]Category I and Category II required CMS approval of a demonstration project under section 1115 of the SSA. In addition to service expenditures, associated administrative costs are also included.

[b]While states applied for and received approval to extend time-limited SCHIP coverage to individuals affected by Hurricane Katrina, no states actually enrolled individuals in SCHIP.

[c]State did not receive an allocation to Category II—time-limited uncompensated care funding.

[d]As of October 2, 2006, state(s) had not submitted claims.

[e]The remaining states that received allocations but had not submitted claims as of October 2, 2006, are: California, Georgia, Massachusetts, North Carolina, North Dakota, Oregon, Pennsylvania, Puerto Rico, Rhode Island, and Virginia.

Only the three directly affected states—Alabama, Louisiana, and Mississippi—were eligible to receive DRA funding for existing Medicaid and SCHIP beneficiaries (Category III). The claims submitted by the directly affected states constituted approximately 58 percent of total allocations to Category III. (See table 7.) In addition, claims from the three directly affected states for existing Medicaid and SCHIP beneficiaries accounted for about 85 percent of all DRA claims filed. While funds for existing Medicaid and SCHIP beneficiaries were available for both programs, about 98 percent of claims submitted were for Medicaid expenditures.

Table 7: Claims Submitted for the Nonfederal Share of Expenditures for Existing Medicaid and SCHIP Beneficiaries (Category III), as of October 2, 2006

States	Total CMS allocations of DRA funds	DRA claims submitted	DRA claims submitted as percentage of CMS allocation
Alabama	$241,144,000	$125,157,859	51.9
Louisiana	699,528,807	333,485,125	47.7
Mississippi	518,482,628	392,320,710	75.7
Total	**$1,459,155,435**	**$850,963,694**	**58.3**

Source: GAO analysis of CMS and MBES data.

It has taken longer than usual for states—both those directly affected by the hurricane as well as states that hosted evacuees—to submit claims. Typically, Medicaid expenditure reports are due the month after the quarter ends. CMS officials estimated that about 75 percent of states submit their Medicaid expenditures within 1 to 2 months after the close of a quarter. However, data are not finalized until CMS and states ensure the accuracy of claims. The process of states submitting claims for DRA-related expenditures has been more prolonged. As with other Medicaid claims, states are permitted up to 2 years after paying claims to seek reimbursement from CMS. Therefore, these initial results are likely to change as states continue to file claims for services. As of October 2, 2006, 10 of 32 states that received allocations of DRA funding had not submitted any claims even though fiscal year 2006 ended on September 30, 2006.

Some state officials told us that they were having difficulties submitting claims because of various obstacles related to processing claims or receiving claims from providers, including needing to manually process claims or adapt computer systems to accommodate the new types of claims being submitted. For example, Mississippi officials explained that they were manually processing claims for time-limited uncompensated care services because they did not have an electronic system for processing such claims. Georgia officials reported that the state's claims processing system had to be adjusted in order to properly accept claims for time-limited uncompensated care services. After such adjustments were made, Georgia officials anticipated accepting these claims from mid-July through the end of August 2006. Alabama officials noted that they had to specifically request that providers submit claims for the costs of providing uncompensated care services they may have assumed would not be reimbursable.

States' Claims Were Concentrated in Three Service Areas

Claims that the four selected states submitted for Medicaid expenditures in the three categories of DRA funding we reviewed varied, but were typically concentrated in three service areas: nursing facilities, inpatient hospital care, and prescription drugs. For example, all four selected states had nursing facility services as one of their top four services for which they submitted claims, while only Alabama had home and community-based services as one of its services with the highest expenditures. Of the claims submitted by states, the proportions attributed to specific services varied across the states. (See table 8.)

Table 8: Percentages of Submitted Claims for Top Four Medicaid Services in Each Selected State, as of October 2, 2006

Selected states	Nursing facilities	Inpatient hospitals	Prescribed drugs	Outpatient hospitals	Physician services	Home and community services	Other practitioners
Alabama	24.8	[a]	18.6	[a]	7.7	11.5	[a]
Louisiana	14.0	19.8	24.8	[a]	8.5	[a]	[a]
Mississippi	18.8	22.9	14.2	9.1	[a]	[a]	[a]
Texas	10.7	38.8	[a]	12.4	[a]	[a]	8.9

Source: GAO analysis of MBES data.

[a]Claims submitted for this service were not among the top four services of this state.

Alabama, Louisiana, and Mississippi submitted claims for the nonfederal share of expenditures for SCHIP services to existing SCHIP beneficiaries. Overall, the dollar amount of claims for SCHIP represented approximately 2 percent of the total value of claims submitted. As of October 2, 2006, the top four SCHIP expenditures in Alabama were for physician services (22.8 percent), prescription drugs (20.7 percent), inpatient hospital services (13.4 percent), and dental services (12.1 percent). The top four SCHIP expenditures in Louisiana were for prescription drugs (45.4 percent), physician services (22.4 percent), outpatient hospital services (12.5 percent), and inpatient hospital services (9.8 percent). For Mississippi, all of the claims for DRA funds were for expenditures associated with paying SCHIP premiums for certain enrollees.

Louisiana and Texas Raised Concerns Regarding Future Funding Needs

Two of our four selected states raised concerns about their ability to meet the future health care needs of those affected by the hurricane once DRA funds have been expended: Louisiana, which is eligible for DRA funding for Category III services that may be provided beyond June 30, 2006; and Texas, which is not eligible for such ongoing assistance. Of the three directly affected states—Alabama, Louisiana, and Mississippi—only Louisiana raised concerns that it would need additional funds to provide coverage for individuals affected by the hurricane who evacuated the state yet remain enrolled in Louisiana Medicaid. Alabama and Mississippi officials did not anticipate the need for additional funding beyond what was already allocated by CMS. In contrast, because Texas is eligible only for the time-limited DRA funds from Category I and Category II, state officials expressed concern about future funding needs in light of the many evacuees remaining in the state. To learn more about this population, the state commissioned a survey that indicated that evacuees

responding to the survey continue to have a high need for services, including health care coverage under Medicaid and SCHIP.

Louisiana's Concerns Centered on Its Ability to Administer and Fund Medicaid Coverage for Out-of-State Evacuees

Only the three directly affected states—Alabama, Louisiana, and Mississippi—are eligible for DRA funds for Category III services, which were designated to compensate states for the state share of expenditures associated with services provided to existing Medicaid and SCHIP beneficiaries from certain areas of directly affected states beyond June 30, 2006. This additional DRA funding could potentially be available from any unused funds of the $1.9 billion allocated on September 30, 2006, and the $136 million remaining from the $2 billion appropriated. It is unclear how much of the $1.9 billion allocation will be unused and thus available for redistribution. Additionally, it is not yet known how the remaining $136 million will be distributed, but CMS will make that determination after reconciling states' claims submitted during the first quarter of fiscal year 2007 with the allocations. Of the three states eligible for ongoing DRA funding, only Louisiana raised concerns that additional funds will be necessary; Alabama and Mississippi did not anticipate additional funding needs beyond those CMS already allocated.

Louisiana's funding concerns were associated with managing its program across state borders as evacuees who left the state continue to remain eligible for Louisiana Medicaid. State officials acknowledged that their immediate funding needs have been addressed by the September 30, 2006, allocation; however, they remain concerned that they do not have the financial or administrative capacity to serve their Medicaid beneficiaries across multiple states.[26] Louisiana officials also cited the difficulty of maintaining what they characterized as a national Medicaid program for enrolled individuals and providers living in many different states.

Louisiana has submitted claims for DRA funding for Category III for existing Medicaid and SCHIP beneficiaries (individuals enrolled in Louisiana Medicaid) who resided in 1 of the 31 affected parishes in Louisiana prior to Hurricane Katrina, but evacuated to another state after

[26]While administrative costs associated with providing services for Louisiana's existing Medicaid beneficiaries would qualify for federal matching funds under Medicaid, Louisiana officials cited the added complexity and cost of ensuring that such beneficiaries were originally from 1 of the 31 affected parishes in order to qualify for funding under Category III. This would increase the state's share of administrative costs, which would not be covered under the DRA.

the hurricane, and who continue to reside in that state.[27] Because many of these evacuated individuals have expressed intent to return to Louisiana, they have not declared residency in the state where they have been living since Hurricane Katrina. Under these circumstances, these individuals have continued to remain eligible for Louisiana Medicaid. However, Louisiana officials were uncertain how long the state would be expected to continue this coverage on a long-distance basis. While DRA funds cover the nonfederal (Louisiana state) share of service expenditures for these Medicaid and SCHIP beneficiaries (Category III), they are not designated to include reimbursement for the administrative costs associated with serving Louisiana Medicaid beneficiaries living in other states.[28]

In particular, Louisiana officials noted the following difficulties, which were also outlined in a May 15, 2006, letter to HHS and a May 26, 2006, letter to CMS. These letters requested specific direction from CMS on the issues presented as well as permission to waive certain federal Medicaid requirements that Louisiana believes it has been unable to comply with. In commenting on a draft of our report, Louisiana officials stated that as of November 30, 2006, they had not received the written guidance that they requested from CMS on the following issues:

- **Managing and monitoring a nationwide network of providers**. Covering individuals who have evacuated from the state but remain eligible for Louisiana Medicaid requires the state to identify, enroll, and reimburse providers from other states.[29] According to Louisiana officials, the state has enrolled more than 16,000 out-of-state providers in Louisiana

[27]Louisiana did not enroll any evacuees entering the state into its time-limited Medicaid demonstration. Because the state did not expand eligibility as permitted under its approved demonstration project, Louisiana enrolled all evacuees who relocated in the state and who were eligible into its traditional Medicaid program. There were 52 individuals who met these criteria and were enrolled in Louisiana Medicaid.

[28]Funds for the nonfederal share of administrative costs are included in Categories I and II, time-limited Medicaid and SCHIP services and time-limited uncompensated care services, but not for Category III, existing Medicaid and SCHIP beneficiaries. Coverage in Category I was limited to services provided from August 24, 2005, through June 30, 2006, for the time-limited Medicaid and SCHIP beneficiaries eligible under a demonstration. Coverage in Category II was limited to services provided from August 24, 2005, through January 31, 2006, for uncompensated care provided to individuals without a method of payment or insurance.

[29]To ensure that evacuees from Louisiana had access to care while temporarily residing in other states, Louisiana Medicaid stated that it had enrolled out-of-state providers by using emergency procedures and waiving some provider enrollment requirements.

Medicaid since August 28, 2005. The state does not believe that it can manage and monitor a nationwide network of providers indefinitely. Therefore, Louisiana is seeking guidance from CMS to ensure that the state is continuing to comply with federal Medicaid requirements for payments for services furnished to out-of-state Medicaid beneficiaries.[30]

- **Redetermining eligibility**. Federal Medicaid regulations require that states redetermine eligibility at least annually as well as when they receive information about changes in individuals' circumstances.[31] Louisiana officials indicated that they had received approval through its demonstration project to defer redetermination processes through January 31, 2006. Officials noted that they have more than 100,000 individuals from affected areas whose eligibility had not yet been redetermined as of May 26, 2006. Officials say they do not want to take beneficiaries who need coverage off the state's Medicaid rolls for procedural reasons, and thus would prefer to conduct mail-in renewals and have a process for expedited reenrollment upon return to the state. According to Louisiana officials, the state's redetermination processes are currently on hold while CMS examines the possibility of granting a waiver for redetermining eligibility for individuals from the most severely affected parishes around New Orleans.

- **Maintaining program integrity**. Louisiana officials explained that running a Medicaid program in multiple states raises issues of program integrity. While some providers have contacted Louisiana Medicaid to report that they have received payment from more than one state, Louisiana officials believe that other providers are not reporting overpayments. State officials indicated that they will conduct postpayment claims reviews to ensure that double billing and other fraudulent activities have not occurred. These officials estimated that this effort to review claims could be time consuming, taking approximately 3 to 8 years to complete. Because Louisiana believes that it is unable to ensure the integrity of the program as long as it continues enrolling out-of-state providers, the state requested specific direction from CMS on whether to continue such enrollment efforts.

[30]See SSA § 1902(a)(16); 42 C.F.R. §431.52 for requirements governing Medicaid payments for services furnished out of state.

[31]See 42 C.F.R §435.916 for regulations governing periodic Medicaid eligibility redeterminations.

- **Ensuring access to services**. Louisiana officials expressed a concern about the state's ability to ensure access to home and community-based services in other states. Officials noted that some states have long waiting lists for this type of long-term care, making it difficult for them to provide services that assist in keeping individuals in the community rather than in an institution. Additionally, as a requirement of providing home and community-based services, measures are needed to protect the health and welfare of beneficiaries. However, officials stated that Louisiana is not in the position to assure the health and safety of individuals requiring these services out of the state. Thus, the state asked CMS for direction on how to continue operating its Medicaid program without violating the federal requirement to assure the health and welfare of beneficiaries receiving home and community-based services.

Texas Is Hosting Large Number of Evacuees Whose Future Plans Are Uncertain

While Texas is not a directly affected state and therefore not eligible for DRA funding for any Medicaid or SCHIP services provided beyond June 30, 2006, it has been significantly affected by the number of evacuees seeking services, thus prompting concern among state officials regarding the state's future funding needs. To address the health needs of evacuees entering the state, Texas enrolled these individuals into Medicaid under Category I—providing time-limited Medicaid services for evacuees who were eligible under an approved demonstration project.[32] In comparison to Alabama and Mississippi, which also enrolled evacuees into time-limited Medicaid services, Texas enrolled the largest number of evacuees—peaking at nearly 39,000 individuals in January 2006. (See table 9).

[32]Under demonstration projects, states were permitted to provide coverage to evacuees for up to 5 months beginning when the individual became eligible but not running beyond June 30, 2006. For example, if a person became eligible for Medicaid coverage under the demonstration on October 1, 2005, his or her eligibility would continue for 5 months, ending on February 28, 2006.

Table 9: Selected States' Monthly Enrollment in Category I, Time-limited Medicaid Services

		Category I enrollment[a]		
Year	**Month**	**Alabama**	**Mississippi**	**Texas**
2005	September	541	0	0
	October	2,755	979	9,049
	November	3,722	2,106	22,694
	December	4,345	3,201	32,687
2006	January	2,751	3,675	38,783
	February	2,110	3,396	28,766
	March	1,439	2,222	14,931
	April	1,088	1,232	6,995
	May	879	691	482
	June	798	132	[b]

Source: States' Medicaid enrollment data.

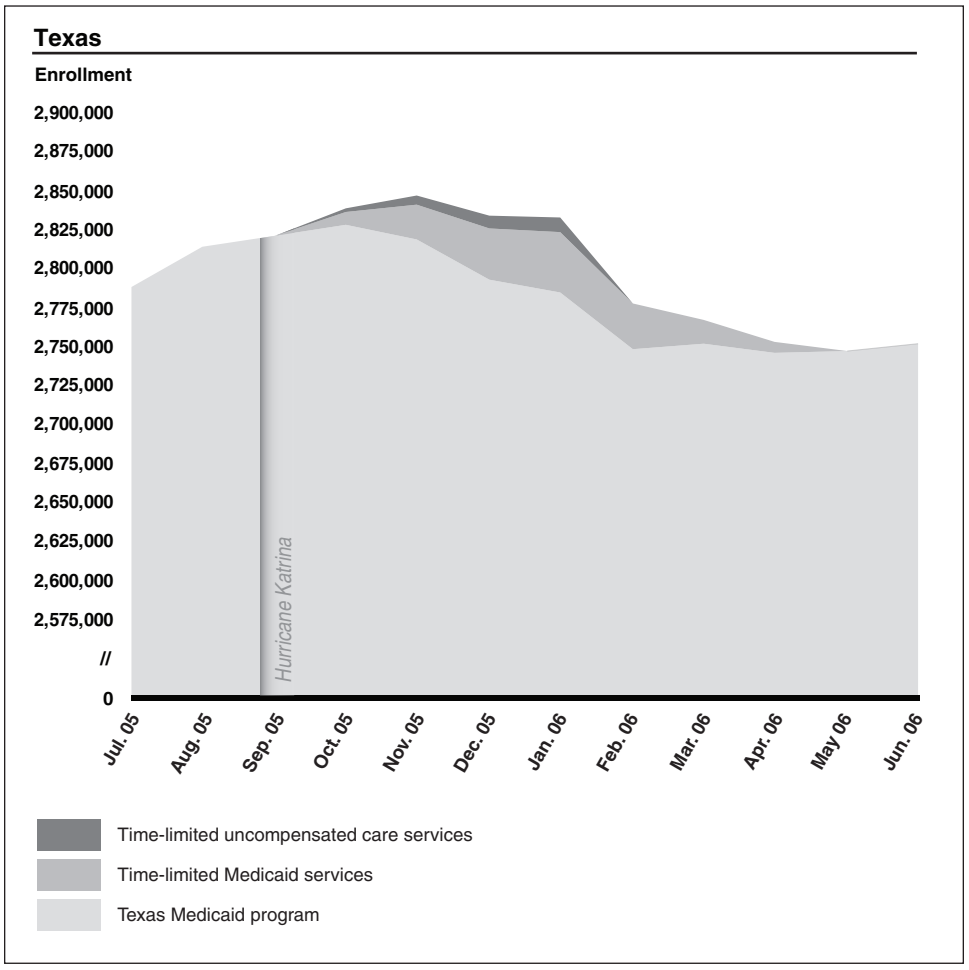
Note: Louisiana was excluded from this table because it did not enroll any evacuees in the time-limited Medicaid category of its demonstration. Louisiana officials informed us that 52 evacuees who relocated to Louisiana met the state's criteria for its traditional Medicaid program and were enrolled in that program.

[a]Category I and Category II required CMS approval of a demonstration project under section 1115 of the SSA. While states applied for and received approval to extend time-limited SCHIP coverage to individuals affected by Hurricane Katrina, no states actually enrolled individuals in SCHIP.

[b]Data were not available.

Texas also submitted claims for Category II DRA funds for time-limited uncompensated care services to evacuees, shortly after the hurricane. Enrollment into this category grew steadily from 2,224 individuals in October 2005 to 9,080 individuals in January 2006. Figure 3 shows the enrollment patterns for the Texas Medicaid program, as well as Category I and Category II services provided for the period following Hurricane Katrina.

Figure 3: Texas Monthly Enrollment for Its Traditional Medicaid Program and DRA Categories I and II, July 2005-June 2006



Source: GAO analysis of state's Medicaid enrollment data.

To better understand the characteristics, needs, and future plans of the evacuee population, the Texas Health and Human Services Commission contracted with the Gallup Organization to survey Hurricane Katrina evacuees in Texas.[33] Data from survey respondents indicated that, as of June 2006, evacuees remaining in the state were predominantly adult women who lived in low-income households with children and had increasing rates of uninsurance since the hurricane.[34] Despite the loss of insurance coverage, the survey indicated that fewer evacuees received Medicaid than previously expected and the loss of insurance primarily affected children's health coverage. Evacuees appear to be turning to hospital emergency departments to meet their health care needs, as survey respondents reported an increase in emergency room visits in the past 6 months. Texas officials confirmed that evacuees who were previously eligible for the two DRA categories for time-limited coverage (Medicaid and uncompensated care services) are beginning to present themselves to local county facilities for their health care needs, thus straining local resources to provide care for all Texas residents. Based on this survey, Texas officials said they are concerned that they will continue to host an evacuee population with high needs who do not have immediate plans to leave the state. In particular, over half of the survey respondents believe they will continue to reside in Texas in the next 6 months and half believe they will still be there in 1 year. Texas was not a directly affected state and is therefore not eligible for ongoing assistance through the DRA; funding for Category I only covers services provided as of June 30, 2006, and funding for Category II only covers services provided as of January 31, 2006.

Agency and State Comments and Our Evaluation

We provided copies of a draft of this report to CMS and the four states we reviewed: Alabama, Louisiana, Mississippi, and Texas. We received written general and additional comments from CMS (see app. II) and from Louisiana and Texas (see apps. III and IV, respectively). Alabama provided technical comments, while Mississippi did not comment on the draft report.

[33]See *Hurricane Katrina Evacuees in Texas*, Texas Health and Human Services Commission, Epidemiology Team, Strategic Decision Support, Financial Services Division, August 2006. The target population for the survey included all Hurricane Katrina evacuees from other states who resided in Texas at the time of the survey, which was administered in May and June 2006. The statewide survey response rate was 38 percent.

[34]Survey respondents largely reported earning less than $1,000 per month before the hurricane.

In commenting on the draft report, CMS provided information on an initiative it took to respond to Hurricane Katrina. The agency indicated that HHS, which oversees CMS, worked closely with Louisiana's Department of Health and Hospitals to assist the state in convening the Louisiana Health Care Redesign Collaborative, which will work to rebuild Louisiana's health care system. We did not revise the text of the report to include information on this effort because it was beyond the scope of this report. However, we have earlier reported on HHS efforts to help rebuild Louisiana's health care system.[35]

CMS also commented on three issues: our characterization of the categories of funding provided through DRA, our description of CMS's reconciliation process, and criticism it faced in communicating with the states, particularly Louisiana and Texas, regarding program implementation, coverage for out-of-state evacuees, and other issues. These comments are addressed below.

CMS commented that we mischaracterized the categories of DRA funding by specifying them in the report as Categories I, II, III, and IV. We developed these four descriptive categories, which were derived from provisions of the DRA, in order to simplify report presentation. However, to respond to CMS's comment, we included additional legal citations in the report to better link the statutory language of the DRA with the categories of funding presented in this report. We did not, however, adopt all of CMS's descriptions of DRA provisions as CMS presented some of the descriptions inaccurately. In particular, CMS presented DRA sections 6201(a)(3) and 6201(a)(4) as providing federal funding under an approved section 1115 demonstration project, but as stated in the report, such approval is irrelevant to this funding.

CMS also commented that the report was misleading because it did not fully describe the reconciliation process that will be used to allocate remaining and unused DRA funds. Specifically, the agency indicated that we did not explain that additional DRA allocations would be made to states not only from the remaining $136 million in unallocated funds but also from any unspent funds already allocated to states. The draft report

[35]See GAO, *Hurricane Katrina: Status of Hospital Inpatient and Emergency Departments in the Greater New Orleans Area*, GAO-06-1003 (Washington, D.C.: Sept. 29, 2006); and *Hurricane Katrina: Status of the Health Care System in New Orleans and Difficult Decisions Related to Efforts to Rebuild It Approximately 6 Months After Hurricane Katrina*, GAO-06-576R (Washington, D.C.: Mar. 28, 2006).

did contain a full explanation of the reconciliation process. However, to address CMS's comment, we clarified this process in the report's Highlights and Results in Brief.

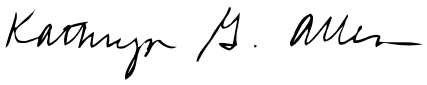
Finally, CMS disagreed with statements in the draft report that Louisiana had not received the requested direction detailed in letters written to HHS on May 15, 2006, and CMS on May 26, 2006. Louisiana's letters included concerns and questions that arose after the state implemented its section 1115 demonstration project. CMS indicated that it provided and continues to provide technical assistance to all states with section 1115 demonstration projects for Hurricane Katrina assistance beyond the states reviewed in this report. In particular, immediately following the hurricane CMS provided guidance to states through a conference call and a September 16, 2005, letter sent to all state Medicaid directors that explained the process of applying for the section 1115 demonstration project, the benefits and eligibility criteria for evacuees, the uncompensated care pool, and other pertinent information. We revised the report to reflect the guidance that CMS provided to the states immediately following the hurricane. CMS also commented that it worked with Louisiana and the other hurricane-affected states on redetermining eligibility through a conference call, and provided information to Louisiana several times regarding regulations that the state should follow for redetermining eligibility on an annual basis. Further, CMS indicated that it provided technical assistance to Louisiana in its efforts to ensure program integrity and access to health care services. While CMS may have provided such assistance, from Louisiana's perspective, it was not sufficient to address the many issues the state is facing. In Louisiana's written comments, state officials maintained that as of November 30, 2006, they had not received written guidance from CMS regarding the issues outlined in their May 15, 2006, letter.

Comments from Louisiana and Texas centered on each state's efforts to assist those affected by the hurricane and the ongoing challenges that exist as a result of Hurricane Katrina. In particular, Louisiana emphasized the lack of response from HHS regarding its concerns about running its Medicaid program in many states and related difficulties to ensuring the program's integrity. Texas commented on its continued need to provide health care services to Hurricane Katrina evacuees given the results of a survey conducted by the Gallup Organization, which indicated that most of the evacuees still residing in Texas were uninsured as of June 2006.

Additional technical and editorial comments from CMS and the states were incorporated into the report as appropriate.

We are sending a copy of this report to the Secretary of Health and Human Services and the Administrator of CMS. We will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7118 or allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.



Kathryn G. Allen
Director, Health Care

List of Congressional Committees

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman
The Honorable Tom Davis
Ranking Member
Committee on Oversight and Government Reform
House of Representatives

Appendix I: Deficit Reduction Act of 2005 Allocations to 32 States

Under the authority of the Deficit Reduction Act of 2005, the Centers for Medicare & Medicaid Services (CMS) allocated funding totaling approximately $1.9 billion to 32 states, as of September 30, 2006. The agency allocated funds to all 32 states for the time-limited Medicaid category of demonstration projects, to 8 of those 32 states for the time-limited uncompensated care category of demonstration projects, and to the 3 directly affected states—Alabama, Louisiana, and Mississippi—for the nonfederal share of expenditures for existing Medicaid and SCHIP beneficiaries. The 4 states selected for this study—Alabama, Louisiana, Mississippi, and Texas—received approximately 97.5 percent of the $1.9 billion allocation. All allocations were based on estimates states submitted for each of the funding categories in response to CMS's July 2006 request for updated estimates. (See table 10.)

Table 10: CMS's Allocation of DRA Funds to States, Based on States' Estimated Expenditures, as of September 30, 2006

	Allocations					
State	Category I Time-limited Medicaid and SCHIP services[a,b,c]	Category II Time-limited uncompensated care services[b,d]	Category III Existing Medicaid and SCHIP beneficiaries[e]	Category IV Restore access to health care[f]	Total allocation	Percentage of DRA allocation
Alabama	$2,377,000	$4,660,000	$241,144,000	[g]	$248,181,000	13.3
Arizona	713,000	0	[h]	[g]	713,000	0.0[i]
Arkansas	670,000	4,700,000	[h]	[g]	5,370,000	0.3
California	1,514,000	0	[h]	[g]	1,514,000	0.1
Delaware	429,000	0	[h]	[g]	429,000	0.0[i]
District of Columbia	80,541	0	[h]	[g]	80,541	0.0[i]
Florida	2,871,000	0	[h]	[g]	2,871,000	0.2
Georgia	3,868,462	14,500,000	[h]	[g]	18,368,462	1.0
Idaho	44,000	0	[h]	[g]	44,000	0.0[i]
Indiana	368,332	0	[h]	[g]	368,332	0.0[i]
Iowa	240,000	0	[h]	[g]	240,000	0.0[i]
Louisiana	23,811	132,091,048	699,528,807	[g]	831,643,666	44.6
Maryland	701,000	0	[h]	[g]	701,000	0.0[i]
Massachusetts	629,000	0	[h]	[g]	629,000	0.0[i]
Minnesota	383,581	0	[h]	[g]	383,581	0.0[i]
Mississippi	1,815,572	75,264,730	518,482,628	[g]	595,562,930	32.0
Montana	25,000	0	[h]	[g]	25,000	0.0[i]
Nevada	250,000	0	[h]	[g]	250,000	0.0[i]
North Carolina	493,415	0	[h]	[g]	493,415	0.0[i]
North Dakota	4,170	0	[h]	[g]	4,170	0.0[i]
Ohio	404,000	0	[h]	[g]	404,000	0.0[i]
Oregon	67,000	0	[h]	[g]	67,000	0.0[i]
Pennsylvania	1,698,000	0	[h]	[g]	1,698,000	0.1
Puerto Rico	125,000	0	[h]	[g]	125,000	0.0[i]
Rhode Island	90,000	0	[h]	[g]	90,000	0.0[i]
South Carolina	1,088,000	124,000	[h]	[g]	1,212,000	0.1
Tennessee	1,850,467	5,678,000	[h]	[g]	7,528,467	0.4
Texas	76,872,000	65,336,000	[h]	[g]	142,208,000	7.6
Utah	275,000	0	[h]	[g]	275,000	0.0[i]
Virginia	1,249,000	0	[h]	[g]	1,249,000	0.1
Wisconsin	1,170,234	0	[h]	[g]	1,170,234	0.1

State	Allocations					Percentage of DRA allocation
	Category I Time-limited Medicaid and SCHIP services[a,b,c]	Category II Time-limited uncompensated care services[b,d]	Category III Existing Medicaid and SCHIP beneficiaries[e]	Category IV Restore access to health care[f]	Total allocation	
Wyoming	14,000	0	[h]	[g]	14,000	0.0[i]
Total	**$102,403,585**	**$302,353,778**	**$1,459,155,435**	[g]	**$1,863,912,798**	**100.00**[j]

Source: GAO analysis of CMS data.

Note: This table accounts for the approximately $1.9 billion of DRA funds allocated to states.

[a]While states applied for and received approval to extend time-limited SCHIP coverage to individuals affected by Hurricane Katrina, no states actually enrolled individuals in SCHIP.

[b]Category I and Category II required CMS approval of a demonstration project under section 1115 of the SSA. In addition to service expenditures, associated administrative costs are also included.

[c]DRA, Pub. L. No. 109-171, § 6201(a)(1)(A),(C), (a)(2), 120 Stat. 132-133.

[d]DRA, Pub. L. No. 109-171, § 6201(a)(1)(B),(D), (a)(2), 120 Stat. 132-133.

[e]DRA, Pub. L. No. 109-171, § 6201(a)(3), 120 Stat. 132-133.

[f]DRA, Pub. L. No. 109-171, § 6201(a)(4), 120 Stat. 132-133.

[g]CMS did not allocate funds to this category.

[h]State was not eligible for funding from this category.

[i]State's percentage of DRA allocation is less than 0.10 percent.

[j]Numbers may not add to 100 percent due to rounding.

Appendix II: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 15 2006

TO: Kathryn G. Allen
Health Care Director
Government Accountability Office

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Government Accountability Office's (GAO) Draft Report: "HURRICANE KATRINA: Allocation and Use of $2 Billion for Medicaid and Other Health Care Needs" (GAO-07-67)

The Centers for Medicare & Medicaid Services (CMS) has reviewed the GAO draft report entitled, "HURRICANE KATRINA: Allocation and Use of $2 Billion for Medicaid and Other Health Care Needs (GAO-07-67)." We appreciate the opportunity to provide comments on the draft report. Although not mentioned in your report, CMS would like to highlight that the Secretary of the Department of Health and Human Services (HHS) has worked very closely with the Louisiana Secretary of the Department of Health and Hospitals (DHH) to provide staffing and other support for the State's convening of the Louisiana Health Care Redesign Collaborative. The Collaborative which was formed to seriously promote rebuilding of Louisiana's health care system, initially starting in the New Orleans area, has submitted to CMS and HHS its preliminary long-term recovery proposal that would involve a Medicare demonstration, Medicaid 1115 waiver, and potential other rebuilding/recovery projects associated with "jump-starting" more efficient and effective health care recovery for all citizens in the greater New Orleans area. The proposal is currently under review by CMS and other relevant HHS Operating Divisions.

We believe the purpose of this report is to discuss the allocation of the $2 billion for Medicaid expenditures and the provision of services to evacuees in the aftermath of Hurricane Katrina. However, information regarding the allocation of the $2 billion for Medicaid expenditures has also been mischaracterized. The Deficit Reduction Act of 2005 (DRA) provides very specific categories for funding of evacuees. The report specifies these funding categories as Category I, Category II, etc. In using these identifiers, the report has no direct linkage to the DRA and is unclear for the reader.

Information regarding the reconciliation process that CMS will undertake in allocating any unexpended DRA funds is also misleading. CMS will reconcile States' expenditures with their allocations and subsequently will determine how to allocate the remaining $136 million previously unallocated and any unexpended amounts from the $1.86 billion in previously allocated DRA funds determined after the reconciliation.

The report does not include any recommendations and provides no specific suggestions on how CMS can improve the process for allocating funds. We have, however, provided specific

comments on these areas and believe it is important to revise the report to clearly articulate the reconciliation process and the categories for funding under the DRA.

The report discusses criticism CMS has faced in communicating with States, particularly Louisiana and Texas, regarding eligibility, program implementation, coverage for out-of-State evacuees, etc. Our specific comments identify the steps CMS has taken to work with all States that have approved Section 1115 demonstrations providing health care coverage to evacuees including convening a conference call with all State Medicaid Agencies shortly after the hurricane to brief States on the State Medicaid Director's letter of September 16, 2005, and to discuss the CMS waiver template through which States could apply for a Section 1115 Multi-State Hurricane Katrina demonstration. CMS has provided information to States in a variety of venues and forms. It is through these communications CMS and the Director, Center for Medicaid and State Operations (CMSO), has provided specific guidance on all implementation issues including eligibility and coverage of out-of-State providers.

The report provides no recommendations or feedback on CMS's communication efforts. We believe the report should identify the specific steps taken by CMS and the Department in order to provide a more accurate description of our guidance provided to all States and the rapid response to provide health care coverage to evacuees in a time of a natural disaster.

Thank you again for the opportunity to comment.

Additional Comments

The Deficit Reduction Act of 2005 (DRA), P.L. 109-171, section 6201, provided authority for the provision of additional Federal payments to States under hurricane-related Multi-State Section 1115 Demonstration Projects:

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, State Children's Health Insurance Program (SCHIP), and premium assistance);

Section 6201(a)(1)(B) and (D). Provides funding for the total expenditures for uncompensated care pool costs for evacuees and 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.

Now pages 1 and 2

Throughout the report, individuals referenced under section 6201(a)(1)(A) and (C) are mischaracterized. For example, on page 1, the last sentence in the paragraph at the bottom of the page reads, "The first category allowed individuals affected by the hurricane who may not otherwise have qualified for Medicaid or State Children's Health Insurance Program (SCHIP) to become eligible for these programs for up to 5 months." The approved section 1115 demonstration programs specify the groups covered and eligible, and the Medicaid/SCHIP benefits available, under such programs. Specifically, the intent of the demonstrations was to provide a vehicle for Host States to quickly re-enroll evacuees who had previously been determined eligible for Medicaid or SCHIP in their own State Medicaid or SCHIP program and to provide a vehicle for States to establish eligibility for those evacuees who now met the eligibility standards of their home State because of Hurricane Katrina. Accordingly, we suggest this sentence be revised (and similar revisions made, as appropriate, to other statements elsewhere in the report) to read as follows: "The first category allowed individuals eligible under the approved section 1115 demonstration to receive benefits under the Medicaid and SCHIP programs for up to 5 months."

Now page 9

The draft report also mischaracterizes the uncompensated care pool by suggesting that these pools provide "coverage" for individuals rather than being limited to providing payment to providers. Specifically, on page 8, the first full paragraph after Table 1 indicates that "States with approved demonstrations for time-limited uncompensated care services **offered coverage** to affected individuals and evacuees who either did not have any other coverage for health care services (such as private or public health insurance), or who had Medicaid or SCHIP but required services beyond those covered under either program.

The award letter to States with approved section 1115 Katrina demonstrations state "(Name of State) will be allowed to reimburse providers that incur uncompensated care costs for medically necessary services and supplies for evacuees who do not have other coverage for such services….."

Now page 9

We suggest that GAO revise the language on page 8 (and any similar language on other pages) to indicate that, "States with approved demonstrations for time-limited uncompensated care services **were authorized to pay providers for some or all costs of furnishing services to affected individuals and evacuees** who either did not….."

Now page 25

On page 24, in the first full paragraph at the top of the page, the report indicates, "As of October 11, 2006, the state had not received the requested direction from HHS or CMS on the following issues:" We disagree with this statement. In particular, as detailed below, with respect to the concerns raised by Louisiana and Texas regarding future funding needs and coverage for out-of-State evacuees, CMS provided and continues to provide technical assistance and support to all States (including Louisiana and Texas) implementing section 1115 Hurricane Katrina demonstrations.

- CMS Guidance. CMS provided guidance to all States in a variety of venues and forums. Specifically, the Director, CMSO, convened a conference call with all State Medicaid Agencies shortly after the hurricane to brief States about the State Medicaid Director's Letter of September 16, 2005, and to discuss the CMS waiver template through which States could apply for a Section 1115 Multi-State Hurricane Katrina demonstration. Through these communications, the Director explained the process for applying for a demonstration, the benefits and eligibility process for Medicaid/SCHIP evacuees, the possibility of an uncompensated care pool, and other relevant information specified in Federal regulations regarding Medicaid eligibility. The Director entertained any questions and concerns from the parties.

  Moreover, CMS Central and Regional Office staff provided support and technical assistance to Louisiana and Texas on numerous occasions and on a continuing basis to address concerns raised by these States regarding displaced evacuees and appropriate payments to individuals.

- Redetermining Eligibility. CMS has worked with Texas, Louisiana and all other affected States in an effort to assist Louisiana in redetermining eligibility for its evacuees. Specifically, the Director, CMSO, convened a conference call with Texas and other affected home States in an effort to enable Louisiana to locate displaced Louisiana Medicaid recipients. Additionally, CMS has provided guidance to Louisiana on several occasions regarding the traditional regulations that the State should follow with respect to the annual redetermination process.

- Maintaining program integrity. CMS provided technical assistance to Louisiana regarding its program integrity program.

- Ensuring Access to Services. CMS provided technical assistance to Louisiana regarding the best possible method for ensuring access to services for individuals receiving health care services in its State.

- Louisiana Health Care Redesign Collaborative. As one of the Department of Health and Human Services' top initiatives, the Secretary (in cooperation with Governor Blanco) has convened the Louisiana Health Care Redesign Collaborative to develop, and oversee the implementation of, a practical blueprint for an evidence-based, quality-driven health care system for Louisiana. This blueprint will serve as a guide to health care policy in Louisiana and for the recovery and rebuilding of health care in the hurricane-affected areas of the State. The Secretary has committed resources to the Collaborative in an effort to seriously promote the rebuilding of Louisiana's health care system.

- On the "GAO Highlights" page (immediately preceding page 1), the last sentence in the first paragraph under "What GAO Found" currently reads: "After CMS reconciles states' expenditures with their allocations, CMS will determine how to allocate the remaining $136 million of available DRA funds." We suggest this sentence be revised to read as

follows: "After CMS reconciles States' expenditures with their allocations, CMS will determine how to allocate any unexpended DRA funds, including the $136 million previously unallocated and any unexpended amounts from the $1.86 billion in previously allocated DRA funds determined after the reconciliation."

- On page 5, just below the bullets at the top of the page, the sentence that reads: "After CMS reconciles state's expenditures. . ." should be replaced with the following: "After CMS reconciles States' expenditures with their allocations, CMS will determine how to allocate any unexpended DRA funds, including the $136 million previously unallocated, and any unexpended amounts from the $1.86 billion in previously allocated DRA funds determined after the reconciliation."

Now page 6

- On page 5, paragraph at the bottom of the page, sentence that reads: "States are permitted up to 2 years after paying claims to seek reimbursement *from* CMS." This sentence should be replaced with the following: "Although, in general, States are permitted up to 2 years after paying claims to seek reimbursement from CMS, CMS is working with States to expedite this process."

Now page 21

- On page 20, in the first paragraph, the sentence that reads: "As with other Medicaid claims, states are permitted up to 2 years after paying claims to seek reimbursement from CMS." This sentence should be replaced with the following: "Although, in general, States are permitted up to 2 years after paying claims to seek reimbursement from CMS, CMS is working with States to expedite this process."

Now page 26

- On page 24, last sentence before footnotes seems to be missing a verb: "Louisiana officials _____that it had received..."

- Throughout the report, we suggest you make clear that the approximately $1 billion in submitted claims for expenditures reported as of October 2, 2006, reflect only claims submitted on the Medicaid and SCHIP Budget and Expenditure System (MBES) expenditure reports through the third quarter fiscal year (FY) 2006. For example, the following sentence on page 4, lines 8-10, reads "Within the MBES, we examined data that states submitted for expenditures that qualified for DRA funding as of October 2, 2006, in order to capture all activity for fiscal year 2006." Without the fourth quarter reports, you cannot capture all reported activity for FY 2006. We suggest this sentence read as follows: "As of October 2, 2006, we examined the MBES for DRA-qualified funding data that States submitted on expenditure reports through the third quarter of FY 2006."

- A discussion of Appendix I does not appear in the report. Footnote 5 on page 2 includes information regarding the Deficit Reduction Act of 2005. Since Appendix I also includes information on the DRA allocations and the 32 States with approved demonstrations, we believe adding a discussion of Appendix I to Footnote 5 is an appropriate placement for such a description.

Appendix III: Comments from the State of Louisiana Department of Health and Hospitals

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

November 30, 2006

Kathryn G. Allen
Director, Health Care
United States Government Accountability Office
Washington, DC 20548

Dear Ms. Allen:

As requested, this letter is in response to the draft report entitled: ***HURRICANE KATRINA: Allocation and Use of $2 Billion for Medicaid and Other Health Care Needs (GAO-07-67).***

As noted in the report, Louisiana continues to have concerns regarding managing what we characterize as a, "National Medicaid Program." We have many Louisiana Medicaid enrollees who are temporarily residing in other states, a large group of out-of-state providers delivering services to this displaced population, and grave concerns relating to ensuring program integrity on a long-distance basis. These concerns were noted in a letter from Governor Kathleen Blanco to Secretary Michael Leavitt dated May 15, 2006 (attached). To date, we still have not received a written response from Centers for Medicare and Medicaid Services (CMS) regarding these critical issues. Louisiana has chosen to take a proactive approach on these issues instead of waiting on a CMS response.

As of this date, we have sent approximately 50,000 families from the New Orleans metropolitan area renewal packets that must be completed and returned in order to maintain their Medicaid eligibility. Individuals who do not return the forms will lose their Medicaid health coverage. For those Medicaid enrollees who indicate their intent to return to Louisiana, and are otherwise Medicaid eligible, the Department of Health & Hospitals will continue Medicaid as long as the enrollee is not receiving Medicaid assistance in another state. We anticipate that as of January 1, 2007 all re-determinations that were deferred due to Katrina will be complete and Louisiana will be back in compliance with the Requirement for Annual Re-determination of Eligibility.

Louisiana Medicaid enrolled 19,464 out-of-state providers under Katrina. Provider Enrollment and is currently working to close those providers that have not billed for six consecutive months. Currently we have 4,253 out-of-state

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"AN EQUAL OPPORTUNITY EMPLOYER"

Ms. Allen
Response to GAO-07-67
November 30, 2006

providers that are actively billing. The great number of out-of-state providers and our inability to manage and monitor a nationwide network of providers indefinitely is a concern. In addition, we are not able to ensure access to home and community-based services or assure the health and safety of these individuals requiring these services in other states.

We do plan to conduct post pay review to ensure that double billing and fraudulent activities have not occurred but this effort could take 3-8 years to complete. Our program integrity monitoring has expanded out-of-state which is atypical. We are unable to use peer group profiling. At best, our Program Integrity Unit works off of complaints on these providers instead of following the standard SURS procedures. As to payments made to these providers, Program Integrity, after discussion with both CMS and the OIG, has deferred the data collection and data mining tasks to the OIG's Special Taskforce and will rely on appropriate referrals from that Taskforce.

Additionally, we have our system in place to track Katrina related claims and have included an update on our expenditures. (Attached)

In summary, we continue to be proactive in our approach to these issues and continue to wait on written guidance from CMS regarding these important issues. Please do not hesitate to call if you need additional information. Thank you for the opportunity to review and respond to the draft report prior to its final release.

Sincerely,

Jerry Phillips
Medicaid Director

JLP/LST

Enclosures

KATHLEEN BABINEAUX BLANCO
GOVERNOR

State of Louisiana
OFFICE OF THE GOVERNOR
Baton Rouge
70804-9004

POST OFFICE BOX 94004
(225) 342-7015

May 15, 2006

The Honorable Michael Leavitt, Secretary
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

Thank you for visiting Louisiana the week of April 24th to both co-host Louisiana's Pandemic Flu Summit and address the Joint Health and Welfare committee. We appreciate your commitment to helping Louisiana rebuild our health care system. The purpose of this letter is to appeal to you on behalf of the citizens of the State of Louisiana. Due to the devastating hurricanes that destroyed so much of our state and disrupted the lives of so many citizens, Louisiana is now in a precarious position with respect to evacuees, our Medicaid and SCHIP Programs, and the federal government.

It has been eight months since the disasters and many thousands of evacuees enrolled in Louisiana Medicaid continue to reside out-of-state. Many of them state that they intend to return to Louisiana when housing is available and circumstances allow, and we are working diligently to make that possible. Our situation is unprecedented and I am confident that federal Medicaid statutes and regulations never contemplated extended absences from a state of this length—perhaps years.

We recognize that complying with federal Medicaid regulations is a condition of Federal Financial Participation (FFP) that we cannot afford to jeopardize. In conversations with Centers for Medicare and Medicaid Services (CMS) staff, we have been cautioned that we should be *very careful* to not deviate from the regulations in 42 CFR. The Office of Inspector General has already shown great interest in our compliance with federal Medicaid regulations post-Katrina and Rita. As we continue to work toward recovery, it is becoming virtually impossible to comply with federal Medicaid policy in a number of important areas:

1) Requirement for Annual Redetermination of Eligibility [42 CFR §435.916]
Louisiana's authority under our approved Section 1115 Disaster Waiver to defer redetermination activity expired January 31, 2006. Our understanding of this policy is that our Medicaid agency "*must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that **may** [emphasis ours] affect his eligibility.*" We currently have well over 100,000 cases for persons in the most severely impacted disaster areas whose annual redeterminations were deferred and must now be completed.

We have developed a plan for completing redeterminations that is intended to assure that persons who remain eligible for Louisiana Medicaid are not closed for procedural reasons and that mitigates the adverse impact on this very vulnerable population. However, that plan has been met with major resistance from The Advocacy Center, who advised me in correspondence dated April 6 of its intent to obtain a Temporary Restraining Order (TRO) in federal court if we proceed with redetermination activity. As a result, our plan to resume annual redeterminations of eligibility is on hold, awaiting additional guidance from CMS. Louisiana is seeking support from CMS to proceed with our plan.

2) State Residence Prohibition [42 CFR § 435.403 (j) (3)]
Federal regulations stipulate that Louisiana "*may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.*"

We believe that there are inherent problems related to access, quality, and program integrity for Louisiana Medicaid enrollees living indefinitely in other states. Their access to care is dependent on the willingness of out-of-state providers to enroll in Louisiana Medicaid. We have enrolled more than 16,000 out-of-state providers in Louisiana Medicaid since August 28. However, we cannot realistically manage and monitor a nationwide network of Louisiana Medicaid providers in an effective manner if we extend benefits indefinitely to those out of state.

3) Payment for Services Furnished Out-of-State [42 CFR § 431.52]
An additional concern to us is that continued payment for Medicaid services provided to evacuees out of state does not appear to meet any of the four conditions under which the State may receive FFP for doing so. We are seeking assurances from you, in writing, that if we continue to pay for services rendered out of state Louisiana will not be in jeopardy of losing FFP. If you cannot make this assurance to us, then please provide us with written notice that our options are 1) to terminate Louisiana Medicaid eligibility or 2) that the state must assume full responsibility for the cost of any services provided without the ability to claim FFP.

4) Protection of Health and Welfare [42 U.S.C. §1396n(c)(2)(A)]
We are required to undertake measures to protect the health and welfare of persons receiving services pursuant to a Home and Community-Based Waiver (HCB). Louisiana continues to have enrollees in our HCB Medicaid Waivers residing out of state who have not returned. They and their advocates are adamant that they continue to meet the Louisiana residency requirement for Medicaid eligibility purposes. Home and community-based services are essential for them to avoid institutionalization and other states have long waiting lists for Medicaid waiver programs. For example, the waiting list in Texas is more than 10 years.

Meanwhile, Louisiana is not in a position to assure health and safety of persons who are out of state. We need direction on how we can continue operating our Medicaid program without violating the federal requirement to assure health and welfare.

5) Program Integrity [42 CFR 455]
As of April 17, 2006, Louisiana has enrolled 16,129 out-of-state providers using emergency procedures and waiving some provider enrollment requirements. These providers were enrolled specifically to ensure that Louisiana evacuees had access to care while temporarily residing in other states. We have been contacted by providers that have received payment from more than one state. While we are appreciative that these providers are concerned with not being overpaid, we expect, based on history, that other providers are not reporting these payments. Unless and until we discontinue enrolling out-of-state providers, we do not have a mechanism to ensure the integrity of the Medicaid program.

Again, we are looking to your staff to provide us with direction. Must Louisiana continue to enroll out-of-state providers or do we have the option to no longer enroll out-of-state providers and begin the process of disenrollment?

As you can see, we are faced with a situation that presents Louisiana with not only moral issues but legal issues as well. Louisiana can ill afford to lose federal funding for our Medicaid Program. We have had many conversations with your staff at CMS but have yet to receive written direction on many of the critical issues.

The Disaster 1115 Demonstration Waiver was effective in resolving immediate issues. We are now requesting that your staff at CMS work with us to grant emergency waivers related to the above regulations in the cases were you have the authority to do so. With the scrutiny that Louisiana and our Medicaid Program is receiving, it is imperative that the State and federal governments work jointly to decide the appropriate course of action and that it be explicit and in writing.

Our experience and "lessons learned" can and should be incorporated into the development of a national policy and model for Disaster Medicaid—one that addresses the inherent conflict between existing Medicaid regulations and the health needs of persons affected by a major disaster. We look forward to working with members of your staff to make this happen.

Sincerely,

Kathleen Babineaux Blanco

Kathleen Babineaux Blanco
Governor

Appendix IV: Comments from the State of Texas Health and Human Services Commission

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

November 30, 2006

Ms. Kathryn G. Allen
Director, Health Care
United States Government Accountability Office
Washington, DC 20548

Dear Ms. Allen:

Thank you for the opportunity to comment on the report entitled *HURRICANE KATRINA: Allocation and use of $2 Billion for Medicaid and Other Health Care Needs* (GAO-07-67). We appreciate the work your staff did on this report and have no technical disagreements or corrections to the report. Texas would, however, like to take this opportunity to emphasize several key points related to Texas use of and need for Deficit Reduction Act (DRA)-provided funding for Medicaid and other health care needs as a result of Hurricane Katrina.

First, we want to emphasize that, while the data, for example, both in Table 9 and in Figure 3, correctly depict the gradual increase and decrease of Texas' utilization of funds for health care, the decrease is not illustrative of a decrease in the need for or evacuees' use of health care, as might otherwise be assumed. Rather, the legislative restriction of a five months maximum individual eligibility period in conjunction with an overall ineligibility for funding beyond June 30, 2006, combined to produce the initial uptake and the quick decline in enrollment for these time-limited services. Note also, for context, that the relative reduction in our baseline Medicaid population followed an extended period of caseload growth, and those trends have started increasing once again.

In our negotiations with Centers for Medicare and Medicaid Services (CMS) soon after the hurricane struck, Texas asked for a lengthier eligibility period to more appropriately address the needs of the hundreds of thousands of evacuees seeking shelter in Texas. However, the individual and collective time limits required by the DRA effectively limited Texas' ability to use available Category I funding (time limited funding for individuals who might not otherwise have qualified for Medicaid or State Children's Health Insurance Program [SCHIP]).

As the Government Accountability Office (GAO) report indicates, Texas continues to have ongoing health care needs. Not only did Texas enroll the largest number of individuals to participate in Category I time-limited Medicaid/SCHIP funding, a survey conducted for Texas by the Gallup Organization indicates that as of June 2006, most of the 251,000 evacuees remaining

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in the state are uninsured adult women living in low-income households with children. Individuals who were previously eligible for the two categories of time limited funding under the DRA are now seeking care through emergency rooms and other public providers, straining existing local resources.

Finally, as the GAO noted in its report, the DRA allowed for a fourth category of funding by CMS: "For other purposes, if approved by the Secretary under the secretary's authority, to restore access to health care in impacted communities." CMS to date has chosen not to allocate funds under that category. Texas respectfully suggests that CMS consider allocated funding under this category to Texas to address our ongoing unmet needs for providing access to care for Katrina evacuees who continue to live in Texas.

Thank you again for the opportunity to comment on the report and we look forward to working with CMS to address the ongoing health care needs of these citizens in the future.

Sincerely,

Chris Traylor
Associate Commissioner for Medicaid and CHIP

CT: RA:kp

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Kathryn G. Allen (202) 512-7118 or allenk@gao.gov

Acknowledgments

In addition to the contact named above, Carolyn Yocom, Assistant Director; Jennie Apter; Laura M. Mervilde; JoAnn Martinez-Shriver; Sari B. Shuman; and Hemi Tewarson made key contributions to this report.

Related GAO Products

Hurricane Katrina: Status of Hospital Inpatient and Emergency Departments in the Greater New Orleans Area. GAO-06-1003. Washington, D.C.: September 29, 2006.

Catastrophic Disasters: Enhanced Leadership, Capabilities, and Accountability Controls Will Improve the Effectiveness of the Nation's Preparedness, Response, and Recovery System. GAO-06-618. Washington, D.C.: September 6, 2006.

Hurricane Katrina: Status of the Health Care System in New Orleans and Difficult Decisions Related to Efforts to Rebuild It Approximately 6 Months After Hurricane Katrina. GAO-06-576R. Washington, D.C.: March 28, 2006.

Hurricane Katrina: GAO's Preliminary Observations Regarding Preparedness, Response, and Recovery. GAO-06-442T. Washington, D.C.: March 8, 2006.

Statement by Comptroller General David M. Walker on GAO's Preliminary Observations Regarding Preparedness and Response to Hurricanes Katrina and Rita. GAO-06-365R. Washington, D.C.: February 1, 2006.

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