Medicaid and CHIP in the U.S. Virgin Islands

The U.S. Virgin Islands (USVI) became a U.S. territory in 1917 (CMS 2016a). Its Medicaid program is administered by the USVI Department of Human Services as a component of the territory's broader government-operated health care system.

For the purposes of Medicaid and the State Children's Health Insurance Program (CHIP), USVI is considered a state unless otherwise indicated (§ 1101(a)(1) of the Social Security Act (the Act)). However, its Medicaid program differs in many aspects from those in the 50 states and District of Columbia. This fact sheet summarizes the key requirements and design features of Medicaid and CHIP in USVI, including eligibility and enrollment, benefits, financing and spending, data and reporting, and quality and program integrity measures.

Eligibility and Enrollment

Eligibility rules in USVI's Medicaid program differ in some ways from those in the states. It is permitted to use a local poverty level to establish income-based eligibility for Medicaid, and is exempt statutorily from requirements applicable to states that extend eligibility to poverty-related children and pregnant women (§ 1902(l)(4)(B) of the Act), and qualified Medicare beneficiaries (§ 1905(p)(4)(A) of the Act). The Medicaid program currently provides coverage to individuals with modified adjusted gross income up to 133 percent of the USVI poverty level (USVIPL), or $26,661 annually for a family of four. This is nearly equal to the 2021 federal poverty level (FPL) for a family of four ($26,500) (CMS 2017b, ASPE 2021).

USVI elected to expand Medicaid to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (CMS 2015a). Additionally, Medicaid covers people age 65 and older, people who are blind, and people with disabilities whose incomes are up to 177 percent USVIPL; that is, $42,495 annually for a family of four, or 165 percent FPL (CMS 2017b, ASPE 2018).

USVI uses CHIP funds as an additional source of funding for children in Medicaid after it has exhausted its Medicaid allotment. It does not offer eligibility to children at a higher income level than the eligibility threshold for Medicaid (CMS 2016a, CMS 2016d).

As of June 2019, 29,033 individuals were enrolled in Medicaid, approximately one-quarter of the population (MACPAC 2021)

USVI implemented a new eligibility and enrollment system in 2017, which the territory planned to expand in 2019 to integrate with other federal programs (Rhymer-Browne 2019).

Benefits

Although the federal rules for Medicaid benefits generally apply to USVI, its program currently does not cover two Medicaid mandatory benefits: rural health clinic and freestanding birth center services (GAO 2016). It does, however, provide certain optional benefits, including dental services and prescription drugs. Enrollees may obtain Medicaid-covered services outside of the territory in certain circumstances. Patients can be referred to out-of-territory facilities for laboratory, X-ray, nursing facility, or inpatient-outpatient hospital services with prior authorization, when medically necessary, and when services are not available in USVI (CMS 2016b, CMS 2010,).

Enrollees under age 21 are provided with early and periodic screening, diagnostic, and treatment (EPSDT) services (CMS 2016c).

Individuals in the new adult group between 100 and 133 percent USVIPL are enrolled in an alternative benefit plan**.** USVI has elected to use the Federal Employee Health Benefits Blue Cross Blue Shield Service Benefit Plan as its base benchmark plan (CMS 2015b).

There are currently no cost-sharing requirements for Medicaid enrollees, including the new adult group (CMS 2015a, CMS 2015b).

Benefits for dually eligible beneficiaries

USVI provides Medicare cost-sharing assistance to dually eligible individuals who are eligible for full Medicaid benefits. It does not provide Medicare cost-sharing assistance to individuals who would have qualified for Medicare Savings Programs because these programs are not available in USVI or the other territories (HHS 2013).[1] Medicaid covers Medicare Part B premiums for individuals dually eligible for Medicare and Medicaid (CMS 2016c).

No Medicare Part D plans are currently available in USVI, but Medicaid pays all prescription drug costs for dually eligible individuals (CMS 2009, CMS 2016c). To help finance this, USVI receives an allotment from the Enhanced Allotment Plan, also referred to as 1935(e) funding. The Enhanced Allotment Plan provides additional federal funding allotments to USVI and the other territories to help low-income beneficiaries purchase prescription drugs.[2] The allotment is separate from the annual Section 1108 allotment described below and can only be used for this purpose (§ 1935(e) of the Act).

Delivery System

The Medicaid program is entirely fee for service, paying for most services at 100 percent of the USVI Medicare fee schedule (CMS 2014b).

Financing and Spending

The federal government and the government of USVI jointly finance the Medicaid program. USVI must contribute its non-federal share of Medicaid spending in order to access federal dollars, which are matched at the designated federal medical assistance percentage (FMAP), or matching rate. Unlike the states, for which federal Medicaid spending is open ended, USVI can access federal dollars only up to an annual ceiling on federal financial participation, referred to as the Section 1108 cap or Section 1108 allotment (§ 1108(g) of the Act).

Federal funding

USVI's Section 1108 allotment is specified in statute and grows with the medical component of the Consumer Price Index for All Urban Consumers (§ 1108(g)). USVI's CHIP allotment is determined by the Centers for Medicare & Medicaid Services (CMS) based on prior year spending, the same methodology used for states.

In general, once USVI exhausts its annual federal Medicaid and CHIP allotments, it must fund its program with local funds.[3] However, Congress has provided time-limited supplemental federal Medicaid funds to USVI and other territories on several occasions; most recently, through the FY 2020 appropriations package, signed into law on December 20, 2019 (P.L. 116-94), and the Families First Coronavirus Response Act, signed into law on March 18, 2020 (FFCRA, P.L. 116-127). These actions raised USVI's FY 2020 allotment from $18.8 million to $128.7 million and its FY 2021 allotment from approximately $19.2 million to $127.9 million (CMS 2019b).[4,5]

Additionally, the ACA provided the territories with a total of $7.3 billion in additional federal funds for their Medicaid programs (i.e., on top of their annual Section 1108 allotments).ACA Section 2005 provided $273.8 million to Guam, which were available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $24.9 million, available from January 2014 to December 2019.[6] Congress subsequently made additional funds available to USVI in response to the impact of Hurricane Maria on the USVI health system: the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) provided USVI with an additional $142.5 million, available for FYs 2018 and 2019.[7]

Congress has not made additional funding available after FY 2021 (i.e., September 30, 2021), which means that for FY 2022 and future years, USVI's Section 1108 allotment will revert to pre-P.L. 116-94 levels (approximately 19.6 million in FY 2022).

Federal medical assistance percentage

The FMAP for USVI and the other territories is set statutorily at 55 percent (§ 1905(b) of the Act), unlike that of the states, where the FMAP is set using a formula based on state per capita income. For FYs 2020 and 2021, USVI has a temporary FMAP of 83 percent. During the national emergency declared in response to the COVID-19 outbreak, effective January 1, 2020, USVI will receive the 6.2 percentage point increase provided by FFCRA to all states and territories. This brings USVI's FMAP to 89.2 percent during the emergency period. USVI will also receive a 100 percent CHIP enhanced FMAP during the emergency period

(CMS 2020a, b).[8] Like the states and other territories, the federal matching rate for almost all program administration is set at 50 percent (§ 1903(a)(7) of the Act).

USVI is eligible for enhanced matching rates for certain expenditures. The territories cannot claim the newly eligible FMAP of 100 percent available to states expanding to the new adult group; however, USVI is eligible for the expansion state FMAP for adults without dependent children that states were eligible to receive for expansions prior to the ACA, which is 93 percent in calendar year 2019 (CMS 2014a, § 1905(z)(2) of the Act).

USVI finances its portion of Medicaid program costs primarily through general funds (CMS 2016d). However, Congress provided a temporary 100 percent federal matching rate on several occasions, including for FYs 2018 and 2019 through the BBA, and for the period October 1, 2019–December 20, 2019 through the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) and the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69).

Total spending

USVI accounts for a small portion of federal Medicaid and CHIP spending in the territories. In FY 2020, its federal Medicaid spending was $77.8 million, or 3 percent of federal Medicaid spending in the territories. Federal CHIP spending was $11.8 million, or 7 percent of federal CHIP spending in the territories (Table 1).

TABLE 1. Medicaid and CHIP Spending in USVI, FY 2011–2020, by Source of Funds (millions)

	Medicaid				CHIP			
Year	Section 1108 allotment	Federal spending	Territory spending	Total spending	Federal allotment	Federal spending	Territory spending	Total spending
FY 2020	$128.7	$77.8	$8.6	**$86.5**	$11.6	$11.8	0.0	**$11.8**
FY 2019	18.3	123.6	27.7	**151.3**	10.9	14.0	1.3	**15.3**
FY 2018	17.9	70.0	7.0	**77.0**	7.3	10.4	1.0	**11.4**
FY 2017	17.3	46.7	22.9	**69.6**	6.9	8.2	0.8	**9.0**
FY 2016	16.8	51.7	27.0	**78.7**	5.3	6.2	0.6	**6.8**
FY 2015	16.5	27.6	18.1	**45.7**	5.0	3.8	1.6	**5.4**
FY 2014	16.1	22.4	16.9	**39.3**	4.0	4.0	1.7	**5.8**
FY 2013	15.8	15.4	12.3	**27.7**	–	–	–	**–**
FY 2012	14.9	21.5	17.5	**39.0**	–	–	–	**–**
FY 2011	14.5	17.6	16.1	**33.7**	–	1.8	0.9	**2.7**

Notes: USVI is U.S. Virgin Islands. FY is fiscal year. Section 1108 allotments reflect the annual federal allotments (also referred to as caps) that territories receive under Section 1108(g) of the Social Security Act Federal spending in excess of the Section 1108 allotment for FYs 2011 – 2019 reflects use of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) and Bipartisan Budget Act of 2018 (P.L. 115-123) as well as spending not subject to the ceiling on

federal financial participation. Federal CHIP allotments are provided under Section 2104 of the Social Security Act. If states and territories exhaust their own available CHIP allotments, they may receive additional funding from unused state CHIP allotments. USVI received these redistributed funds in FYs 2011 and FYs 2016–2020. USVI did not receive a CHIP allotment in FYs 2011–2013 because it did not report CHIP expenditures properly, which resulted in CMS adjusting its allotment to zero. CMS and territory officials have worked to correct these errors and restore the CHIP allotment (CMS 2016d). For FYs 2011–2015, spending data are from CMS and reflect prior period adjustments realigned from the year they were reported to the year they were applicable, so the values do not match the CMS-64 FMR net expenditure data. For FYs 2016–2019, data are from the CMS-64 FMR net expenditures data; spending for these years could change once prior period adjustments made in subsequent years are taken into account.

– Dash indicates a true zero.

Sources: MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2020; CMS 2019b.

As noted above, additional funds provided to USVI by P.L. 116-94 and FFCRA were structured as part of USVI's FYs 2020 and 2021 Section 1108 allotments. As a result, federal spending in FY 2020 did not exceed the allotment and is unlikely do so in FY 2021. In FYs 2011 through FY 2019, federal spending for Medicaid in USVI exceeded the annual Section 1108 allotments. This spending reflects the use of additional funds available through Sections 2005 and 1323 of the ACA and BBA 2018. Federal spending increased in FYs 2018 and 2019 relative to previous years due to the BBA's 100 percent FMAP, but decreased in FY 2020 (Table 1).

Data and Reporting

USVI reports data on Medicaid and CHIP enrollment, budgets, and expenditures using Form CMS-37, and on aggregate and category-specific spending using Form CMS-64 (CMS 2016d).

Like the other territories, USVI is not required to submit quarterly statistical and program expenditure data for CHIP (42 CFR 457.740). In addition, it is not required to report use of EPSDT services on Form CMS-416 or data on upper payment limit payments (CMS 2016d).

USVI has an operational Medicaid Management Information System (MMIS) for claims processing, which it implemented in partnership with West Virginia in 2013.[9] USVI contributes toward the cost of maintenance and operations and can access federal funds not countable toward the annual Medicaid cap at a 75 percent match for this purpose (GAO 2015, CMS 2016d). USVI is currently reporting data to the Transformed Medicaid Statistical Information System (T-MSIS).[10]

USVI must report to the chair and ranking member of the House Committee on Energy and Commerce and of the Senate Committee on Finance on how it used the extra funds provided by P.L. 116-94 within 30 days of the end of FYs 2020 and 2021.

Quality and Program Integrity

USVI has implemented several program integrity measures required for states and territories, including provider screening and enrollment measures, as well as provisions related to non-payment for health care-acquired conditions and provider-preventable conditions (CMS 2013a). It also conducts post-payment

reviews of claims to detect improper payments using the Surveillance and Utilization Review Subsystem, which is a subset of the MMIS (GAO 2015).

Unlike the states, USVI is statutorily exempt from the Payment Error Rate Measurement program, from facing repayments under the Medicaid Eligibility Quality Control program, and is not required to implement an asset verification system with a financial institution (42 CFR 431.954; §§ 1903(u)(4) and1940(a)(4) of the Act). It implemented a MFCU in 2018, consistent with the BBA's requirement to make progress toward establishing one as a condition of additional funding.

P.L. 116-94 included new program integrity requirements for USVI. Before the end of FY 2020, USVI is required to designate a program integrity lead within the Medicaid agency other than the Medicaid director.[11]

Endnotes

[1] Unlike the states, USVI and the other territories are not required to establish Medicare Savings programs (§ 1905(p)(4)(A) of the Act).

[2] Like the other territories, USVI is not eligible for the Medicare Part D low-income subsidy (§ 1935(e)(1)(A) of the Act).

[3] Federal funds for the Enhanced Allotment Plan, electronic health record incentive program payments, and the establishment and operation of eligibility systems and Medicaid Management Information Systems (MMIS) do not count against the Section 1108 allotment.

[4] P.L. 116-94 raised the FYs 2020 and 2021 allotments to $126 million. Subsequently, FFCRA further raised the FY 2020 allotment to $128.7 million and the FY 2021 allotment to $127.9 million.

[5] We estimate what the FY 2021 allotment would have been without P.L. 116-94 by trending the pre-P.L. 116-94 FY 2020 allotment by 2.3 percent (percent change in the medical component of the Consumer Price Index for All Urban Consumers for the 12-month period ending March 2019).

[6] With the funds from Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. Neither USVI nor the other territories chose to establish an exchange.

[7] Of these funds, $35.6 million were conditional on USVI achieving milestones related to data reporting and program integrity. The territory met these conditions and will receive the full amount (CMS 2018b).

[8] Prior to P.L. 116-94 and FFCRA, USVI's FY 2020 CHIP enhanced FMAP was 80 percent (§ 2101(a) of the ACA; MACPAC 2019). The 89.2 percent FMAP provided during the emergency period serves as the base for calculating the CHIP enhanced FMAP during the emergency period (CMS 2020a, b).

[9] West Virginia began allowing USVI to use its MMIS in 2013 in a first-of-its-kind partnership. While West Virginia does not charge USVI for the use of the system, USVI does contribute towards maintenance and operating costs, which it pays directly to the fiscal agent. This arrangement allows USVI to avoid having to construct a system from scratch and allows West Virginia to reduce its own contribution towards maintenance and operations (CMS 2016d).

[10] $35.6 million of the $142.5 million in federal Medicaid funds provided by BBA 2018 were conditional on USVI making reasonable and appropriate steps, as certified by and on a timeline specified by the Secretary of the U.S. Department of Health and Human Services, toward establishing methods of collecting and reporting reliable data to T-MSIS and establishing a Medicaid fraud control unit (MFCU). The territory met these requirements and received the full amount of BBA funds (CMS 2018b)

[11] If this requirement is not met, USVI will be subject to an FMAP reduction in each quarter of FY 2021. The amount of the potential reduction is 0.25 percentage points multiplied by the number of quarters the requirement is not satisfied (not to exceed 5 percentage points).

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