MACPAC | Medicaid and CHIP Payment and Access Commission

Statement of
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Medicaid and CHIP
Payment and Access Commission

Before the
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives

June 20, 2019

Medicaid and CHIP Payment
and Access Commission

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Summary

Medicaid and CHIP play a vital role in providing access to health services for low-income individuals in the five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. The territories face similar issues to those in the states: populations with significant health care needs, an insufficient number of providers, and constraints on local resources. With some exceptions, they operate under similar federal rules and are subject to oversight by the Centers for Medicare & Medicaid Services.

However, the financing structure for Medicaid in the territories differs from state programs in two key respects. First, territorial Medicaid programs are constrained by an annual ceiling on federal financial participation, referred to as the Section 1108 cap or allotment (§1108(g) of the Social Security Act). Territories receive a set amount of federal funding each year regardless of changes in enrollment and use of services. In comparison, states receive federal matching funds for each state dollar spent with no cap.

Second, the federal medical assistance percentage (FMAP), often referred to as the matching rate, is statutorily set at 55 percent rather than being based on the territory's per capita income, as is the case with states. If it were set using the formula used for states, the matching rate for all five territories would be the maximum: 83 percent.

These two policies have resulted in chronic underfunding of the program in the territories, requiring Congress to step in at multiple points to provide additional resources. In addition to a substantial infusion of federal funds in 2010 under the Patient Protection and Affordable Care Act, the Balanced Budget Act of 2018 provided Puerto Rico and USVI with further funding available at a 100 percent FMAP until September 30, 2019. Earlier this month, enactment of the Additional Supplemental Appropriations for Disaster Relief Act of 2019 provided additional funds to CNMI at 100 percent FMAP through the end of this fiscal year (FY). It also allowed American Samoa and Guam to access their remaining ACA funds during this period at a 100 percent matching rate; these funds would otherwise have gone unspent given constraints on these territories' ability to provide the non-federal share.

All five territories should now have sufficient funding to cover program expenses through the remainder of FY 2019. However, because all sources of supplemental funds will expire in 2019, MACPAC anticipates that all five will experience federal funding shortfalls in FY 2020. The territories must consider how to proceed. Options include funding Medicaid entirely with unmatched local funds if available, cutting services, rolling back eligibility, reducing or suspending provider payments, or a combination thereof.

As Congress considers the pending shortfall, it is important to note that an additional infusion of federal funds would avert a fiscal cliff and ensure the continued delivery of critical health care services to eligible individuals in the short term. However, such action would not address underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term, reliable access to care for Medicaid beneficiaries residing in these jurisdictions.

Statement of Anne L. Schwartz, PhD, Executive Director Medicaid and CHIP Payment and Access Commission

Good morning Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee. I am Anne Schwartz, executive director of the Medicaid and CHIP Payment and Access Commission (MACPAC). As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing policies for Medicaid and the State Children's Health Insurance Program (CHIP) and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on issues affecting these programs. The Commission's 17 members, including Chair Melanie Bella and Vice Chair Chuck Milligan, are appointed by the U.S. Government Accountability Office (GAO). While the insights and information I will share this morning are based on analyses conducted by MACPAC's staff, they are in fact the views of the Commission itself. We appreciate the opportunity to share MACPAC's work as this body considers the role of Medicaid and CHIP in the five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands (USVI).

As in the states and the District of Columbia, Medicaid and CHIP play a vital role in providing access to health services for low-income individuals in the territories. The territories face similar issues to those in the states: populations with significant health care needs, an insufficient number of providers, and constraints on local resources. With some exceptions, they operate under similar federal rules and are subject to oversight by the Centers for Medicare & Medicaid Services (CMS).

However, the financing structure for Medicaid in the territories differs from state programs in two key respects. First, rather than having an open-ended financing structure, territorial Medicaid programs are constrained by an annual ceiling on federal financial participation, referred to as either the Section 1108 cap or Section 1108 allotment (§1108(g) of the Social Security Act (the Act)). This means that territories receive a set amount of federal funding each year regardless of changes in enrollment and use of services. In comparison, states receive federal matching funds for each state dollar spent with no cap.

Second, the federal medical assistance percentage (FMAP), often referred to as the matching rate, is statutorily set at 55 percent rather than being based on per capita income. If it were set using the formula used for states, the matching rate for all five territories would be the maximum: 83 percent.

These two policies have resulted in chronic underfunding of the program in the territories, requiring Congress to step in at multiple points to provide additional resources. In addition to a substantial infusion of federal funds in 2010 under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the Balanced Budget Act of 2018 (BBA 2018, P.L. 115-123) provided Puerto Rico and USVI with further funding available at a 100 percent FMAP until September 30, 2019. Earlier this month, enactment of the Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L.116-20) provided additional funds to CNMI at 100 percent FMAP through the end of this fiscal year (FY). It also allowed American Samoa and Guam to access their remaining ACA funds during this period at a 100 percent matching rate; these funds would otherwise have gone unspent given constraints on these territories' ability to provide the non-federal share.

MACPAC's most recent estimates suggest that all five territories should now have sufficient funding to cover program expenses through the end of FY 2019. However, because all sources of supplemental funds will expire in 2019, MACPAC anticipates that all five will experience federal funding shortfalls in FY 2020.

In the face of such a shortfall, the territories must consider how to proceed. Options include funding Medicaid entirely with unmatched local funds if available, cutting services, rolling back eligibility, reducing or suspending provider payments, or a combination thereof. The specific date of funding exhaustion in each territory will depend on actual spending.

As the Commission noted in its analysis of Puerto Rico's Medicaid program in its June 2019 report to Congress, the history of responding to crises with short-term infusions of funds has caused a great deal of uncertainty. Although an additional time-limited allotment of federal funds would prevent a fiscal cliff and ensure the continued delivery of critical health care services to eligible individuals in the short term, it would not address the underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term, reliable access to care for Medicaid beneficiaries residing in these jurisdictions (MACPAC 2019d).

Below I describe how Medicaid operates in the territories, focusing on policies related to eligibility and enrollment, benefits, delivery system, data and reporting, quality and program integrity, and financing. It is important to note that while territory Medicaid programs differ from the states, they also differ from each other, reflecting their unique geography, history, local economy, and health system infrastructure.

My testimony then turns to spending patterns and MACPAC's latest estimates as to when territories will exhaust current supplemental sources of federal funding.

How Medicaid Operates in the Territories

Under the Social Security Act, the territories are considered states for the purposes of Medicaid and CHIP, unless otherwise indicated (§1101(a)(1) of the Act). Two territories, CNMI and American Samoa, operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them. This provision allows the HHS Secretary to waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the FMAP, and the requirement that payment can only be for services otherwise coverable by Medicaid. It is also important to note that while neither provides all of Medicaid's mandatory benefits, these territories are considered in compliance with federal Medicaid law.

Eligibility and enrollment

All five territories are permitted to establish income-based eligibility using a measure other than the federal poverty level (FPL). Guam, Puerto Rico, and USVI use local poverty levels to establish eligibility, which are updated by an amendment to the Medicaid state plan. These three territories are also statutorily exempt from providing Medicaid coverage to certain mandatory groups including poverty-related children and pregnant women and qualified Medicare beneficiaries (§§1902(l)(4)(B) and 1905(p)(4)(A) of the Act). American Samoa and CNMI are exempt from these requirements under their 1902(j) waivers.

American Samoa and CNMI use unique methods to establish income-based eligibility. In American Samoa, Medicaid eligibility is not determined on an individual basis and individuals do not enroll in Medicaid or CHIP as they do in all other territories and states. Instead, federal Medicaid and CHIP funds pay for care provided in the territory in proportion to the population of American Samoans with incomes that would

have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent FPL (CMS 2014). CNMI, the only territory participating in Supplemental Security Income (SSI), uses SSI income and asset standards to determine Medicaid eligibility (CMS 2016a).

Guam, Puerto Rico, and USVI have elected to expand their Medicaid programs to the new adult group up to 133 percent of the local poverty level (CMS 2016a).

All five territories operate Medicaid-expansion CHIP programs (CMS 2015). Puerto Rico is the only territory that uses its CHIP funds to cover additional children whose income levels exceed regular Medicaid eligibility levels. The other four territories use their CHIP funds to pay for services provided to children under age 19 in their Medicaid programs and can access CHIP's enhanced FMAP for these individuals (CMS 2016a).

Territories vary widely in the percentage of their populations covered by Medicaid or CHIP due to differences in eligibility standards and methodologies, as well as differences in economic conditions (Table 1).

TABLE 1. Medicaid and CHIP Enrollment as a Share of the Population, August 2017

Territory	Number of enrollees	Approximate percentage of population enrolled in Medicaid or CHIP
American Samoa	41,214	79 %
CNMI	15,472	33
Guam	35,559	21
Puerto Rico	1,232,367	37
USVI	17,552	16

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Enrollment figures for American Samoa are estimates of the portion of the population below 200 percent of the federal poverty level, the population for which Medicaid pays for health care services. American Samoa does not make individual eligibility determinations and does not have an enrolled population. Enrollment figures for Puerto Rico include 85,188 children enrolled in CHIP as reported by Puerto Rico for September 2017.
Sources: CMS 2018b. Departamento de Salud 2019. MACPAC analysis of population data estimates from the 2017 American Community Survey and Central Intelligence Agency World Factbook as of October 2017.

Benefits

Medicaid benefits vary across territories. American Samoa and CNMI are not required to offer mandatory Medicaid benefits under their Section 1902(j) waivers. Guam, Puerto Rico, and USVI are required to offer all mandatory benefits, but currently Guam is the only territory to do so. For example, USVI does not cover freestanding birth center or rural health clinic services; Puerto Rico does not cover non-emergency medical transportation or nursing facility services, citing lack of infrastructure and funding (GAO 2016).

In all territories, individuals under age 21 are eligible to receive early and periodic screening, diagnostic, and treatment services (EPSDT) (GAO 2016, CMS 2016e).[1] Additionally, all territories provide some optional benefits. For example, all territories cover prescription drugs, clinic services, dental services, and eyeglasses.[2]

In all five territories, Medicaid offers some form of cost-sharing assistance for Medicare enrollees who are also eligible for full Medicaid benefits (CMS 2016b). Medicaid programs in American Samoa, Guam, CNMI, and USVI pay Medicare Part B premiums for dually eligible individuals (CMS 2016e). Puerto Rico pays premiums and cost sharing for Medicare Platino plans, a type of Medicare Advantage special needs plan that includes Medicare Part A and B services as well as outpatient prescription drugs. Almost all dually eligible Puerto Ricans are enrolled in Medicare Platino (CMS 2013).

The Medicare Savings Programs, which provide cost sharing assistance to individuals who would qualify as partially dually eligible individuals in the states, are not available in the territories.[3] Similarly, Medicare Part D plans are not available in the territories, but territorial Medicaid programs typically provide prescription drugs to dually eligible beneficiaries. To offset the cost of doing so, territories each receive an additional allotment from the Enhanced Allotment Plan, also referred to as 1935(e) funding. This allotment is separate from the Section 1108 allotment and can only be used to help pay for prescription drugs for low-income beneficiaries (§1935(e) of the Act).[4]

Delivery system

Puerto Rico is currently the only territory to use managed care, in which the entire Medicaid population is enrolled. Managed care organizations (MCOs) provide commonwealth-wide acute, primary, specialty, and behavioral health services. They are paid risk-based capitated payments. MCOs contract with primary medical groups, which in turn create preferred provider networks (PPNs). Enrollees are auto-assigned to a health plan but may switch once per year, and do not need referrals for specialists in their PPN (MACPAC 2019d).

The Medicaid programs in the other four territories operate on a fee-for-service basis. In American Samoa, Guam, and CNMI, most Medicaid services are provided by one hospital that is owned and operated by the territory. In recent years, these territories have expanded the availability of services at other locations and increased provision of off-island services when medically necessary or when services are not available in the territory (CMS 2016a, MACPAC 2019a-c).

The territories do not receive a Medicaid disproportionate share hospital (DSH) allotment and therefore do not make DSH payments to hospitals (§1923(f)(9) of the Act).

Data and reporting

Like states, the territories report Medicaid and CHIP budget projections using Form CMS-37 and provide data on enrollment and spending (both aggregate and by category) using Form CMS-64. The territories are not required to report expenditures in excess of their federal limits, although, in general, they report all of their spending (CMS 2016e).

Under their Section 1902(j) waivers, American Samoa and CNMI are exempt from all data and reporting requirements. Additionally, none of the territories are considered states for the purpose of required quarterly reporting of statistical and program expenditure data for CHIP (42 CFR 457.740). Due to administrative capacity constraints, American Samoa, Guam, and Puerto Rico are unable to report all of the same data as states even when they are not statutorily exempt. For example, CMS does not collect EPSDT service data via Form CMS-416 from any of the territories, or data on upper payment limit (UPL) payments for any of the territories except Guam (CMS 2016d).

Use of the Medicaid Management Information System (MMIS), which states typically use for processing claims, has been limited among the territories but is changing. Puerto Rico and USVI now both have a fully operational MMIS certified to report data to the CMS Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS is the primary administrative data set used for Medicaid program oversight and accountability, and includes data on eligibility, enrollment, utilization, and spending. USVI implemented its MMIS in partnership with West Virginia (GAO 2015). For the purposes of developing an MMIS, territories can access federal Medicaid funds that do not apply toward their annual Section 1108 allotments at a 90 percent federal match (CMS 2016c).

The Bipartisan Budget Act of 2018 conditioned a portion of the additional funds it provided to Puerto Rico and USVI on their making improvements to data reporting and program integrity capacity. The territories were required to take reasonable and appropriate steps, as certified by and on a timeline specified by the Secretary, toward establishing methods of collecting and reporting reliable data to T-MSIS and establishing a Medicaid fraud control unit (MFCU). Both Puerto Rico and USVI met their targets on schedule and will receive the full amount of BBA 2018 funds (CMS 2018c). Similarly, under the recent disaster relief legislation, P.L. 116-20, American Samoa and Guam must each submit a plan by September 30, 2019 that describes the steps they will take to collect and report reliable data to T-MSIS.

Quality measurement and program integrity

Territories are not required to participate in many of the quality and program integrity efforts that apply to states. CNMI and American Samoa are exempt from these requirements through their 1902(j) waivers. Puerto Rico, USVI, and Guam are statutorily exempt from the Payment Error Rate Measurement (PERM) program, from facing repayments under the Medicaid Eligibility Quality Control program (MEQC), and are not required to implement asset verification systems with financial institutions (42 CFR 431.954, and§§1903(u)(4) and 1940(a)(4) of the Act).

Some territories have implemented provider screening, as well as provisions related to non-payment for health care acquired and provider preventable conditions. Puerto Rico, whose entire Medicaid population is enrolled in managed care, requires quality reporting in its managed care contracts (CMS 2016e). It further

increased expectations for plans' quality and program integrity responsibilities in its most recent managed care restructuring, implemented in 2018 (MACPAC 2019d).

Puerto Rico and USVI established MFCUs in 2018 and 2019, respectively (CMS 2018c). Guam is also required to establish a MFCU but has not yet done so. Expenditures for establishing an MFCU do not count toward the Section 1108 allotment.

Financing

As noted above, the federal and territorial governments jointly finance Medicaid. Each territory must contribute its non-federal share of Medicaid spending in order to access federal dollars. Non-federal share is matched at the designated FMAP, which is statutorily set for most expenditures at 55 percent. Unlike the states and the District of Columbia, for which federal Medicaid spending is open ended, the territories can only access federal dollars up to the annual Section 1108 allotment.

Federal funding sources and amounts. The territories' Section 1108 allotments are specified in statute, and grow with the medical component of the Consumer Price Index for All Urban Consumers (CPI-U) (§1108(g)). The territories' CHIP allotments are determined by CMS based on prior year spending, the same methodology used for states.

Historically, the amount of Section 1108 allotment funding has been insufficient to fund Medicaid in the territories. In general, once a territory exhausts its annual federal Medicaid and CHIP allotments, it must fund its program with local funds. However, Congress has provided additional federal Medicaid funds on a temporary basis to the territories on multiple occasions. For example, the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) raised each territory's annual allotment by 30 percent for the period between October 1, 2009 and June 30, 2011 (§5001(d) of ARRA).

The ACA also provided the territories with additional federal funding for their Medicaid programs. Under Section 2005, $6.3 billion was to be allocated by the Secretary and made available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $1 billion to the territories, $925 million of which was directed to Puerto Rico and the remainder of which was allocated by the

Secretary. These funds are available to be drawn down between January 2014 and December 2019. In total, this additional funding ranged from $109.2 million for CNMI to $6.3 billion for Puerto Rico (CMS 2016a).

The territories have all accessed these supplemental funds, but have done so at different rates, reflecting differences in the structure of their programs and availability of funds to provide the non-federal share. Puerto Rico and CNMI drew down their allotments more quickly than other territories, with Puerto Rico facing imminent funding shortfalls in FY 2017 and 2018, and CNMI experiencing a gap in federal Medicaid funds in March 2019.

In subsequent legislation, Congress provided further additional funds for certain territories, which are available through September 30, 2019. These additional appropriations were made to address the shortfalls in Puerto Rico and CNMI noted above, and to respond to natural disasters affecting all five territories in 2017, 2018, and 2019. Funding was provided as follows:

- The Consolidated Appropriations Act of 2017 (P.L. 115-31) provided Puerto Rico with an additional $295.9 million.
- BBA 2018 (P.L. 115-123) provided Puerto Rico with an additional $4.8 billion and USVI with an additional $142.5 million in federal Medicaid funds in response to the impact of Hurricane Maria on those territories health systems.
- The Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L. 116-20) provided CNMI with an additional $36 million (Table 2).

TABLE 2. Sources of Federal Medicaid Funding for Territories and Periods of Funding Availability

Territory	FY 2019 § 1108 allotment	ACA			P.L. 115-31	BBA 2018	P.L. 116-20
		§ 2005	§ 1323	Total ACA funds			
	Grows annually with CPI-U	July 2011-September 2019	January 2014–December 2019	July 2011–September or December 2019	May 2017–September 30 2019	FYs 2018 and 2019	January 1 2019–September 30 2019
American Samoa	$12.15 million	$181.31 million	$16.51 million	197.82 million	None	None	None
CNMI	$6.70 million	$100.14 million	$9.11 million	$109.25 million	None	None	$36 million
Guam	$17.97 million	$268.34 million	$24.44 million	$292.78 million	None	None	None
Puerto Rico	$366.70 million	$5.48 billion	$925.00 million	$6.40 billion	$295.9 million	$4.8 billion	None
USVI	$18.33 million	$273.82 million	$24.93 million	$298.75 million	None	$142.5 million	None

Notes: § 1108 allotment reflects the annual federal allotments (or caps) for federal funds that territories receive under Section 1108(g) of the Social Security Act. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-142, as amended). BBA 2018 is the Bipartisan Budget Act of 2018 (P.L. 115-123). CPI-U is the consumer price index for all urban consumers. FY is fiscal year. CNMI is the Commonwealth of the Northern Mariana Islands. P.L. 115-31 is the Consolidated Appropriations Act of 2017. P.L. 116-20 is the Additional Supplemental Appropriations for Disaster Relief Act of 2019. USVI is the U.S. Virgin Islands.
Sources: CMS 2019b; MACPAC analysis of the ACA. BBA, P.L. 115-31, and P.L. 116-20.

Once the available funds expire or are exhausted, territories generally will not be able to spend federal dollars beyond their respective allotments for Medicaid and CHIP.[5]

Federal medical assistance percentage. The FMAP for the territories is set statutorily at 55 percent, unlike those for states which are set using a formula based on states' per capita incomes (§1905(b) of the Act). For the states, the FMAP provides higher reimbursement to those with lower per capita incomes relative to the national average and vice versa, and is intended to reflect states' differing abilities to fund Medicaid from their own revenues. The FMAP for states has a statutory minimum of 50 percent and a maximum of 83 percent.

There are several exceptions to the 55 percent FMAP. The territories' CHIP enhanced FMAP is 91.5 percent (§2101(a) of the ACA; MACPAC 2015a). Like the states, the matching rate for almost all program administration is set at 50 percent (§1903(a)(7) of the Act).

While the territories cannot claim the higher FMAP for covering the ACA's new adult group, they were eligible for a temporary 2.2 percentage point increase in their regular FMAP for all state plan populations between January 1, 2014 and December 31, 2015 (§§1905(y)(1) and 1905(z)(1)(A) of the Act) (CMS 2016b). This raised their FMAPs to 57.2 percent during this period. Additionally, territories are eligible for the expansion state enhanced 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 (§1905(z)(2) of the Act). Currently, only Guam, Puerto Rico, and USVI are accessing this early expansion FMAP.[6]

In general, territories must contribute a non-federal share at the applicable matching rate in order to gain access to federal funds. However, Congress made some of the territories' supplemental appropriations available at a 100 percent matching rate, including:

- funds provided for Puerto Rico and USVI under BBA 2018;
- ACA Section 2005 funds expended by American Samoa and Guam between January 1, 2019 and September 30, 2019; and,
- funds provided to CNMI under the recent disaster relief bill.

Sources of the non-federal share. The territories fund the non-federal share of their Medicaid and CHIP programs through general fund revenues and certified public expenditures. Puerto Rico, USVI, and Guam primarily operate using general funds, American Samoa primarily uses certified public expenditures, and CNMI uses a combination (CMS 2016e).

Once they reach their annual cap, territories must cover any additional Medicaid expenses entirely with unmatched territorial or local funds. Historically, this has resulted in FMAPs that are effectively lower than 55 percent. For example, at times, the effective federal contribution for Puerto Rico has been 20 percent or lower (Muñoz et al. 2011, Acevedo-Vilá 2005).

Spending

In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. For American Samoa, CNMI, and Guam, this spending reflects the use of the additional funds available under Sections 2005 and 1323 of the ACA. For Puerto Rico and USVI, it primarily reflects use of BBA 2018 funds. In FY 2019, federal spending over the annual Section 1108 allotment amount is likely to increase, because all five territories will have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds.

Spending in Puerto Rico accounts for the vast majority of federal Medicaid and CHIP spending in the territories, primarily due to its significantly larger covered population. In FY 2018, federal Medicaid spending in all five territories totaled $2.46 billion, with $2.29 billion (93 percent) attributable to Puerto Rico. Federal CHIP funding totaled $229.6 million, with $173.4 million (76 percent) attributable to Puerto Rico (Table 3).

TABLE 3. Medicaid and CHIP Funding and Spending in the Territories, FY 2018 (millions)

Territory	Medicaid			CHIP		
	§ 1108 allotment	Spending		Federal allotment	Spending	
		Federal	Territory		Federal	Territory
American Samoa	$11.9	$20.1	$15.3	$3.1	$4.6	$0.2
CNMI	6.6	25.0	20.0	7.1	10.6	0.8
Guam	17.6	56.3	29.5	28.1	30.6	2.6
Puerto Rico	359.5	2,290.5	203.0	203.8	173.4	16.1
USVI	17.87	70.0	7.0	7.3	10.4	1.0

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. USVI is the U.S. Virgin Islands. § 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act, while the actual federal spending reflects utilization of the additional allotments provided by the ACA and BBA 2018 as well as spending not subject to the cap 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. American Samoa, CNMI, Guam, and USVI received these redistributed funds in FY 2018.
Sources: CMS 2018c; MACPAC 2018b; MACPAC 2019 analysis of CMS-64 financial management report net expenditure data as of March 27, 2019; MACPAC 2018 analysis of American Samoa, CNMI, and Guam Medicaid program expenditure narrative reports.

Exhaustion of Federal Medicaid Funds

Because annual Section 1108 funds have been historically inadequate to cover the federal share of Medicaid spending, all five territories have relied on supplemental funds since 2011. However, as noted above, all sources of supplemental funds will expire in 2019, and MACPAC anticipates federal funding shortfalls in all five territories in FY 2020. The specific date of funding exhaustion in each territory will depend on the extent to which actual spending matches projections, and the amount of unspent funds available (Table 4).

TABLE 4. Date of Expected Federal Medicaid Funding Shortfall by Territory

Territory	Date range for shortfall
American Samoa	July–September 2020
CNMI	April–June 2020
Guam	April–June 2020
Puerto Rico	March 2020
USVI	January–March 2020

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Date range indicates the timeframe in which the territories will exhaust available federal funds. Sufficient funds may not be available for the entirety of the timeframe, as territories may exhaust available funds earlier or later in the period depending on actual spending and other specific circumstances.
Sources: MACPAC 2019 analysis of CMS 2019a, b; CMS-37 projections of spending for FYs 2019–2020 submitted in May 2019.

Additionally, having sufficient federal funding available to cover Medicaid spending at the 55 percent FMAP does not necessarily indicate that all health needs will be met; several territories have struggled to generate the non-federal share needed to draw down federal funds. At times, lack of local funds, rather than federal funds, has caused territories to suspend payments to providers or deny services. For example, in the territories relying on a single hospital that provide the local share through certified public expenditures, that hospital's physical capacity to provide services limits expenditures and thus the amount of non-federal share that can be raised. Furthermore, certified public expenditures cannot be used to provide the non-federal share for services provided outside the hospital, which include costly off-island services for individuals with complex health care needs (King Young 2019). Difficulty generating non-federal share has been a key barrier to American Samoa's ability to draw down federal dollars (CMS 2018a).

Endnotes

[1] While all territories technically provide the EPSDT benefit under the state plan, there are instances of limitations on the benefit. For example, a report by the 2011 President's Task Force on Puerto Rico's Status found that the children in Puerto Rico's Medicaid program only received limited benefits through EPSDT (Muñoz et al. 2011).

[2] Historically, territories were not included in the Medicaid drug rebate program but may have received territorial government-mandated price concessions and other discounts. Effective April 1 2020, territories will be included in the Medicaid drug rebate program but may request a waiver to opt out (CMS 2016d).

[3] Unlike the states, the territories are not required to establish Medicare Savings Programs (§ 1905(p)(4)(A) of the Act).

[4] Individuals in the territories are not eligible for the Medicare Part D Low-Income Subsidy (§1935(e)(1)(A) of the Act).

[5] Federal funds for the Enhanced Allotment Plan, electronic health record incentive program payments, and the establishment and operation of eligibility systems, Medicaid Management Information Systems (MMIS), and—beginning on July 1, 2017 for Puerto Rico and January 1, 2018 for USVI—Medicaid fraud control units do not apply toward the annual Section 1108 allotment.

[6] Because of these exceptions to the FMAP, the overall federal share of spending can be higher than 55 percent. For example, in FY 2017, federal spending covered 66.4 percent of total spending in Puerto Rico (MACPAC 2019d).

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