MACPAC | Medicaid and CHIP Payment and Access Commission

Statement of
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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) is statutorily set at 55 percent rather than being based on per capita income. If it were set using the state formula, the matching rate for all five territories would be significantly higher, and for most, would likely be the maximum of 83 percent.

These two policies have resulted in chronic underfunding of Medicaid in the territories, requiring Congress to step in at multiple points to provide additional resources. The most recent infusions of federal funds were enacted as part of the Further Consolidated Appropriations Act, 2020 (P.L. 116-94) and the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). P.L. 116-94, enacted in December 2019, substantially raised each territory's Section 1108 allotment for fiscal years (FYs) 2020 and 2021 and raised the FMAP to 76 percent for Puerto Rico and 83 percent for the other territories. It provided an additional $200 million for Puerto Rico for each of those fiscal years, conditional on implementation of a provider payment increase. It also created new requirements for reporting, administration, and program integrity. In March 2020, FFCRA further raised allotments for FYs 2020 and 2021. It also extended a 6.2 percentage point FMAP increase to all states and territories effective January 1, 2020 through the end of the quarter in which the national public health emergency ends, bringing territory FMAPs to 82.2 percent for Puerto Rico and 89.2 percent for other territories.

This additional funding is sufficient for territories to continue Medicaid program operations, and in some cases, pursue new initiatives and improvements for FYs 2020 and 2021. However, MACPAC anticipates that all five will experience federal funding shortfalls in FY 2022 when Section 1108 allotments return to their regular levels. The territories must consider how to proceed. Options include cutting services, rolling back eligibility, reducing or suspending provider payments, or a combination thereof. We do not expect that the territories will be able to fill the funding gap with local funds.

As Congress looks ahead, 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 Guthrie, 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 today 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). I also want to point out that while MACPAC has reached out to the territories and to the Centers for Medicare & Medicaid Services (CMS) in the course of our analytic work, we do not do oversight or conduct audits.

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 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, all territories would receive a much higher FMAP. Specifically, American Samoa, CNMI, Guam, and Puerto Rico would likely receive the maximum of 83 percent. The USVI would likely receive an FMAP that is among the top five highest matching rates. In fiscal year (FY) 2021, the top five highest matching rates range from 72.1 percent (Kentucky) to 77.8 percent (Mississippi).[1]

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.

The most recent infusions of federal funds were enacted as part of the Further Consolidated Appropriations Act, 2020 (P.L. 116-94) and the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). P.L. 116-94, enacted in December 2019, substantially raised each territory's Section 1108 allotment for FYs 2020 and 2021 and raised the FMAP to 76 percent for Puerto Rico and 83 percent for the other territories. It provided an additional $200 million for Puerto Rico for each of those fiscal years, conditional on implementation of a provider payment increase.[2] It also created new requirements for reporting, program administration, and program integrity. Shortly thereafter, FFCRA raised allotments further. Moreover, it extended a 6.2 percentage point FMAP increase to all states and territories effective January 1, 2020 through the end of the quarter in which the national public health emergency declared in response to the COVID-19 pandemic ends. This brought FMAPs to 82.2 percent for Puerto Rico and 89.2 percent for other territories.

MACPAC's most recent estimates suggest that all five territories should now have sufficient funding to cover program expenses through the end of FY 2021. However, because Section 1108 allotments will revert to their regular levels (as specified in the Social Security Act) in FY 2022, MACPAC anticipates that all five will experience federal funding shortfalls in FY 2022 (Table 1).

TABLE 1. Territory Section 1108 Allotments for Fiscal Years 2019–2022 (millions)

Territories	2019	2020		2021		2022[1]
		Without P.L. 116-94 and FFCRA	Current law	Without P.L. 116-94 and FFCRA[1]	Current law	
American Samoa	$12.2	$12.4	$86.3	$12.7	$85.6	$13.0
CNMI	6.7	6.9	63.1	7.1	62.3	7.2
Guam	18.0	18.4	130.9	18.8	129.7	19.2
Puerto Rico	366.7	375.1	2,716.2	383.7	2,809.1	392.5
USVI	18.3	18.8	128.7	19.2	127.9	19.6

Notes: Section 1108 allotments reflect the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. P.L. 116-94 is the Further Consolidated Appropriations Act of 2020. FFCRA is the Families First Coronavirus Response Act (P.L. 116-127). CNMI is Commonwealth of the Northern Mariana Islands. USVI is U.S. Virgin Islands. The Further Consolidated Appropriations Act of 2020 initially raised each territory's FYs 2020 and 2021 allotments to $84.0 million per fiscal year for American Samoa, $60.0 million per fiscal year for CNMI, $127.0 million per fiscal year for Guam, and $126.0 million per fiscal year for USVI; it also raised Puerto Rico's FY 2020 allotment to $2.6 billion and its FY 2021 allotment to $2.7 billion. FFCRA subsequently raised these allotments to the amounts shown.

In addition to the amounts shown, Puerto Rico was eligible to receive $200 million in each of fiscal years 2020 and 2021 if the Secretary certifies that Puerto Rico established a payment floor for physician services of at least 70 percent of the payment rates that would apply for such services under Medicare Part B. Puerto Rico implemented this increase in 2020 (ASES 2020a).

[1] Estimated by trending FY 2020 allotments (prior to enactment of the Further Consolidated Appropriations Act of 2020) by 2.3 percent (i.e., percent change in the medical component of the Consumer Price Index for All Urban Consumers for the 12-month period ending March 2019).

Source: MACPAC analysis of the Further Consolidated Appropriations Act of 2020 and FFCRA; CMS 2019a.

In the face of such a shortfall, the territories must consider how to proceed. Typically, options include cutting services, rolling back eligibility, reducing or suspending provider payments, or a combination thereof. We do not expect that the territories will be able to fill the funding gap with local funds. The specific date of funding exhaustion in each territory will depend on actual spending. At this time, MACPAC does not have sufficient data on actual and projected spending to comment on the timing of the exhaustion. It is also important to note that the timing of such shortfalls will also be affected by when the public health emergency ends.

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 provided temporary relief but has also 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 2019).

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, noting relevant recent programmatic improvements. It is important to note that while territory Medicaid programs differ from the states, they also differ from each other in size and other factors, reflecting their unique geography, history, local economy, and health system infrastructure.

My testimony will then turn to spending patterns for the territories and the upcoming fiscal cliff. I conclude by noting some of the unique challenges facing the territories that affect current and future funding needs.

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 these two territories. 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 can be updated by an amendment to the Medicaid state plan (MACPAC 2021a – c). 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).[3] 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 (MACPAC 2021d). CNMI, the only territory participating in Supplemental Security Income (SSI), uses SSI income and asset standards to determine Medicaid eligibility (MACPAC 2021e).

Guam, Puerto Rico, and USVI adopted the Medicaid expansion to the new adult group up to 133 percent of the local poverty level (MACPAC 2021c – e). In addition, both USVI and Puerto Rico subsequently increased eligibility further through amendments to their local poverty levels. Puerto Rico's increase in eligibility is temporary through the end of FY 2021 (Galva Rodriguez 2021).

All five territories operate Medicaid-expansion CHIP programs (MACPAC 2021f). 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.

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. In each territory, the share of the population enrolled in Medicaid or CHIP is larger than the national average for the 50 states and District of Columbia (17.3 percent) (MACPAC 2020a) (Table 2).

TABLE 2. Medicaid and CHIP Enrollment as a Share of the Population, June 2019

Territory	Number of enrollees	Approximate percentage of population enrolled in Medicaid or CHIP
American Samoa	37,829	68.4%
CNMI	16,336	28.6
Guam	35,499	21.2
Puerto Rico	1,209,026	37.9
USVI	29,033	27.2

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 FPL, 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.

Sources: MACPAC analysis of Medicaid enrollment data collected through the Medicaid Budget and Expenditure System, April – June 2019 and 2019 World Populations Prospects data.

More recent data is available for some territories. In CNMI, Medicaid enrollment grew from 16,000 in June 2019 to 27,000 in March 2021 (Sablan 2021). USVI also experienced an increase, from approximately 29,000 in June 2019 to approximately 32,000 in March 2021 (Smith 2021). Enrollment in Puerto Rico increased from 1.2 million in June 2019 to 1.4 million in February 2021 (Puerto Rico Medicaid 2021).

Benefits

Medicaid benefits vary across territories and from the states. 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). American Samoa and CNMI are not required to offer mandatory Medicaid benefits under their Section 1902(j) waivers.

In all territories, individuals under age 21 are eligible to receive services under the early and periodic screening, diagnostic, and treatment (EPSDT) benefit (MACPAC 2021f).[4] Additionally, all territories provide some optional benefits. For example, all territories cover prescription drugs, clinic services, dental services, and eyeglasses.[5]

In recent years, several territories have expanded benefits. For example, USVI began offering telehealth services during the COVID-19 pandemic, and is currently implementing a state plan amendment to cover personal care attendant services (Smith 2021). Puerto Rico recently expanded coverage of drugs to treat hepatitis C, which were previously covered only in limited circumstances (Galva Rodriguez 2021).

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 (MACPAC 2021f). 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. However, Puerto Rico does not does not provide assistance with Medicare Part B premiums. Most dually eligible Puerto Ricans are enrolled in Medicare Platino (MACPAC 2021d).

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.[6] Similarly, Medicare Part D plans are not available in the territories, but territorial Medicaid programs typically cover prescription drugs for dually eligible beneficiaries. To offset the cost of doing so, each territory receives 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).[7]

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 2019). In recent years, Puerto Rico has made several changes to improve its delivery system, including a managed care restructuring in 2018 intended to improve access to care and enhance program integrity (MACPAC 2019). Over the last year, Puerto Rico increased payments for certain providers, including an

increase for acute care hospitals, and an increase for physician services to ensure that rates are at least 70 percent of Medicare Part B rates (ASES 2020a).

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, including private clinics, and increased provision of off-island services when medically necessary or when services are not available in the territory (MACPAC 2021a – 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

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 systems certified to report data on eligibility, enrollment, utilization, and spending to the CMS Transformed Medicaid Statistical Information System (T-MSIS), the primary administrative data set used for Medicaid program oversight and accountability.[8] USVI implemented its MMIS in partnership with West Virginia (GAO 2016).[9] American Samoa, CNMI, and Guam do not have an MMIS nor do they report information to T-MSIS, but they are required to demonstrate reasonable progress towards doing so by October 1, 2021 (P.L. 116-94). Guam is actively working towards production of T-MSIS (CMS 2021). CNMI has also taken steps towards establishing systems necessary for reporting to T-MSIS (Sablan 2021).

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 2016). Under their Section 1902(j) waivers, American Samoa and CNMI are exempt from all data and reporting requirements. Additionally, none of the territories are required to report statistical and program expenditure data for CHIP (42 CFR 457.740).

In addition, 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 2016).

For the purposes of developing certain administrative systems, including MMIS, territories can access federal Medicaid funds that do not apply toward their annual Section 1108 allotments at a 90 percent federal match (MACPAC 2021f).

Territories are also facing new reporting requirements under P.L. 116-94. Each territory 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 they used the extra funds provided by P.L. 116-94 within 30 days of the end of FYs 2020 and 2021. Puerto Rico is subject to additional requirements, including that it must establish and maintain a system for tracking amounts paid by the federal government to the territory and provide information about how these amounts were spent; report on selected measures in the Medicaid and CHIP Scorecard; and, upon CMS request, submit all documentation on contracts awarded by the territory Medicaid program. According to Puerto Rico Medicaid officials, Puerto Rico is in compliance with, or on-pace to comply with all requirements before their deadlines (Galva Rodriguez 2021, ASES 2020b).

Quality measurement and program integrity

Historically, territories have not been required to participate in many of the quality and program integrity efforts that apply to states. For example, USVI and Guam are statutorily exempt from the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs. Moreover, Puerto Rico, USVI, and Guam 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). CNMI and American Samoa are exempt from these requirements through their 1902(j) waivers.

This situation is changing, however. Under new requirements enacted through P.L. 116-94, Puerto Rico is now required to develop and publish plans to satisfy PERM and MEQC program requirements by June 2021. Under that law, all five territories are now also required to designate a program integrity lead within the Medicaid agency; the lead may not be the Medicaid director. As of March 2021, at least CNMI, USVI, and Puerto Rico have established a program integrity lead (Sablan 2021, Smith 2021, ASES 2020b).[10]

P.L. 116-94 also included several new reporting and program integrity requirements specific to Puerto Rico.[11] These include:

- Puerto Rico must establish and maintain a system for tracking amounts paid by the federal government to the territory. Beginning in December 2020, it must report quarterly to CMS with information on Medicaid expenditures in the prior fiscal quarter including the total amount of expenditures and a description of how funds were spent. It must also include information on expected expenditures for the upcoming fiscal quarter.
- Puerto Rico must submit all documentation on contracts awarded by Puerto Rico Medicaid to CMS upon request.
- Beginning December 2020, Puerto Rico must report on selected measures included in the Medicaid and CHIP scorecard.
- Within 12 months of enactment, Puerto Rico must develop a contracting reform plan to combat fraudulent, wasteful, or abusive contracts.[12,13]

It is our understanding that Puerto Rico has complied or is on schedule to comply with these requirements by their deadlines.

Some territories have implemented provider screening, as well as provisions related to non-payment for health care-acquired conditions and provider-preventable conditions. Puerto Rico, whose entire Medicaid population is enrolled in managed care, requires quality reporting in its managed care contracts (MACPAC 2019). The commonwealth required managed care plans to take on new quality and program integrity responsibilities in its most recent managed care restructuring, implemented in 2018.

In addition, Puerto Rico established a Medicaid fraud control unit (MFCU) in 2018 and USVI in 2019 (CMS 2018). American Samoa, CNMI, and Guam must now take reasonable steps towards establishing MFCUs by October 2021.[14] Expenditures for establishing an MFCU do not count toward the Section 1108 allotment.[15]

Moreover, CNMI, along with USVI, have initiated efforts to implement electronic visit verification systems and health information exchanges (Sablan 2021, Smith 2021).

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. The non-federal share is matched at the designated FMAP, which is statutorily set for most expenditures at 55 percent (with temporary increases as noted above under recent legislation). 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. Congress has provided time-limited FMAP increases along with supplemental funds on several prior occasions (Appendix Table 1A).

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, as noted previously, Congress has provided additional federal Medicaid funds on a temporary basis to the territories on multiple occasions over the last decade (Table 1A). 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 Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided the territories with additional federal Medicaid funding on top of their existing Section 1108 allotments. Section 2005 provided a total of $6.3 billion in additional federal funds for the territories available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $1 billion to the territories available to be drawn down between January 2014 and December 2019.[16,17]

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.

Like the states, the territories' federal matching rate for almost all program administration is set at 50 percent (§ 1903(a)(7) of the Act). In addition, 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 90 percent in calendar year 2021 (§ 1905(z)(2) of the Act). Currently, only Guam, Puerto Rico, and USVI are accessing this early expansion FMAP.[18]

As noted above, for FYs 2020 and 2021, Congress increased the FMAPs for all territories. For American Samoa, CNMI, Guam, and USVI, the FMAP is 83 percent, and for Puerto Rico, it is 76 percent. FFCRA further increased FMAPs (as it did for all states) by 6.2 percentage points. This increase was effective January 1, 2020 and extends until the end of the quarter in which the public health emergency ends. As such, Puerto Rico's current FMAP is 82.2 percent; it is 89.2 percent for the other territories. The FFCRA increase also applies to territories' CHIP enhanced FMAPs, which are 87.5 percent for Puerto Rico and 92.4 percent for the other territories (MACPAC 2020b).[19]

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.[20] Puerto Rico, USVI, and Guam primarily operate using general funds, American Samoa primarily uses certified public expenditures, and CNMI uses a combination (MACPAC 2021f).

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

Spending in Puerto Rico accounts for most federal Medicaid and CHIP spending in the territories. In FY 2020, federal Medicaid spending in all five territories totaled $2.8 billion, with $2.5 billion (90 percent) attributable to Puerto Rico. Federal CHIP funding totaled $174.5 million, with $111.4 million (64 percent) attributable to Puerto Rico (Table 3).

TABLE 3. Medicaid and CHIP Funding and Spending in the Territories, FY 2020 (millions)

Territory	Medicaid			CHIP		
	Section 1108 allotment	Spending		Federal allotment	Spending	
		Federal	Territory		Federal	Territory
American Samoa	$86.3	$46.1	4.9	$5.1	$5.8	$0.0
CNMI	63.1	39.1	3.6	11.8	16.5	0.0
Guam	130.9	122.8	12.0	35.0	29.1	0.0
Puerto Rico	2,716.2	2,516.9	327.9	192.8	111.5	0.8
USVI	128.7	77.8	8.6	11.6	11.8	0.0

Notes: FY is fiscal year. CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act, including the temporary increases provided for FY 2020 under P.L. 116-94 and the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). 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, and USVI received these redistributed funds in FY 2020. For spending and allotments for FYs 2011–2019, see MACPAC fact sheets specific to each territory.

0.0 indicates a value less than 0.05.

Sources: MACPAC 2021 analysis of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) and CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2020c.

Territory spending FYs 2011 – 2020

For the most part, prior to FY 2020, territory spending steadily increased since FY 2011. In FYs 2011 – 2019, territories spent in excess of their Section 1108 allotments, using additional available federal funds (primarily those available under the ACA) (Appendix Figures 1B – 5B). In FY 2020, spending did not exceed the Section 1108 allotment, which was raised for FYs 2020 and 2021.[21] Spending in all territories but Guam and Puerto Rico declined from FY 2019 to 2020, perhaps due to the effects of COVID-19 on use of services (a phenomenon observed in many states as well during this period) or the ability of territories to raise the local share needed to draw down available funds (Figures 1 and 2). Spending data for FY 2020 may change as territories finalize those data in the coming months.

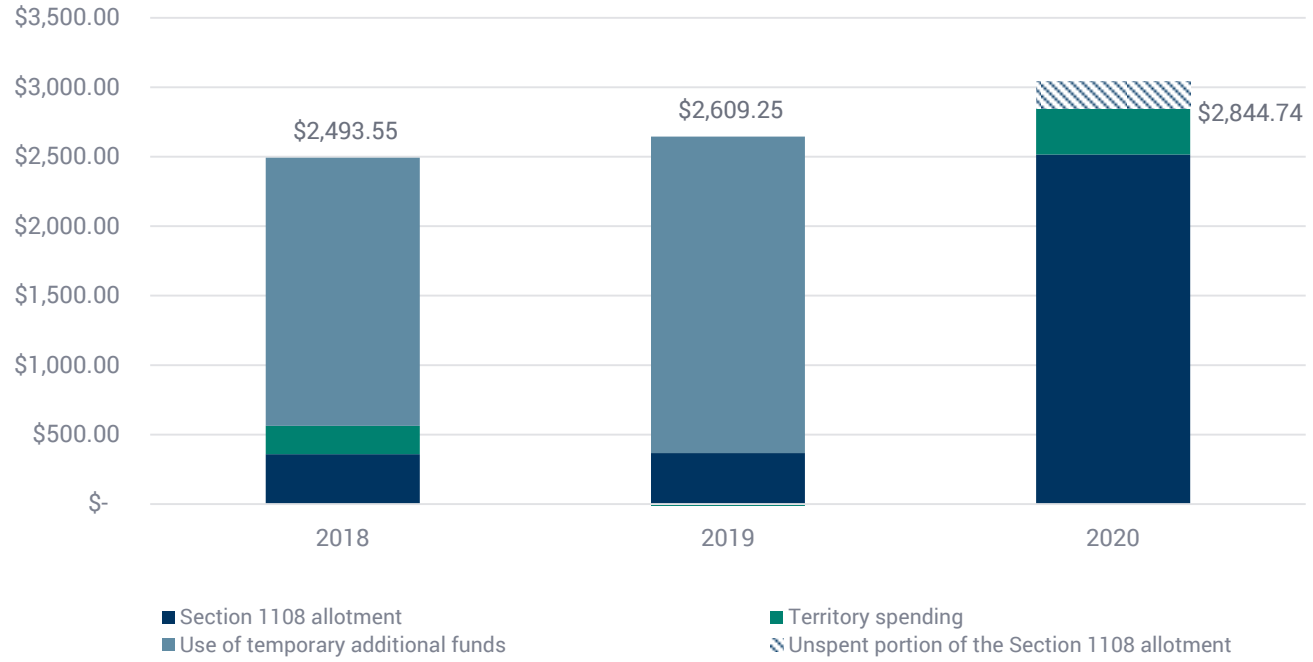
FIGURE 1. Medicaid Spending in American Samoa, CNMI, Guam, and USVI by Year and Source of Funds, FYs 2018 – 2020 (millions)

Notes. FY is fiscal year. CNMI is Commonwealth of the Northern Mariana Islands. USVI is U.S. Virgin Islands. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in FYs 2011 – 2019 reflects use of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), the Bipartisan Budget Act of 2018 (BBA, P.L. 115–123), and P.L. 116-20, as well as spending not subject to the Section 1108 cap.

* The USVI reported $137.7 million in medical assistance expenditures on the CMS-64 financial management report for FY 2019, but $55.3 million was to make adjustments to expenditures reported in prior years. Excluding the prior period adjustments, the USVI spent approximately $82.4 million in medical assistance that was applicable to FY 2019, which is the amount that would have been applied to the FY 2019 allotment. For more information on prior period adjustments, see MACPAC's issue brief Interpreting Trends in Spending Data: Effect of Prior Period Adjustments at https://www.macpac.gov/wp-content/uploads/2020/06/Interpreting-Trends-in-Spending-Data-Effect-of-Prior-Period-Adjustments.pdf.

Source. MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2021a – c, e.

FIGURE 2. Medicaid Spending in Puerto Rico by Year and Source of Funds, FYs 2018 – 2020 (millions)



Notes. FY is fiscal year. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in 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 the Bipartisan Budget Act of 2018 (BBA, P.L. 115–123), as well as spending not subject to the Section 1108 cap.

Source. MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2021d.

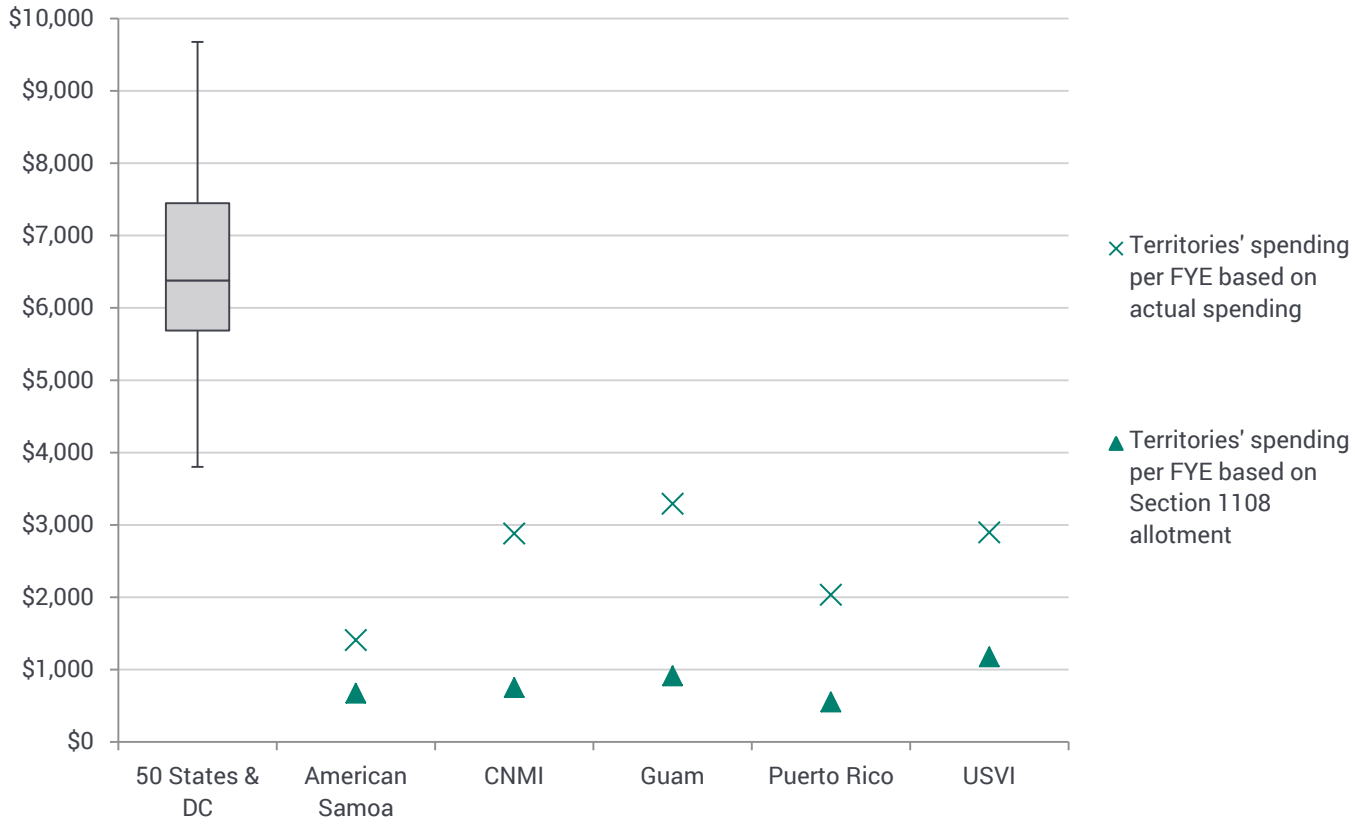
Comparing territory spending to state spending

Spending per full-year equivalent (FYE) enrollee is substantially lower in each territory than it is for the 50 states and the District of Columbia, even in years when additional federal funds are available at an enhanced FMAP.[22]

In FY 2019, when all territories had access to additional federal funds and a 100 percent FMAP for all or part of the year, spending per FYE in each of the 50 states and the District of Columbia exceeded spending per FYE in each of the territories. Had such funds not been available in FY 2019, spending would have been much lower given the amount permitted under their Section 1108 allotments. For example, Guam's actual spending per FYE was $3,292 but its Section 1108 cap of $18 million would have allowed for just $911 per FYE at the 55 percent FMAP, assuming the same level of enrollment.

By contrast, the state with the lowest spending per FYE spent $3,802; the median state spent $6,380. These figures exclude spending on long-term services and supports which territories generally do not provide (Figure 3). Absent additional funds or temporary increases, Section 1108 allotments would allow for less than one-third of what other states spent per FYE on medical assistance.

FIGURE 3. Medical Assistance Spending per Full-Year Equivalent Enrollee, FY 2019



Notes. FY is fiscal year. FYE is full-year equivalent enrollee. CNMI is Commonwealth of the Northern Mariana Islands. DC is the District of Columbia. USVI is U.S. Virgin Islands. State spending excludes spending for long-term services and supports, which territories generally do not provide. Territories spending per FYE based on actual spending represents actual FY 2019 spending, while territories spending per FYE based on Section 1108 allotment is the amount territories could have spent if they did not exceed the Section 1108 allotment, assuming the same level of enrollment, the entire allotment was used for medical assistance expenditures, and the 55 percent FMAP remained in place. Spending has been adjusted to realign prior period adjustments back to the period to which they apply and may not match spending reported in other figures. For example, the USVI reported $137.7 million in medical assistance expenditures on the CMS-64 financial management report for FY 2019, but $55.3 million was to make adjustments to expenditures reported in prior years. The amount shown here for the USVI reflects the $82.4 million that was applicable to FY 2019, which is the amount that would have been applied to the FY 2019 allotment. For more information on prior period adjustments, see MACPAC's issue brief Interpreting Trends in Spending Data: Effect of Prior Period Adjustments at https://www.macpac.gov/wp-content/uploads/2020/06/Interpreting-Trends-in-Spending-Data-Effect-of-Prior-Period-Adjustments.pdf.
Sources. MACPAC, 2021, analysis of FY 2019 CMS-64 financial management report as of March 10, 2021 and CMS-64 enrollment reports as of October 27, 2020.

Upcoming Fiscal Cliff

As noted above, Section 1108 allotments and FMAPs have been temporarily raised through FY 2021. However, for FY 2022, annual allotments and FMAPs will revert to their statutorily specified levels, resulting in a new fiscal cliff.[23] Such a reduction may threaten normal program operations as well as program improvement or expansion efforts that are underway.

Effects of a reduction in available federal funds

Past experiences shed light on the potential consequences of another fiscal cliff in October of this year. For example, when CNMI experienced a lapse in appropriations in March 2019, it began to severely curtail services, including suspending services from all private providers. Beneficiaries were able to receive services only through the Commonwealth Healthcare Corporation, the territory's public health system. CNMI also limited off-island care and services for individuals who were already hospitalized off-island (Sablan 2019). Officials from CNMI have indicated that it would need to take similar actions if a lapse in funds occurs in FY 2022 (Sablan 2021).

Previous MACPAC analysis can also provide insights. Specifically, in our 2019 report chapter, we projected that a drop in federal funds to typical Section 1108 allotment levels in FY 2020 would result in Puerto Rico having to cut between $1.01 and $1.49 billion from its program annually, depending on the availability of local funds to fill the gap. According to our estimates, Puerto Rico would have had to reduce enrollment by 455,475–669,943 individuals (36–53 percent), or eliminate all optional benefits (including dental and prescription drugs) and find additional savings through reductions in amount, scope, and duration of mandatory benefits (MACPAC 2019). Officials from Puerto Rico have indicated that a lapse in funds in FY 2022 would result in eligibility reductions of 350,000 – 400,000 enrollees, substantial service reductions, and rollbacks of recent provider payment increases (Galva Rodriguez 2021).

Effects of a reduction in FMAP

Although the territories' capped allotments are often cited as the source of their financing challenges, all five territories have, at various points, experienced difficulty raising the local share needed to draw down federal funds (Arcangel 2019, King Young 2019, Rhymer-Browne 2019, Sablan 2019). In some cases, such

challenges have resulted in supplemental funds expiring unspent, or territories having to temporarily suspend payments to providers or deny services.[24] All territories are likely to experience difficulty contributing the local share of funds in FY 2022 if their FMAPs revert to the 55 percent level, especially in light of the COVID-19 pandemic's effects on tourism, and territories' tourism-dependent economies. In short, an increase in available federal funding may not be helpful to territories without an accompanying increase in the FMAP.

Unique Challenges Facing the Territories

Finally, as Congress considers the future of Medicaid in the territories, it is important to note that territory Medicaid programs face a number of other unique challenges, many of which relate to their geographic isolation. Medicaid officials from the Pacific territories (American Samoa, CNMI, and Guam) have noted that their remote locations result in high costs for certain items and services; they must often transport patients to New Zealand, Hawaii, or the mainland U.S. for services that are unavailable locally, at times requiring air ambulances (Arcangel 2019, King Young 2019, Sablan 2019). Similarly, USVI must often transfer patients to Puerto Rico, Florida, or other places on the mainland. Off-island hospitals frequently do not accept Medicaid payment rates, further increasing costs to the territories. Guam Medicaid officials also noted in 2019 that the cost of drugs is more expensive in Guam than in the mainland U.S. due to the small number of pharmaceutical wholesalers and distributors that can ship drugs or medical devices to the island (Arcangel 2019).

Puerto Rico faces particular challenges given that government spending must be approved by the Financial Oversight Management Board (FOMB) which was put in place in 2016 in response to congressional action to address the commonwealth's debt crisis. Medicaid administrators in Puerto Rico must secure approval from the FOMB before making any program changes.[25] In 2020, the need for FOMB approval resulted in delayed implementation of the planned provider payment increase requested by Congress. Additionally, implementation of Puerto Rico's eligibility expansion was delayed as due to the FOMB approval process (Vázquez Garced 2020).

All territories have limited administrative capacity, limited health care infrastructure, and provider shortages, especially in more remote areas of each territory. For example, 72 of Puerto Rico's 78

municipalities are designated as medically underserved areas, and 32 of them are designated as primary care shortage areas (MACPAC 2019). Puerto Rico also lacks an adequate supply of certain types of specialists, and is experiencing major declines in its health care workforce (Galva Rodriguez 2021, MACPAC 2019).

Endnotes

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[1] Per capita income for the territories is not reported by the U.S. Department of Commerce's Bureau of Economic Analysis, the source used for the FMAP calculation. MACPAC estimated FMAPs using per capita income data from the 2010 Census and American Community Survey. These estimates do not account for any relative changes in per capita incomes at the state and territory level since 2010.

[2] The Further Consolidated Appropriations Act of 2020 specified that Puerto Rico would receive an additional $200 million per FY 2020 and FY 2021 if the Secretary certifies that Puerto Rico establishes a payment floor for physician services of at least 70 percent of the payment rates that would apply for such services under Medicare Part B. Puerto Rico has enacted that increase (ASES 2020a).

[3] Pregnant women and children are eligible if they have incomes below 133 percent of the local poverty level. In addition, in Puerto Rico, children with incomes under 266 LPL are eligible for Medicaid-expansion CHIP.

[4] While all territories technically provide the EPSDT benefit under the state plan, the extent to which they provide all services is unclear. 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).

[5] 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 are included in the Medicaid drug rebate program but may request a waiver to opt out (MACPAC 2021f)

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

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

[8] The Bipartisan Budget Act of 2018 conditioned a portion of the additional funds it provided to Puerto Rico and USVI on 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. Both Puerto Rico and USVI met their targets on schedule and received the full amount of BBA 2018 funds.

[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 for the use of the system, USVI contributes toward maintenance and operating costs, which it pays directly to the fiscal agent. This arrangement benefited by USVI because it did not have to construct a system from scratch and allows West Virginia to reduce its own costs for maintenance and operations (GAO 2016, CMS 2016).

[10] Territories that do not satisfy this requirement 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).

[11] P.L. 116-94 provided Puerto Rico $5 million per year in federal Medicaid funds for FYs 2020 and 2021 for the purposes of fulfilling the new reporting requirements.

[12] The Further Consolidated Appropriations Act of 2020 also required certain federal agencies to conduct additional oversight over Puerto Rico's Medicaid program. Specifically, by December 2020, the U.S. Comptroller General was required to submit a report on Puerto Rico's Medicaid-related contracting practices (i.e., the process used to evaluate bids and award contracts, information on contracts that are not subject to competitive bidding, etc.) to the Chair and Ranking Member of the House Committee on Energy and Commerce and of the Senate Committee on Finance. The U.S. Office of the Inspector General (OIG) of HHS is required to submit a report identifying payments made to Medicaid managed care organizations that the OIG determines to be at high risk for fraud, waste, or abuse, and a plan for investigating such payments.

[13] In each fiscal quarter from January 1, 2020 through September 30, 2021, Puerto Rico is subject to an FMAP reduction for each of the above program integrity requirements that are unmet. The FMAP reduction is equal to 0.25 percentage points multiplied by the number of consecutive quarters Puerto Rico has not fully complied with the requirements, not to exceed 2.5 percentage points. The Secretary can make exceptions if Puerto Rico has made reasonable progress towards meeting the requirements or has extenuating circumstances that prevent it from meeting the requirements.

[14] American Samoa and CNMI are not required to establish MFCUs under their Section 1902(j) waivers, but P.L. 116-94 required the Secretary to periodically reevaluate whether the waivers should continue to apply to MFCU requirements.

[15] Federal financial participation for such expenditures has been excluded from Puerto Rico's annual Section 1108 allotment since July 1, 2017 and from the USVI's annual allotment since January 1, 2018 (§ 1108(g)(4) of the Act).

[16] With the funds from Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. None of the territories chose to establish an exchange.

[17] Section 2005 funds were allocated to each territory by the Secretary. Of the $1 billion provided by Section 1323, $925 million was directed to Puerto Rico by Congress and the remainder was allocated by the Secretary.

[18] Because of these exceptions to the FMAP, the overall federal share of spending can be higher than 55 percent, even in years when Congress has not provided a temporary enhanced FMAP. For example, in FY 2017, federal spending covered 66.4 percent of total spending in Puerto Rico (MACPAC 2019).

[19] The higher FMAPs provided during the emergency period (82.2 percent for Puerto Rico and 89.2 percent for the other territories) serve as the base for calculating CHIP enhanced FMAPs during the emergency period. If the public health emergency ends in FY 2021, CHIP enhanced FMAPs will be 83.2 percent for Puerto Rico and 88.1 percent for the other territories (MACPAC 2020).

[20] A certified public expenditure (CPE) is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider (e.g., county hospital, local education agency), incurs an expenditure eligible for federal financial participation (FFP) under the state's approved Medicaid state plan (§ 1903(w)(6) of the Social Security Act; 42 CFR 433.51). The governmental entity certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims FFP. CPE-based financing must recognize actual costs incurred. As a result, CMS requires cost reimbursement methodologies for providers using CPEs to document the actual cost of providing the services, typically determined through a statistically valid time study, periodic cost reporting, and reconciliation of any interim payments (MACPAC 2021g).

[21] Temporary additional funds provided through the Further Consolidated Appropriations Act of 2020 and FFCRA were designed to bring Section 1108 allotments for FYs 2020 and 2021 in line with or higher than territory spending in recent years. It is important to note that these additional funds are structured differently than most of the temporary additional

funds previously provided to the territories. Previously, Congress created separate allotments that could be drawn down over a set time period, in addition to the regular, statutorily specified Section 1108 allotments. For example, the additional funds provided by the ACA could be drawn down at any time between July 2011 and December 2020.

[22] Full-year equivalent (FYE) may also be referred to as average monthly enrollment.

[23] P.L. 116-94 initially raised each territory's FYs 2020 and 2021 allotments to $84.0 million per FY for American Samoa, $60.0 million per FY for CNMI, $127.0 million per FY for Guam, and $126.0 million per FY for USVI; it also raised Puerto Rico's FY 2020 allotment to $2.6 billion and its FY 2021 allotment to $2.7 billion. FFCRA subsequently raised these allotments further (Table 2).

[24] For example, American Samoa and Guam drew down the additional funds provided to them by the ACA slowly compared to other territories due to such difficulties. As a result, they were expected to leave a large portion unspent by the expiration date until Congress intervened to provide a 100 percent FMAP for those funds for CY 2019 (Table A2). American Samoa reported in 2019 that at times, lack of local funds has caused them to suspend or make partial payments to providers or deny services (King Young 2019).

[25] FOMB was established under the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA, P.L. 114-187), enacted in June 2016. FOMB was given discretion over the territory's budget and financial plans and the power to force debt restructuring with bondholders and other creditors. The board is made up of seven members chosen by the President of the United States from lists submitted by the Speaker and Minority Leader of the House of Representatives and the Majority and Minority Leaders of the Senate (§ 101(e) of PROMESA).

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Appendix A

TABLE 1A. Timeline of Congressional Action on Territory Medicaid Financing, 2009 – 2020

Effective period	Law	Changes to available federal funds	Changes to FMAP	Circumstances
October 1, 2009 – June 30, 2011	American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5)	Raised each territory's annual Section 1108 allotment by 30 percent	None	Provided in response to 2008 financial crisis and recession as part of larger recovery package
Funds provided through Section 2005 available July 1, 2011 - September 30, 2019 Funds provided through Section 1323 available January 1, 2014 - December 31, 2019 FMAP changes permanent unless otherwise noted	Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)	Provided funds to territories, available to be drawn down at any time during the authorized period; these funds were available in addition to annual Section 1108 allotments Section 2005 provided a total of $6.3 billion Section 1323 provided a total of $1 billion Total additional funding for each territory ranged from $109.2 million (CNMI) to $6.3 billion (Puerto Rico)	Permanently raised statutory FMAP from 50 to 55 percent 2.2 percentage point increase available for all territories in CYs 2014-2015 under 1905(z)(1)(A) of the Act Guam, Puerto Rico, and USVI are accessing expansion state FMAP under § 1905(z)(2) of the Act	Section 2005 funds intended to supplement annual allotments Section 1323 funds intended to either help establish an exchange under the ACA or supplement Medicaid funds (none of the territories chose to establish an exchange)
July 1, 2017 – September 30, 2019	Consolidated Appropriations Act, 2017 (P.L. 115-31)	Added $295.9 million to Puerto Rico's initial ACA Section 2005 allotment	None	Added to ACA Section 2005 allotment to prevent Puerto Rico from exhausting its supplemental funds early, which would have caused a lapse in federal funds

Effective period	Law	Changes to available federal funds	Changes to FMAP	Circumstances
January 1, 2018 – September 30, 2019	Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123)	Provided Puerto Rico with $4.8 billion and USVI with $142.5 million (added to their ACA Section 2005 allotments)	Additional funds available at 100 percent FMAP for FYs 2018 and 2019	Provided in response to effects of Hurricane Maria
January 1, 2019 – September 30, 2019	Additional Supplemental Appropriations for Disaster Relief Act, 2019 (P.L. 116-20)	Added $36 million to CNMI's ACA Section 2005 allotment	CNMI's additional funds available at 100 percent FMAP Provided 100 percent FMAP to American Samoa and Guam for all expenditures	Added to ACA Section 2005 allotment because CNMI exhausted its ACA funds in March 2019; provided 100 percent FMAP to respond to natural disasters affecting CNMI 100 percent FMAP provided to American Samoa and Guam because these territories were experiencing difficulty contributing the non-federal share needed to draw down their ACA allotments prior to expiration
October 1, 2019 - December 20, 2019	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)	None	Provided all territories with 100 percent FMAP for expenditures occurring during this period	100 percent FMAP provided as a stopgap measure to assist territories while congressional negotiations regarding a longer-term funding agreement were underway. Territories each had unspent ACA Section 1323 set to expire in December 2019

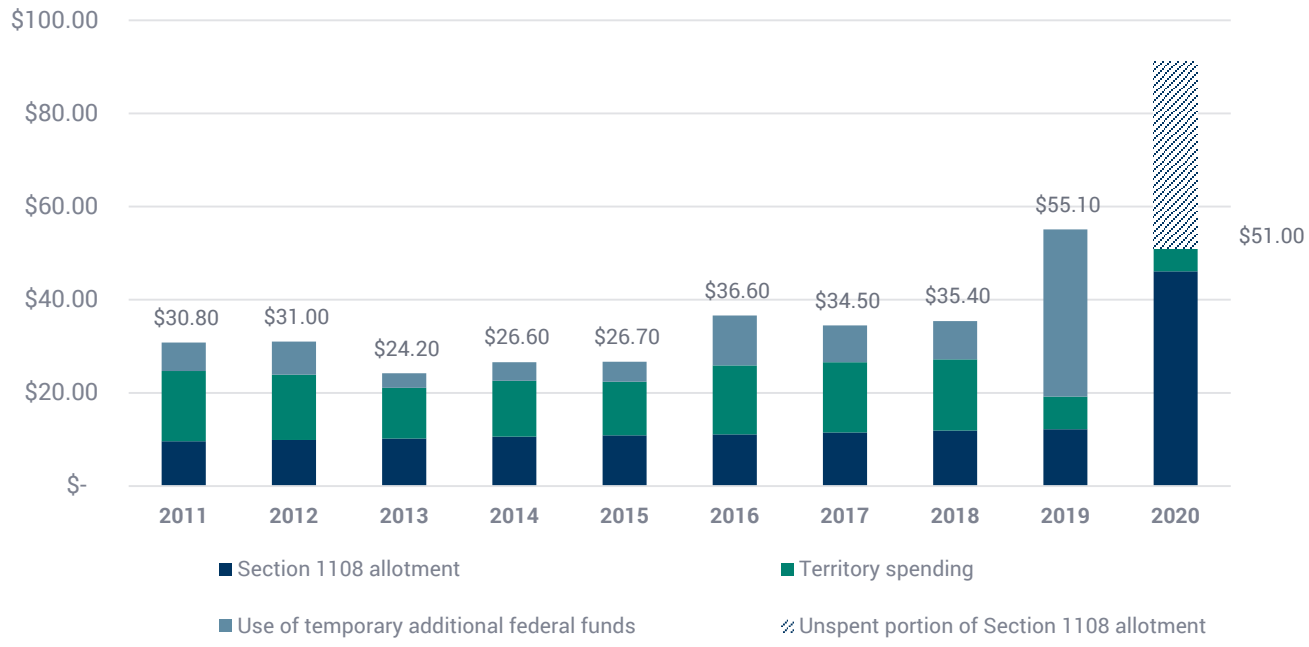
Effective period	Law	Changes to available federal funds	Changes to FMAP	Circumstances
FYs 2020 and 2021	Further Consolidated Appropriations Act, 2020 (P.L. 116-94)	Raised each territory's Section 1108 allotments for FYs 2020 and 2021 as follows: • $84.0 million per FY for American Samoa • $60.0 million per FY for CNMI, • $127.0 million per FY for Guam • $126.0 million per FY for USVI • For Puerto Rico, $2.6 billion for FY 2020 and $2.7 billion for FY 2021	Raised territory FMAPs for FYs 2020 and 2021: • 83 percent for American Samoa, CNMI, Guam, and USVI • 76 percent for Puerto Rico	Provided to avert FY 2020 fiscal cliff
FYs 2020 and 2021 unless otherwise noted	Families First Coronavirus Response Act (FFCRA, P.L. 116-127)	Further raised allotments for FYs 2020 and 2021 • $86.3 million for FY 2020 and $85.6 million for FY 2021 for American Samoa • $63.1 million for FY 2020 and $62.3 million for FY 2021 for CNMI • $130.9 million for FY 2020 and $129.7 million for FY 2021 for Guam • $2.72 billion for FY 2020 and $2.8 billion for FY 2021 for Puerto Rico • $128.7 million for FY 2020 and $127.9 million for FY 2021 for USVI	Territories can receive the 6.2 percentage point increase to FMAP, if maintenance of effort provisions met (available to all states and territories in response to the COVID-19 public health emergency). FMAP increase is effective January 1, 2020 through the quarter in which the public health emergency period ends	Additional funding and enhanced FMAP provided in response to the COVID-19 pandemic

Notes. CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. FMAP is federal medical assistance percentage. CY is calendar year. FY is fiscal year.

Source. MACPAC analysis of the following laws: ARRA; ACA; Consolidated Appropriations Act, 2017; BBA 2018; Additional Supplemental Appropriations for Disaster Relief Act, 2019; Continuing Appropriations Act, 2020 and Health Extenders Act of 2019; Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019; Further Consolidated Appropriations Act, 2020; and FFCRA.

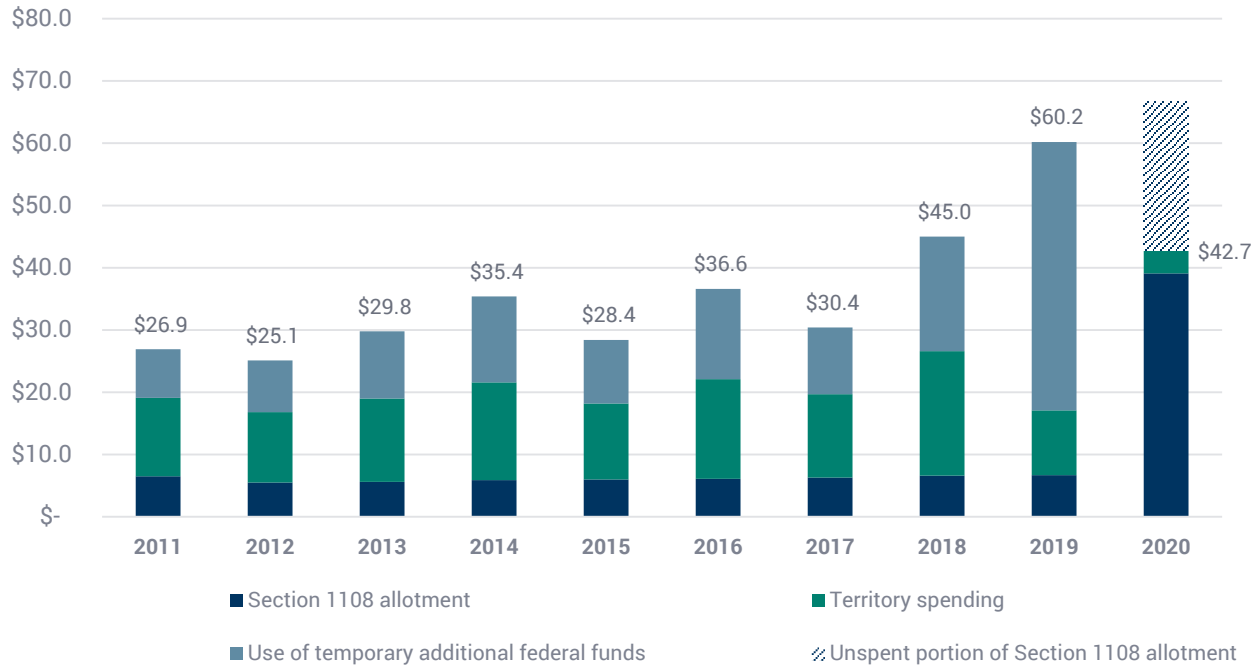
Appendix B

FIGURE 1B. Medicaid Spending in American Samoa by Year and Source of Funds, FYs 2011–2020 (millions)



Notes. FY is fiscal year. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in FYs 2011 – 2019 reflects use of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), as well as spending not subject to the Section 1108 cap.
Source. MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2021a.

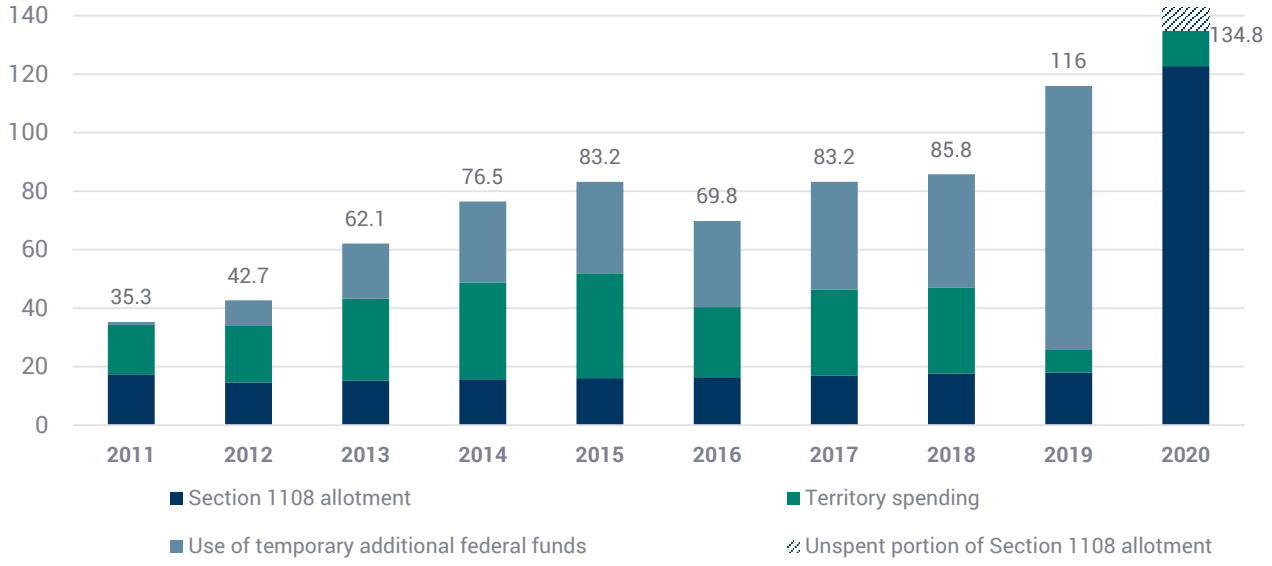
FIGURE B2. Medicaid Spending in the Commonwealth of the Northern Mariana Islands by Year and Source of Funds, FYs 2011–2020 (millions)



Notes. FY is fiscal year. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in 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 P.L. 116-20), as well as spending not subject to the Section 1108 cap.

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

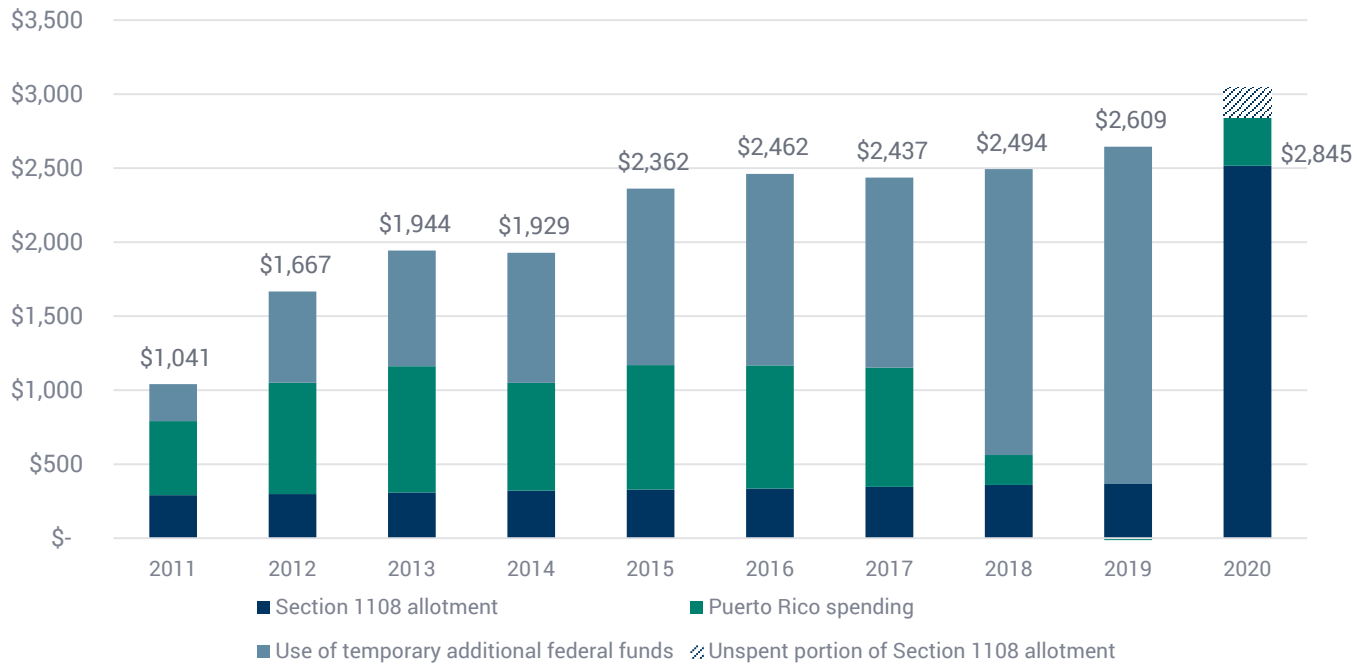
FIGURE B3. Medicaid Spending in Guam by Year and Source of Funds, FYs 2011–2020 (millions)



Notes. FY is fiscal year. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in FYs 2011 – 2019 reflects use of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), as well as spending not subject to the Section 1108 cap.

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

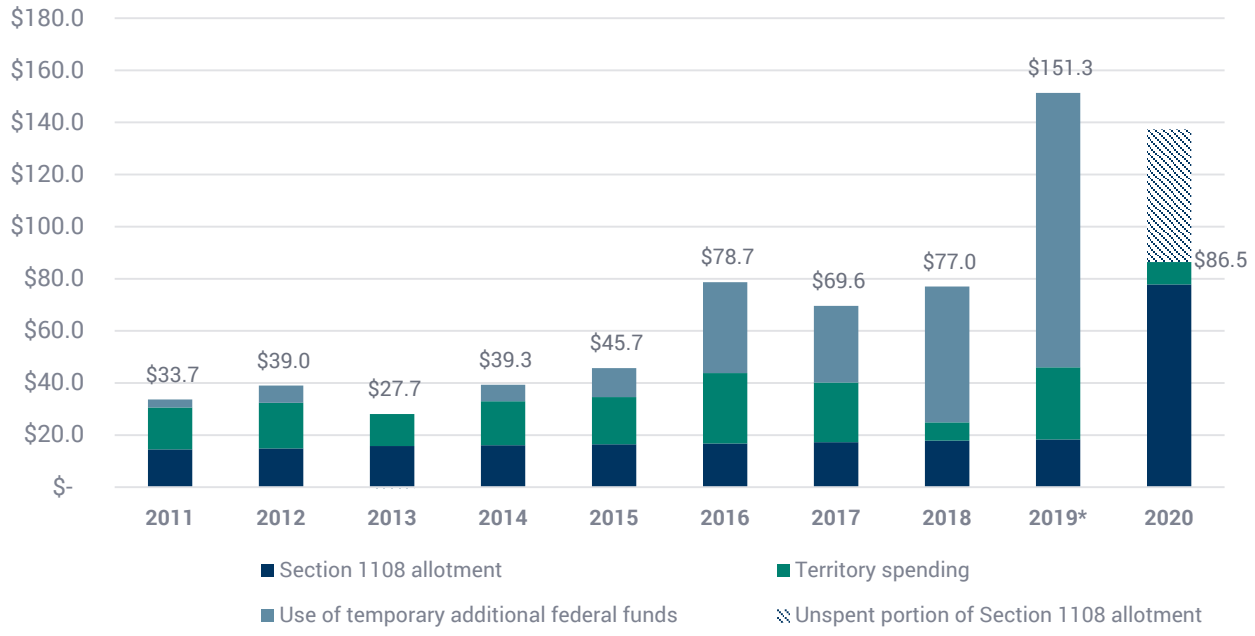
FIGURE B4. Medicaid Spending in Puerto Rico by Year and Source of Funds, FYs 2011–2020 (millions)



Notes. FY is fiscal year. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in 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 the Bipartisan Budget Act of 2018 (BBA, P.L. 115–123), as well as spending not subject to the Section 1108 cap.

Source. MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2021d.

FIGURE 5. Medicaid Spending in the U.S. Virgin Islands by Year and Source of Funds, FYs 2011–2020 (millions)



Notes. FY is fiscal year. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Use of temporary additional federal funds in 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 the Bipartisan Budget Act of 2018 (BBA, P.L. 115–123), as well as spending not subject to the Section 1108 cap.

* The USVI reported $137.7 million in medical assistance expenditures on the CMS-64 financial management report for FY 2019, but $55.3 million was to make adjustments to expenditures reported in prior years. Excluding the prior period adjustments, the USVI spent approximately $82.4 million in medical assistance that was applicable to FY 2019, which is the amount that would have been applied to the FY 2019 allotment. For more information on prior period adjustments, see MACPAC's issue brief Interpreting Trends in Spending Data: Effect of Prior Period Adjustments at https://www.macpac.gov/wp-content/uploads/2020/06/Interpreting-Trends-in-Spending-Data-Effect-of-Prior-Period-Adjustments.pdf.

Source. MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2021e.