Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Strengthening Health Care in the U.S. Territories for Today and Into the Future"
June 20, 2019

Anne Schwartz

The Honorable Michael C. Burgess, M.D.

1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll 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. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

Response

Table 1 provides estimates of federal funding shortfalls for FY 2020 under different scenarios: if only the annual allotment under Section 1108(g) of the Social Security Act were available in FY 2020, per the question above, and under current law -- that is, if territories use Section 1108 funds as well as available Section 1323 funds. Funding under Section 1323 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) is available to territories until December 31, 2020 and thus can be used to cover spending occurring in quarter 1 (Q1) of FY 2020.[1]

A number of factors could influence these estimates. First, estimates are based on federal allotment balances provided to MACPAC by the Centers for Medicare & Medicaid Services (CMS) and FY 2020 spending projections submitted to CMS by the territories on Form CMS-37

[1] Assuming that spending is equally distributed across quarters, all territories except the Commonwealth of the Northern Mariana Islands (CNMI) are expected to have sufficient ACA Section 1323 funds to cover spending in Q1 of FY 2020 (CMS 2019). CNMI exhausted its Section 1323 funds in FY 2019.

in August 2019.[2] Second, we assume that all data are accurate.[3] Third, we note that the amount and timing of actual spending may differ from projected spending due to enrollment or utilization changes. Last, other territory-specific circumstances could affect actual shortfall amounts.

TABLE 1. Projected Spending, Section 1108 Allotment, and Estimated Federal Medicaid Funding Shortfall in U.S. Territories, FY 2020 (millions)

Territory	Projected federal spending	Section 1108 allotment	If only Section 1108 funds are used	Current law (If Section 1108 funds and ACA Section 1323 funds are used)
American Samoa	$29.27	$12.43	$16.84	$9.52
CNMI	9.61	6.85	2.76	2.76
Guam	19.74	18.38	1.36	–
Puerto Rico	1,934.70	375.10	1,559.60	1,075.92
USVI	77.35	18.75	58.60	39.26

Notes: ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. USVI is the United States Virgin Islands. Q refers to quarter of the fiscal year. Section 1108 allotment reflects the annual ceiling on federal funds that the territories receive under Section 1108(g) of the Social Security Act. CNMI shows the same shortfall amount under both scenarios because it exhausted its Section 1323 funds in FY 2019 and will have none remaining in FY 2020. Assumes spending is equally distributed across quarters. Spending is projected; actual shortfall amounts will differ depending on amount and distribution of actual spending.
– Dash indicates zero.
Sources: CMS 2019a, b; MACPAC 2019 analysis of CMS-37 projections of spending for FYs 2020 submitted in August 2019.

The Honorable Gus M. Bilirakis

1. The pending Medicaid fiscal cliff is not only an issue for the U.S. Territories but is a U.S. issue – especially for the state of Florida who is often the first to experience the influx of Medicaid patients from the Territories seeking care. This places an additional burden on Florida's Medicaid program, provider network, and patient benefits.

    a. Is the Medicaid program in the U.S. Territories administered differently than in the States, and if so, how?

[2] Projections presented in MACPAC's written testimony for this hearing were based on FY 2020 projections submitted to CMS by the territories on Form CMS-37 in May 2019. Between the May and August submissions, projections of federal spending increased by 57.1 percent for American Samoa and 1.8 percent for CNMI. These projections decreased by 63.8 percent for Guam and 2.4 percent for Puerto Rico. There were no changes for the U.S. Virgin Islands.

[3] Data and projections exclude allotments provided to the territories for the Enhanced Allotment Plan (EAP), also referred to as Section 1935(e) funding. This annual allotment, separate from the annual Section 1108 allotment, can only be used to help pay for prescription drugs for individuals dually eligible for Medicare and Medicaid. Excluding the EAP allotment does not materially affect shortfall estimates.

b. Is it more costly to manage a chronic disease patient in the U.S. Territories or in the States?

c. How is the current fiscal crisis impacting the availability of providers in the Territories – is it hard to recruit and retain quality providers?

d. Does this impact continuity of care and drive unnecessary, costly hospital readmissions?

Response to 1a

Under the Social Security Act (the Act), the territories are considered states for the purposes of Medicaid and CHIP, unless otherwise indicated (§1101(a)(1) of the Act). Below we describe key ways that territories are similar to and differ from states.

Guam, Puerto Rico, and the U.S. Virgin Islands (USVI)

Medicaid program administration in Guam, Puerto Rico, and USVI is similar to state Medicaid programs particularly in terms of the roles, responsibilities, and administrative structures of the Medicaid agency. For example:

Medicaid provides health insurance coverage to enrolled individuals;
eligibility for Medicaid is determined on an individual basis using modified adjusted gross income (MAGI);
Medicaid delivery systems are similar to those in state Medicaid programs (fee-for-service delivery systems are used in Guam and USVI and managed care is used in Puerto Rico); and
the territories administer and oversee their programs and report data and other information to CMS.

Important differences include:

the territories use territory-specific poverty levels, rather than the federal poverty level (FPL), to determine Medicaid eligibility;
only Guam provides all mandatory Medicaid benefits; and
historically, the territories have not been able or required to report all of the same data to CMS as states or required to participate in the same program integrity initiatives.[4]

American Samoa and the Commonwealth of the Northern Mariana Islands (CNMI)

American Samoa and CNMI operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them (§ 1902(j) of the Act). This provision allows the

[4] Territories have cited lack of infrastructure and financial resources as barriers to providing all benefits and reporting all data. For example, Puerto Rico does not have long-term care facilities, and thus, does not provide long-term care. CNMI has not yet established a Medicaid Management Information System to report data to the Transformed Medicaid Statistical Information System because of concerns about the cost effectiveness (Sablan 2019).

Secretary of Health and Human Services to waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the federal medical assistance percentage (FMAP), and the requirement that payment can only be for services otherwise coverable by Medicaid. This means that they are not required to comply with other federal Medicaid requirements that apply to states, including those related to mandatory benefits, covered populations, program integrity, or data and reporting requirements.

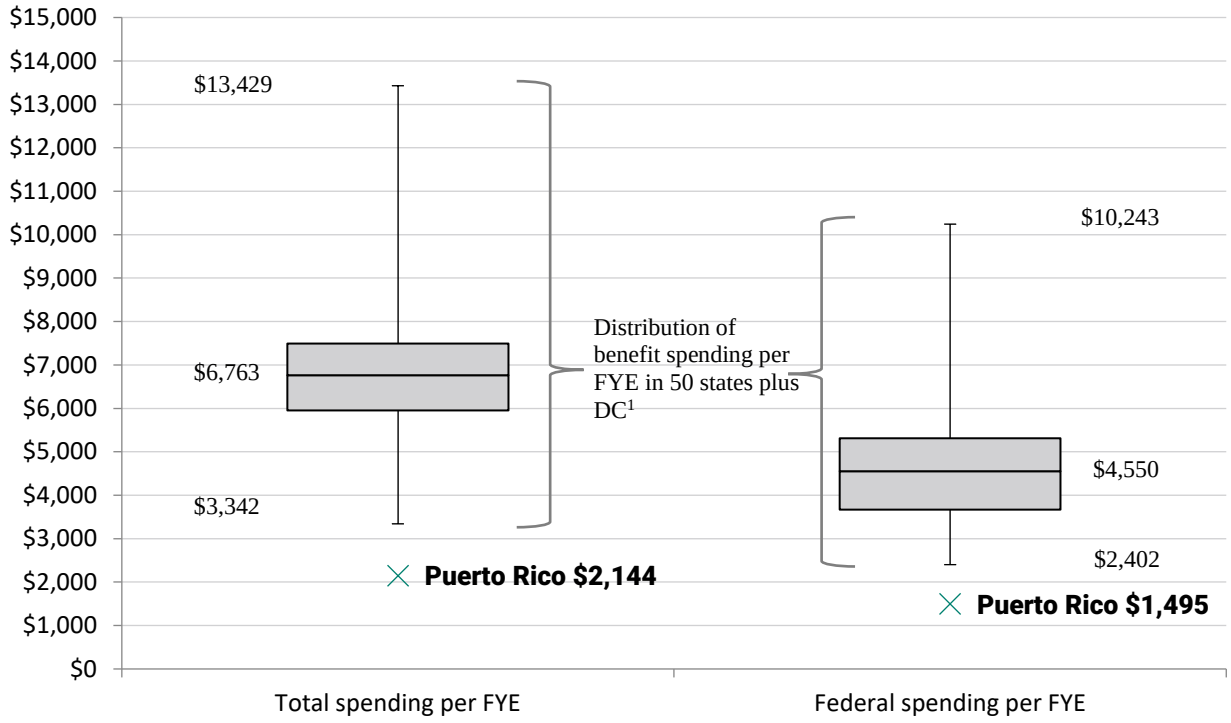
- In American Samoa, Medicaid eligibility is not determined on an individual basis and there is no enrollment process. Instead, federal Medicaid and CHIP funds pay for care provided in the territory in proportion to the population of American Samoans with income that would have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent FPL.
- CNMI, the only territory participating in Supplemental Security Income (SSI), uses that program's income and asset standards to determine Medicaid eligibility, covering individuals who meet up to 150 percent of income and resource requirements for SSI but are not necessarily disabled.

In both of these territories, as well as in Guam, the majority of all services are provided by each territory's one public hospital.

Response to 1b

MACPAC does not have detailed information to compare the cost of serving patients with specific health care needs in the territories to the states. However, MACPAC has found that in general, the spending on services to beneficiaries in Puerto Rico is lower than in states. For example, Puerto Rico's projected total spending per full-year-equivalent (FYE) enrollee is $2,144. This is 36 percent lower than the state with the lowest spending ($3,342), 68 percent lower than the median ($6,763) and 84 percent lower than the state with the highest spending ($13,429) (Figure 1). MACPAC does not have data needed to estimate per capita Medicaid spending in the other territories.

FIGURE 1. Projected Medicaid Benefit Spending per FYE in Puerto Rico Compared to Distribution of Projected Medicaid Benefit Spending per FYE in 50 States and DC, FY 2020



Notes: FYE is full-year equivalent. FY is fiscal year. DC is District of Columbia. Total spending includes federal and state funds. Excludes Medicaid-expansion CHIP enrollees. Excludes spending for administration and long-term services and supports (LTSS). FY 2013 benefit spending from Medicaid Statistical Information System (MSIS) data were adjusted to reflect CMS-64 totals. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. FY 2013 spending per FYE for each eligibility group was trended forward to FY 2020 using CMS Office of the Actuary (OACT) projected growth rates for that eligibility group. For adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, FY 2017 benefit spending per FYE calculated from CMS-64 spending and enrollment data was trended forward to FY 2020 using OACT projections. To adjust for differences in enrollment mix across states and Puerto Rico, the enrollment mix across eligibility groups in each state was reweighted to match the distribution of enrollees across eligibility groups in Puerto Rico.
[1] Excludes Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.
Sources: ASES 2019a, b. OACT 2018. MACPAC 2019 analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of June 2016; CMS-64 FMR net expenditure data as of July 20, 2018; and CMS-64 enrollment reports as of September 19, 2018.

Response to 1c

The administrative data available to MACPAC cannot be used to assess provider availability, recruitment, or retention. However, based on the work of others, we understand that all five territories have experienced provider access challenges, which predated, but have been exacerbated by, recent natural disasters. Low provider payment rates and uncertainty related to Medicaid fiscal crises have been identified as likely contributing to these challenges. Factors such as the territories' geographic isolation, infrastructure issues, and economic conditions may also play a role.

In Puerto Rico, primary care physician, general surgeon, and dentist availability in has tracked closely with the United States as a whole (AAMC 2017, 2013); however, it varies across geographic regions within the territory. For example, 72 of Puerto Rico's 78 municipalities are designated as medically underserved areas, and 32 are designated as primary care shortage areas (HRSA 2019). Puerto Rico also lacks an adequate supply of certain types of specialists. Prior to Hurricane Maria, 23 percent of municipalities had a shortage of pediatricians and 68 percent had a shortage of obstetrician-gynecologists. In 2017, the supply of emergency room physicians; neurosurgeons; plastic surgeons; and ear, nose, and throat specialists was less than half the rate on the mainland (ASPE 2017).

USVI is designated by the Health Resources and Services Administration as a geographic high needs health professional shortage area and is experiencing shortages of physicians and other clinical staff, including shortages of mental health professionals (USVI Hurricane Recovery and Resilience Task Force 2018).

American Samoa and Guam have similarly experienced shortages of physicians, nurses, and other medical staff and recruitment challenges (Faumuina 2017, DOI 2014). In recent years, they have each covered off-island services if necessary services are unavailable.

MACPAC has limited information about the availability of providers in CNMI. However, like American Samoa and Guam, the territory relies on one public hospital and its ancillary clinics to provide most services. Territory Medicaid officials have expressed concerns about the effects on access to care if CNMI becomes unable to provide access to private or off-island providers due to a lack of federal Medicaid funds (Sablan 2019).

Response to 1d

MACPAC does not have information on effects of the territories' Medicaid fiscal crises on continuity of care or hospital readmissions.

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