Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Averting a Crisis: Protecting Access to Health Care in the U.S. Territories"
March 17, 2021

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The Honorable Gus Bilirakis (R-FL)

1. The pending Medicaid fiscal cliff is not only an issue for the U.S. Territories, but is also a U.S. issue – especially for the state of Florida which 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 it more costly to manage a chronic disease patient in the U.S. Territories or in the States?

MACPAC does not have data to compare the cost of managing a patient with chronic disease in the U.S. territories to the cost in the 50 states and District of Columbia. However, we know that 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. For example, in fiscal year (FY) 2018, the state with the lowest spending per FYE spent $3,802; the median state spent $6,380. By contrast:

- American Samoa spent $1,407;
- the Commonwealth of the Northern Mariana Islands (CNMI) spent $2,880;
- Guam spent $3,292;
- Puerto Rico spent $2,034; and
- the U.S. Virgin Islands (USVI) spent $2,895 (Schwartz 2021).

It is important to note that these statistics exclude spending for long-term services and supports, which the territories generally do not provide. We are also unable to adjust for differences in health status of enrollees, or enrollment mix (i.e., the distribution of enrollees across different eligibility groups).

Lower spending per FYE in the territories may reflect several factors. For example, the Section 1108 cap limits available funding for Medicaid services. In addition, territories that have difficulty raising the nonfederal share of expenditures may be limited in their ability to draw down federal matching funds, limiting resources available for services and other program costs. For example, some territories faced challenges drawing down additional federal funds available in FY 2018 through the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and the Bipartisan Budget Act of 2018 (BBA, P.L. 115-123).

Lower spending per enrollee may also reflect lower provider payment rates. Prior MACPAC work found that Medicaid physician fees are lower in Puerto Rico compared to other states for certain services, including primary care and maternity services. For example, from July 2016 to July 2017, Medicaid physician fees were 19 percent of Medicare rates for primary care services and 50 percent of Medicare for maternity services, compared to the national average of 66 percent of Medicare rates for primary care and 81 percent of Medicare for obstetric care (MACPAC 2019). We do not have similar data for other territories, although anecdotal information indicates that provider payments are also low in other territories.

Territories incur substantial costs for patients who must be treated off island. Territories commonly send patients to Hawaii, the U.S. mainland, or even New Zealand when specialists or services are unavailable in the territory, incurring costs for transportation and boarding in addition to the cost of care. Territories negotiate payment rates with off-island providers on a case-by-case basis, and must often pay rates that are higher than the state or territory's Medicaid payment rates (Sablan 2021, Smith 2021, Galva Rodriguez 2021). As a result, the cost of care for an individual patient treated off-island may be higher than the cost of care for an individual patient residing in a state who can be treated locally.

b. How is the current fiscal cliff and pandemic impacting the availability of providers in the territories – is it hard to recruit and retain quality providers?

Territories report facing substantial challenges recruiting and retaining health care providers; these challenges predate the current fiscal cliff and COVID 19 pandemic.

Provider recruitment and retention challenges facing the territories are not specific to Medicaid. Puerto Rico has experienced major declines in the physician workforce over the last decade or longer, consistent with larger trends of outmigration among Puerto Ricans, which are particularly pronounced among working-age adults (MACPAC 2019). Other territories also report difficulty retaining and recruiting providers, citing their relatively small populations, geographically isolated locations, lack of training opportunities, and low salaries compared to physician salaries elsewhere (including on the U.S. mainland) (MACPAC 2019, DPHSS 2021, Plaskett 2021).

Medicaid's financing structure may also contribute to territories' ability to recruit and retain providers. Limits on funding due to the annual Section 1108 cap on federal Medicaid funds and

the 55 percent federal medical assistance percentage (FMAP) make it difficult for territories to increase provider payment levels. In some cases, lack of funding has led some territories to delay or suspend payments, circumstances that run counter to efforts to recruit and retain quality providers.

Territories have at times been able to maintain or increase provider payment rates during periods in which temporary additional federal funds and enhanced FMAPs are available. However, Medicaid fiscal cliffs (i.e., points at which temporary additional funds and enhanced FMAPs expire) including the one that will occur on October 1, 2021 and the one that occurred on October 1, 2019, create substantial uncertainty for providers. For example,

- Since the enactment of the Further Consolidated Appropriations Act, 2020, (P.L. 116-94), Puerto Rico has implemented provider payment increases necessary to maintain an adequate provider network. Puerto Rico Medicaid officials have indicated that they will have to roll back the increases if additional federal Medicaid funds are not provided beyond September 2021 (Galva Rodriguez 2021).

- In March 2019, CNMI experienced a lapse in federal Medicaid funds and had to suspend payments to providers. CNMI also restricted services to those provided by the Commonwealth Healthcare Corporation, meaning Medicaid beneficiaries could not see private providers during this time. (Schwartz 2021).

- In several instances, Guam has delayed payments to providers because of difficulty raising the nonfederal share required to draw down federal matching funds (GRMC 2021).

MACPAC does not have data to examine the effects of the pandemic on provider recruitment or retention efforts. However, experience with past emergencies, including hurricanes and typhoons, suggest how disruptions of tourism and other economic sectors can affect Medicaid. Territories may experience challenges raising the nonfederal share, even at the temporarily enhanced matching rates, constraining resources available to pay providers and creating additional uncertainty.

Emergencies can also accelerate outmigration and affect supply of physicians and other health care workers. For example, following Hurricane Maria in September 2017, between 2017 and 2018, Puerto Rico lost an estimated 123,399 residents to outmigration, almost double the amount observed in the previous three years (MACPAC 2019).

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

MACPAC does not have data to assess continuity of care in the territories, how continuity of care may be affected by the availability of providers, or effects on hospital readmissions.

2. Has the pandemic impacted the territories' ability to make meaningful progress towards implementation of program integrity requirements and, if so, how, and how might this Committee address those challenges?

While uncertainty about future funding can make it difficult for the territories to make program investments, according to the territories, they are either in compliance with program integrity requirements imposed by the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), or on track to comply by the deadline (ASES 2021, Guerrero 2021, King Young 2021, Sablan 2021, Smith 2021). In some cases, they are implementing additional systems that promote program integrity. For example, CNMI and USVI have initiated efforts to implement electronic visit verification systems for personal care services and health information exchanges (Sablan 2021, Smith 2021). MACPAC does not have independent sources of information that would enable us to comment further.

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