Inaugural Survey of Territory Medicaid Directors

November 2019

NAMD
National Association of Medicaid Directors

Introduction

The National Association of Medicaid Directors (NAMD) serves Medicaid Directors from all 50 states, the District of Columbia, and the five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands.

Each year, NAMD administers its Operations Survey to Medicaid Directors in the 50 states and District of Columbia, and presents the information collected in an annual Operations Survey Report. For the first time, NAMD administered a new, territory-specific survey to the five U.S. territories for FY 2018. This survey is NAMD's first attempt to help elevate awareness and appreciation of the unique nature of the territories' programs as well as the unique financial challenges they face.

Just as the U.S. territories' Medicaid programs differ from that of the states, they also differ drastically from each other, especially in population size, and therefore also in the number of beneficiaries (as of September 2017)[1]:

- Puerto Rico (1.2 million beneficiaries)
- American Samoa (41,000 beneficiaries)
- Guam (35,000 beneficiaries)
- US Virgin Islands (23,000 beneficiaries)
- Commonwealth of the Northern Mariana Islands (17,000 beneficiaries)

Additionally, the territories have distinct standards and processes for determining eligibility. Guam, Puerto Rico and the US Virgin Islands are permitted to use the local poverty level to establish income-based eligibility for Medicaid, and are exempt from statutory requirements to provide poverty-related eligibility to children and pregnant women, as well as qualified Medicare beneficiaries. CNMI uses the income and resource requirements for the federal Supplemental Security Income (SSI) program to automatically qualify people for Medicaid. In American Samoa, Medicaid pays for care provided at a specified medical center in proportion to the number of residents with incomes below Medicaid income eligibility standards. For that reason, eligibility is not individually determined. There are also differences in what benefits are provided, the structure of delivery systems, and much more. For a more detailed analysis of the differences between the territories' programs, please see MACPAC's Fact Sheet from July 2019.[2]

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Medicaid Directors and their Programs in the U.S. Territories

In April 2019, the median territory Director tenure was 24 months **(Figure 1)** with three of the Directors having started in 2017, and the other two Directors having served for over 6 years. While this is slightly higher than the median tenure for the states, which was 21 months for FY 2018, it is still a short amount of time, which reflects a number of factors, including, but not limited to, turnover of political administrations, changes in program priorities, low salary, private sector opportunities and burnout.

In FY 2018, the salaries of Medicaid Directors in the U.S. territories averaged approximately $67,000. The salaries of Medicaid Directors in the States averaged approximately $145,000.

As is also true in the states, in the territories, Medicaid Directors have a wide variety of reporting structures within their territorial government. In 2018, two of the territory Directors reported directly to the Governor or Governor's office, one Director reported directly to a cabinet-level leader, and the remaining two reported to someone who reports to a cabinet-level leader. **(Figure 2)**

All the Medicaid Directors reported that there are some expertise and knowledge gaps within their workforce. These gaps can be attributed to the relatively small populations of their territory, low compensation packages that make it difficult to hire expert staff, and to the remoteness of the territories, which makes off-island hiring a challenge. These hiring struggles have led to gaps in technical areas such as code updates and National Correct Coding Initiatives (NCCI) edits, as well as much larger gaps in information technology (IT), policy, and financial areas.

Territorial Medicaid Directors and their teams have to be creative when addressing these challenges. Some territories have begun to outsource care to programs outside of the U.S. and/or outsource programmatic work to consultants, while others are utilizing external sources for technical assistance.

Figure 1. Territory Medicaid Director Tenure as of April 2019

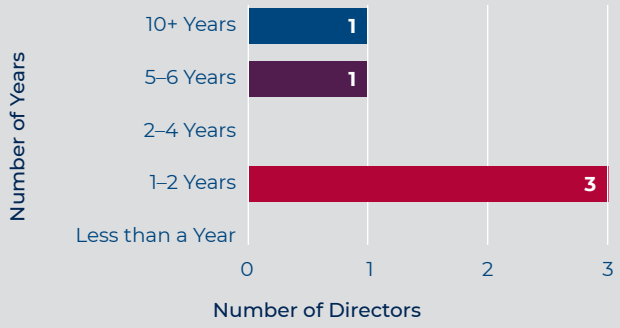
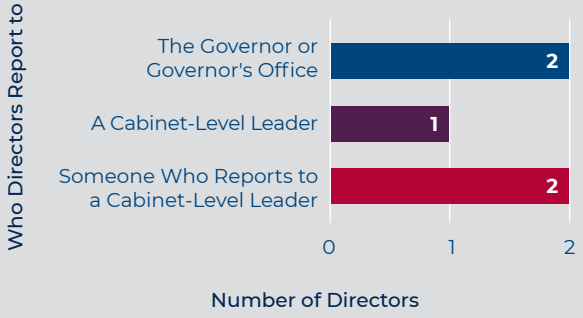


Figure 2. Who Medicaid Directors Report to in the Territory Government



Financial Challenges in the U.S. Territories

Since the establishment of Medicaid in 1965, the federal government has used a complex formula to determine each state's Federal Medical Assistance Percentage (FMAP). This dictates how the federal and state governments share in the cost of the program.[3] For the 50 U.S. states,* the federal government calculates a state's FMAP rate using a formula which compares the per capita income for each state relative to the national average.[4] In statute, the federal government's share of Medicaid program spending must be at least 50%.[5] In the 50 states, Title XIX of the Social Security Act allows FMAPs to be as high as 83% federal spending where per capita incomes are the lowest. Currently the highest state FMAP rate is 77%. In addition, for the 50 U.S. states and the District of Columbia there is no cap on how much the federal government can contribute, it is an open-ended federal entitlement in which the federal government must match all appropriate state spending.

This is not the same for the U.S. territories. The territories all have a fixed FMAP rate of 55% federal and 45% state dollars, regardless of actual per capita income. Additionally, unlike the 50 states, the territories are subject to a statutory cap on federal Medicaid funding (often referred to as a capped allotment or block grant), which grows only with the medical component of the Consumer Price Index (CPI-U). The federal funding cap are as follows for each individual territory as of FY 2018:

- Puerto Rico—$359.5 million
- US Virgin Islands—$17.87 million
- Guam—$17.6 million
- American Samoa—$11.9 million
- Commonwealth of the Northern Mariana Islands—$6.6 million[6]

* For the District of Columbia, the FMAP rate is not determined by the FMAP formula, rather it is set at 70% per section 4725(b) of the Balanced Budget Act of 1997, P.L. 105-33.

Financial Challenges in the U.S. Territories (Continued)

Additional Funding for the U.S. Territories

Aside from the capped federal funding, Congress has provided additional, temporary federal Medicaid funds for Puerto Rico and the territories on a limited number of occasions to address economic downturns and natural disasters. For example, the American Recovery and Reinvestment Act (P.L. 111-5) raised each territory's annual allotment by 30 percent for the period between October 1, 2009 and June 30, 2011.

Additionally, since 2011, the territories have had access to additional federal funds through three provisions in the Affordable Care Act (ACA). The territories have all accessed these supplemental funds, but have done so at different rates. The three main funding provisions are the following:

1. **The ACA permanently increased the traditional territory federal matching rate from 50 percent to the current rate of 55 percent** (plus 2.2 percentage points for 2014 and 2015) and provided the territories with a higher matching rate for non-disabled adults without children (87 percent in 2017).
2. **The ACA also provided a total of $6.3 billion in federal Medicaid funds** (in addition to the allotments) which the territories could access between July 2011 and September 2019.
3. **The ACA provided $1.0 billion in additional Medicaid funding for those territories that did not establish health insurance exchanges.** Because none of the territories established exchanges, the $1.0 billion was distributed among all of the territories for the period of January 1, 2014, through December 31, 2019.

Congress has also made multiple adjustments to Medicaid funding for the territories in the aftermath of natural disasters which have impacted the territories at different points since 2017. For example, in response to Hurricanes Maria and Irma, in 2018 Congress increased the allotments for Puerto Rico and the US Virgin Islands and made additional funding available contingent on certain steps. Importantly, for this additional funding only, Congress increased the federal match rate from 55% to 100%—which essentially removed the requirement of spending local dollars in order to access the federal disaster funding. Following Typhoons Mangkhut and Yutu, in 2019 Congress approved similar disaster funding provisions for CNMI, American Samoa, and Guam. Congress recently extended these disaster relief provisions for all of the territories through November 21, 2019.

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Financial Challenges in the U.S. Territories (Continued)

Although the additional funding provided by the ACA and the disaster relief bills has been critical to the territories over the past few years, the underlying fiscal construct poses significant ongoing challenges. The first financial challenge the territories face is that each year, they deplete their capped federal funds well before the end of the fiscal year. Three of the five territories deplete their capped federal funds in the 1st quarter, with the other two depleting them between the 2nd and 3rd quarter, so that by the 4th quarter of every fiscal year, not a single territory has any federal funds left due to the cap.

The second financial challenge that the territories face is an inadequate FMAP rate of 55%. One territory reported that in 2010, the US median household income was $61,544, while the territory's median income was $19,958. If this territory were given the same FMAP calculation that state Medicaid programs follow, the territory FMAP would be the 83% statutory max.

All of the territories have difficulties supplying the non-federal share for their programs. Without those dollars, they are unable to draw down the federal match. Due to this, many territories are forced to run their programs at a perpetual deficit.

When these challenges coincide in the later quarters of the fiscal year, the territories are then completely liable for the remaining Medicaid expenditures made that year—there are no federal dollars available to them. This creates one of two scenarios in the territories: some of the more resource constrained territories simply shut down the program and notify providers that they will no longer be paid for the rest of the fiscal year. The remaining territories that are able to do so try to backfill the gaps with territorial/local funding, which leads to an effective match rate for the territories as low as 13% federal and 87% territorial.

The problems discussed above regarding the high territorial match rate and inability of the territories to identify funding for the non-federal share, has also affected the territories' ability to draw down their allotted ACA funds. Millions of federal dollars have been "left on the table" to potentially expire. In FY2019, one territory had a Medicaid ACA balance of $181 million, and they had only drawn down $46 million, leaving $135 million to expire, as the territorial government could not identify a source of funding for the non-federal share. In the Spring of 2019, Congress passed provisions permitting territories to continue using the ACA funds through the end of 2019, allowing several of the territories who had been unable to fully draw down on these funds to attempt to do so (for some territories this amount exceeds $150 million).

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Territory Recommendations

When asked about how to improve their Medicaid program, territory Directors' main recommendation focused on the financial challenges they face due to insufficient capped federal funds and inequitable FMAP rates. Primarily, the territories have recommended lifting the Section 1108 (g) of the Social Security Act federal budget cap and allowing the territories to use the same FMAP calculation that states do, based on per capita personal income. Two additional recommendations from the territories were to establish specific service contractors for non-available services and supplies just for the territories, and to allow territory hospitals to receive Disproportionate Share Hospital (DSH) payments.

The historical lack of funding has required the territories to operate their Medicaid programs very differently than the states. Congress has stressed that if the federal government were to appropriate additional funding for the territories, they would want to ensure that the additional funding would be spent appropriately and in a meaningful way. All five of the territories recognize this expectation and the emphasis CMS and Congress put on reporting and fiscal responsibility. The territories are all taking a variety of steps to strengthen their infrastructure in many ways which would justify any potential increase in funding. Examples of these efforts include:

- Implementing advance IT reporting software, MMIS, Medical Claims Data Warehouses, and reporting to CMS via T-MSIS;
- Implementing Fraud Control Units;
- Taking steps to receive technical assistance in program integrity activities from external contractors; and
- Working with CMS Program Integrity and Office of Inspector General to receive recognition for their program integrity work.

However, territorial Medicaid programs should not be expected to look identical to state programs, due to their difference in geographical, political, and fiscal situations. Because of this, they cannot and should not be treated exactly like states. Instead, as the territories work towards increased and improved accountability and integrity in their Medicaid programs, they should receive increasingly equitable funding to the 50 U.S. states and DC, to adequately fund their programs throughout the entire fiscal year.

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Methodology

Between February and April of 2019, the five U.S. territory Directors received a 10-question survey via email. These 10 questions all required fill-in-the-blank, qualitative responses. The responses to these questions were analyzed by the NAMD staff, and a narrative was created using reference material from MACPAC, Thorn Run Partners, the Kaiser Family Foundation and other resources.

Acknowledgments

The National Association of Medicaid Directors (NAMD) first thanks its U.S. territory members for their time and thoughtful insight in responding to this survey and the significant contributions of their staff. We recognize that this survey requires a significant amount of time and effort, and that there are always numerous demands on their time, and we greatly appreciate their commitment to this new survey effort. NAMD thanks Dawn Cutler for her assistance in administering the survey tool, collecting and analyzing the resulting data, and serving as one of the primary authors of this report. NAMD also thanks Thorn Run Partners for their background research and contribution of the "Additional Funding for the U.S. Territories" section of the report.

Endnotes

1 Medicaid and CHIP Payment and Access Commission (MACPAC). "Medicaid and CHIP in the Territories." July 2019. **https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf**

2 Medicaid and CHIP Payment and Access Commission (MACPAC). "Medicaid and CHIP in the Territories." July 2019. **https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf**

3 The Henry J. Kaiser Family Foundation. "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)." September 30, 2012. **https://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/**

4 The Henry J. Kaiser Family Foundation. "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)." September 2012. **https://kff.org/wp-content/uploads/2013/01/8352.pdf**

5 The Henry J. Kaiser Family Foundation. "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." July 15, 2019. **https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

6 Medicaid and CHIP Payment and Access Commission (MACPAC). "Medicaid and CHIP in the Territories." July 2019. **https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf**