Permanent, Sustainable Medicaid Financing for U.S. Territories Policy Statement

POSITION:

ASTHO recognizes the need for permanent, sustainable Medicaid financing in the U.S. territories. Medicaid plays a critical role in providing access to health services for low-income individuals in the five U.S. territories. Historically, Medicaid financing in the territories has been underfunded compared to states for two primary reasons: 1) the Federal Medical Assistance Percentage (FMAP) is statutorily set at 55%, and 2) there is an annual cap on total federal funding.[i] While Congress has provided a patchwork of short-term, enhanced funding solutions through recent appropriation bills,[ii] they are set to expire on Dec. 13, 2022, which could trigger a "Medicaid cliff" and result in drastic cuts to territorial Medicaid programs.[iii] A permanent solution for equitable financing and access to health services for individuals living in U.S. territories, on par with states, is needed. Finally, this policy aligns with ASTHO's priority of advancing health equity across all states and territories by ensuring that individuals in territories have equitable access to health services through an adequately financed and high-quality health system.

Summary of Recommendations:

- Apply the equivalent FMAP formula based on per-capita income that is used by states, to U.S. territories.
- Remove the annual cap on the total Medicaid federal funding allotment to U.S. territories.

BACKGROUND:

Medicaid is the largest health insurance program in the United States and is jointly financed by federal and state/territorial governments for low-income and other eligible individuals.[iv] Medicaid and the Children's Health Insurance Program cover a significant portion of territorial populations (American Samoa: 68.4%; CNMI: 28.6%; Guam 21.2%; Puerto Rico: 37.9%; and USVI: 27.2%).[v] Likewise, Medicaid and CHIP cover a significant portion of state populations ranging from the lowest of 9.3% in Utah to 32.7% in New Mexico, with the state average at 19.8%.[vi] Despite near identical reliance on the program, the territories operate Medicaid programs under different rules than the 50 states and Washington, D.C. Section 1108 of the Social Security Act (SSA) establishes an annual ceiling on federal financial funds to the Medicaid programs in the territories.[vii] Whereas states have an open-ended financing structure based on a formula that relies on average per capita income and other factors, the FMAP for territories is statutorily set at 55%. Historically, territories often exceed the annual cap, after which they must fund their programs using unmatched territorial or local funds.[viii]

Over the past decade, Congress has provided additional federal Medicaid funds to territories through short-term increases to the annual allotment and/or FMAP. During the COVID-19 pandemic, Congress increased both territorial Medicaid caps and FMAPs. The fiscal year (FY) 2020 and 2021 appropriations packages and the Families First Coronavirus Response Act (FFCRA) raised each territory's Section 1108 cap by 700% to 900% for FY 2020 and 2021. In September 2021, CMS calculated FY 2022 allotments for the territories that extended the elevated FY 2021 allotments.[ix] FFCRA funds were also extended through December 13, 2022.

The FMAP for territories has also been raised for FY 2020,2021, and 2022 through FY appropriations.[2] For American Samoa, CNMI, Guam, and USVI, the FMAP is 83%; for Puerto Rico, it is 76%. The FMAP was temporarily increased by 6.2% across states and territories in response to the COVID-19 pandemic provided by the FFCRA.[x] Without additional action by Dec. 13, 2022, enhanced territorial Medicaid

funding provided in the annual appropriation process would end, and the FMAP for territories would revert to 55%.

Except for these temporary increases, territories on average typically receive three-to-four times less funding than state Medicaid programs.[xi] With the increased funding, territories have been able to expand access to healthcare and improve health outcomes. For example, clinic visits in CNMI have nearly doubled since 2013 and readmission rates significantly dropped following the implementation of a discharge planning process.[11] Finally, territories face unique challenges given their geographic isolation and often transport patients off-island for certain specialty services, which might be uncompensated for the hosting jurisdiction. As increased Medicaid funding has allowed expanded capacity of local hospitals and health systems, increased funding will reduce the need to travel off-island for access to services.

RECOMMENDATIONS/EVIDENCE-BASE:

ASTHO recommends the following actions from Congress to ensure permanent, sustainable Medicaid funding for the U.S. territories.

1. Apply the equivalent FMAP formula based on per-capita income that is used by states, to U.S. territories.
    - If the FMAP methodology for states was applied to territories, American Samoa, CNMI, Guam, and Puerto Rico would likely receive the maximum FMAP of 83%.[4]
    - The economic disparity is clear: 52% of CNMI residents live at or below the Federal Poverty Level compared to 15% in the United States and the median household income was less than half of the U.S. household income in 2010.[xii,xiii]
2. Remove the annual cap on federal Medicaid funding to the territories.
    - There is significant evidence that temporary enhanced funding, including removing the annual cap, has led to increased access to critical healthcare services in the territories.
        - For example, with the additional funding from the Further Consolidated Appropriations Act, 2020,[2] Puerto Rico was able to cover Hepatitis C treatment for Medicaid patients for the first time and the CNMI established an oncology center in 2019 that benefited the whole community, not just Medicaid beneficiaries.[xiv]
        - In one year, off-island referrals for cancer patients reduced from 307 to 25 after the CNMI hospital established an oncology center. The increased funding lowered costs and improved care for patients.[13]
    - If this enhanced funding expires on Dec. 13, 2022, each of the territories would be forced to either cut services, roll back eligibility, reduce provider payments, or make a combination of cuts, to accommodate the reduction in funds.[5]
    - Sustainable funding solutions are required to ensure funding is reliably available not only year-round, but during public health emergencies such as natural disasters and disease outbreaks.
        - For example, in 2018, following Typhoon Yutu, CNMI exhausted its federal funding in March 2019, six months before the end of the fiscal year. CNMI had to make decisions on the Medicaid program to ration care, cut services, reduce enrollment, or take-on massive debt. It was not until December 2019 that Congress approved enhanced funding and 83% FMAP to CNMI for two years to prevent significant cuts.[xv]

APPROVAL DATES:

Insular Affairs Subcommittee Approval: May 21, 2021
Population Health and Informatics Policy Committee Approval: May 27, 2021
Board of Directors Approval: June 23, 2021; September 14, 2022 (revised)
Policy Expires: June 30, 2024

ASTHO membership supported the development of this policy, which was subsequently approved by the ASTHO Board of Directors. Be advised that the statements are approved as a general framework on the issue at a point in time. Any given state or territorial health official must interpret the issue within the current context of his/her jurisdiction and therefore may not adhere to all aspects of this Policy Statement.

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[v] Medicaid and CHIP Payment and Access Commission. "Statement of Anne L. Schwartz, PhD Executive Director." Available at https://www.macpac.gov/wp-content/uploads/2021/03/Testimony-Medicaid-and-CHIP-in-the-U.S.-Territories.pdf. Accessed 5-12-2021

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[xi] Committee on Energy and Commerce Subcommittee on Health. "Hearing on Averting a Crisis: Protecting Access to Health Care in the U.S. Territories." Available at https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Opening percent20Statement_Eshoo_HE_2021.3.17.pdf. Accessed 5-12-2021

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