United States Government Accountability Office

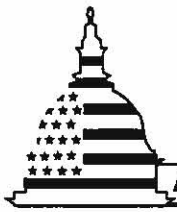
GAO

Report to Congressional Requesters

October 2005

U.S. INSULAR AREAS

Multiple Factors Affect Federal Health Care Funding



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Accountability * Integrity * Reliability

GAO-06-75

October 2005

U.S. INSULAR AREAS

Multiple Factors Affect Federal Health Care Funding

GAO Accountability Integrity Reliability

Highlights

Highlights of GAO-06-75, a report to congressional requesters

Why GAO Did This Study

Five insular areas of the United States—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands—benefit from federal health care financing and grant programs that help fund health care services to their over 4 million residents. However, notable differences exist in how the programs are funded or operate in the insular areas, such as statutory limits on federal Medicaid funding to the insular areas that do not apply in the states. To help understand these differences, GAO was asked to identify (1) the key sources of federal health care funding in the insular areas, (2) differences between insular areas and the states in the methods used to allocate these funds, and (3) differences in spending levels per individual between insular areas and the states.

In commenting on a draft of this report, American Samoa, CNMI, and Puerto Rico suggested the need for additional information on certain issues, such as implications of statutory limits on federal Medicaid spending and a more comprehensive analysis of local circumstances that affect the availability and costs of health care services.

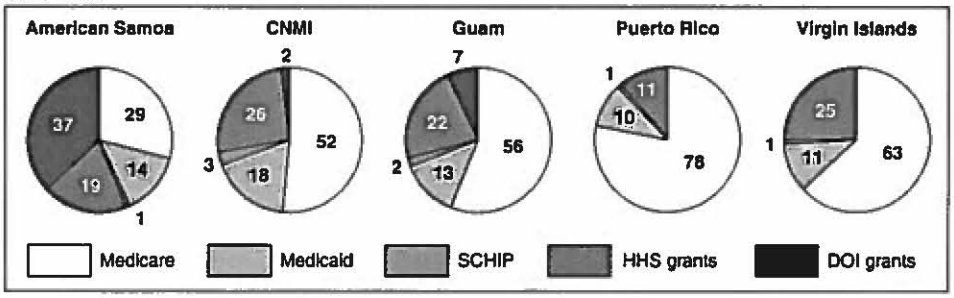
www.gao.gov/cgi-bin/getrpt?GAO-06-75.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

Multiple federal programs fund health care services in the insular areas. Federal health care financing programs—Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)—represented nearly 90 percent of the $2.2 billion in health care funding to these areas in fiscal year 2003, with Medicare alone representing over three-quarters of total funding. The Departments of Health and Human Services (HHS) and the Interior (DOI) also provide grants to the insular areas. Significant variation exists among the insular areas in terms of the distribution of funds by these sources, largely due to the number of Medicare beneficiaries in each area.

Key Federal Health Care Funding Sources to Five Insular Areas, by Percentage, Fiscal Year 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI

The methods used to allocate these federal funds to insular areas often differ from methods used in the states. For example, Medicare pays hospitals in most insular areas based on their costs rather than the prospective payment system used for most hospitals in the states. Similarly, federal funding for Medicaid and SCHIP is subject to statutory limits that do not apply to states, including minimum federal contributions and a cap on federal Medicaid payments. In addition, certain HHS grants use different rules to determine insular areas' funding.

Differences in allocation methods as well as other factors contribute to lower spending levels per individual in the insular areas compared to the states. For example, Medicare spending per beneficiary in the insular areas was less than half the amount it was in the states, due in part to differences in payment policies and to beneficiaries' lower utilization of services. In addition, the statutory limits on federal Medicaid funding in these areas contributed to lower federal Medicaid per capita payments in the five insular areas compared to the national average. However, in light of limits on federal funding, the insular areas are not held accountable for covering all Medicaid benefit requirements, such as nursing facility services that represent nearly one-third of Medicaid expenditures in the states. Insular areas benefit from certain HHS grant allocation formulas that result in higher per capita payments to them than the states, on average.

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Abbreviations

AS	American Samoa
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services

CNMI	Commonwealth of the Northern Mariana Islands
DOI	Department of the Interior
DSH	disproportionate share hospital
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESRD	end stage renal disease
FMAP	federal medical assistance percentage
FPL	federal poverty level
FQHC	federally qualified health center
GU	Guam
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MUA	medically underserved areas
NF	nursing facility
NIH	National Institutes of Health
OIA	Office of Insular Affairs
PPS	prospective payment system
PR	Puerto Rico
PSA	physician scarcity areas
RHC	rural health clinic
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SSI	Supplemental Security Income
TAGGS	Tracking Accountability in Government Grants System
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
VI	Virgin Islands

GAO
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United States Government Accountability Office
Washington, DC 20548

October 14, 2005

Congressional Requesters

The five largest insular areas of the United States—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands—and their more than 4 million residents have a unique relationship with the federal government.[1] With the exception of American Samoa, those born in the insular areas are U.S. citizens; however, insular area residents are not afforded all of the rights of citizens residing in the 50 states.[2,3] Although numerous federal health care financing and social programs—including Medicare, the federal health care program for the elderly and disabled, and Medicaid, the joint federal-state program that finances health care for certain low-income individuals—have been extended to insular area residents to varying degrees, notable differences exist in how these programs are funded or operate in the insular areas compared to the states. For example, the insular areas are subject to statutory limits on federal Medicaid funding that do not apply to the states. To help understand these differences, you asked us to identify (1) the key sources of federal health care funding in the insular areas, (2) the extent to which the methods used to allocate these sources of health funds differ from the methods used in the states, and (3) how spending levels per individual from these key sources differ between insular areas and the states.

To identify key sources of health care funding to the insular areas, we reviewed the Census Bureau's *Consolidated Federal Funds Report* and interviewed officials at the Departments of Health and Human Services (HHS) and the Interior (DOI) as well as officials from each of the five insular areas. For the key sources identified, we obtained comprehensive

[1]These five insular areas are the subject of this report. Nine smaller insular areas of the United States, which are not included in the scope of this report, are Navassa Island in the Caribbean Sea, and Baker Island, Howland Island, Kingman Reef, Jarvis Island, Johnston Atoll, Midway Atoll, Palmyra Atoll, and Wake Island in the Pacific Ocean.

[2]Throughout this report, the term states refers to the 50 states and the District of Columbia.

[3]Those born in American Samoa are considered to be American nationals of the United States. An American national is either a citizen or someone who "owes permanent allegiance to the United States." 8 U.S.C. § 1101(a)(21), (22) (2000). While American nationals are not entitled to all the benefits for which only citizens qualify, they are not aliens and therefore cannot be expelled or deported.

health expenditure data for federal fiscal years 1999 through 2003 from the respective agencies. To assess the reliability of HHS and DOI data, we discussed data quality control procedures and reviewed relevant documentation with officials. We determined the data were sufficiently reliable for the purposes of this report.

To determine the extent to which methods used to allocate funds to the insular areas differ from those used in the states, we reviewed federal laws and guidance on this funding and interviewed agency and insular area officials. To determine the extent to which spending levels per individual from these key sources differ between insular areas and the states, we examined trends in program expenditures between states and insular areas. To assess the reliability of the program expenditure data, we reviewed relevant documentation, interviewed agency officials about the data, and conducted electronic data testing. We determined that the program expenditure data were sufficiently reliable for the purposes of this report. We conducted our work from October 2004 through September 2005 in accordance with generally accepted government auditing standards. (For additional information on our methodology, see app. I.)

Results in Brief

Multiple federal programs, such as federal health care financing programs and various HHS and DOI grant programs, fund health care services in the insular areas. In fiscal year 2003, funding from these sources to the five insular areas totaled $2.2 billion. Medicare was the single largest source of health care funding, representing over three-quarters of total funding. When funding from the other federal health care financing programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—is added to the Medicare total, the federal health care financing programs represented nearly 9 of every 10 federal dollars spent in the five insular areas. However, because Puerto Rico represents over 90 percent of the total insular area population, the aggregate spending numbers mask the often significant variation that exists in the sources of funding among the insular areas. Specifically, while the proportion of federal spending by source in Puerto Rico largely mirrored the aggregate numbers, health care grant funding represented a much larger proportion of health care funding in the other four insular areas, largely due to their comparatively smaller Medicare populations. For example, grant funding represented about 56 percent of total funding in American Samoa in fiscal year 2003 but only 11 percent of total funding in Puerto Rico. In addition, the extent to which the insular areas relied on grant funding often fluctuated significantly from year to year. For example, from fiscal years 1999 through 2001, DOI

funding to CNMI grew from 2 to 26 percent of total health care funding and fell back to 2 percent in 2003.

Notable differences exist in methods used to allocate federal health care funds in the insular areas compared to the states, and these differences are often statutory in nature. For example, while most hospitals in the states and Puerto Rico are paid under Medicare's inpatient prospective payment system (PPS),[4] hospitals in the other insular areas are not included in the PPS statutory provision and are instead paid based on their costs. Similarly, under the new Medicare prescription drug benefit, to be implemented in January 2006, certain low-income beneficiaries in the insular areas will not receive direct subsidies to help pay for their premiums, deductibles, and copayments that are available to certain beneficiaries in the states. Instead, CMS will provide each insular area with an allotment, which they will then use to administer the program to low-income beneficiaries based on a locally developed plan. In addition, federal funding for the Medicaid and SCHIP programs in the insular areas is subject to statutory limits that do not apply to states. For example, the statutory formula used to calculate the federal share of a state's Medicaid expenditures, which results in a higher federal share of Medicaid expenditures in poorer states, does not apply to the insular areas. In contrast, the federal contribution to the insular areas is set by statute at the minimum rate available to states, although nearly all of the insular areas have a lower median household income than the poorest state. In addition, unlike the states, where there are no caps on the federal share of Medicaid funding as long as the state contributes its share of program expenditures, federal Medicaid funding in the insular areas is subject to an annual statutory cap. Although similar methods are used to allocate some HHS grants to states and insular areas, other grants use separate rules to determine funding amounts in the insular areas.

Multiple factors, including differences in funding allocation methods, compliance with program requirements, and beneficiaries' use of program services, all contribute to differences in program spending per individual in insular areas compared to the states. For example, Medicare spending per beneficiary in the insular areas is less than half the amount it is in the states, due in part to differences in methods used to pay for certain

[4]Since 1984, Medicare payments to most hospitals have been based on PPS instead of on their allowable incurred costs, which was the previous practice. Under PPS, each hospital receives a standard rate for each discharge related to a specific diagnosis, which is adjusted based on local costs and the delivery setting.

services and beneficiaries' utilization of services. In addition, the statutory limits on federal Medicaid funding in the insular areas—particularly the minimum federal matching contribution and funding cap—contribute to federal Medicaid spending per capita levels in the insular areas that are significantly lower than in the states. However, insular areas are not required to meet all Medicaid eligibility requirements, and in light of limits on federal funding, CMS does not hold these areas accountable for covering all Medicaid benefit requirements, which may help explain lower per capita spending. For example, none of the insular areas provides full coverage for nursing facility services, which represented nearly one-third of Medicaid expenditures in the states in fiscal year 2003. In contrast, HHS grant funding per capita is higher in the insular areas than in the states due in part to allocation formulas that result in higher payments to them as well as to states with smaller populations.

We received written comments on a draft of this report from DOI, American Samoa, CNMI, and Puerto Rico, and technical comments from HHS and Puerto Rico. DOI acknowledged that improving health care in the insular areas is a priority for both the agency and the insular areas and commented that the report identifies areas of disparity that may be reviewed for improvement. The three insular areas expressed concern that the report did not sufficiently address certain issues, such as implications of statutory limits on federal Medicaid spending and a more comprehensive analysis of local circumstances that affect the availability and costs of health care services. Where appropriate, we revised the report to include information about local circumstances that may affect the provision or cost of health care services. However, a more comprehensive analysis of insular areas' local contribution to total health care funding or their health care infrastructures was beyond the scope of this report.

Background

Five insular areas—American Samoa, Guam, CNMI in the Pacific Ocean, and the Commonwealth of Puerto Rico and the Virgin Islands in the Caribbean Sea—represent the largest insular areas of the United States. More than 4 million U.S. citizens and nationals live in these insular areas under the sovereignty of the United States. These areas vary in terms of how they came under the sovereignty of the United States and also in terms of their demographics, such as median age and education levels. However, all of these insular areas participate in three major federal health care financing programs—Medicare, Medicaid, and SCHIP—and are eligible for a variety of federal health grant programs.

Relationship to United States

These five areas have come under the sovereignty of the United States in various ways. Puerto Rico and Guam were ceded to the United States by treaty at the end of the Spanish-American War in 1898, and the Virgin Islands were purchased from Denmark in 1917. Following the renunciation by Great Britain and Germany of their claims to what is now American Samoa and the cession of these islands by the Samoan chiefs to the United States, the Congress ratified the instruments ceding the islands to the United States in 1929. The United States was responsible for administering the Northern Mariana Islands after World War II under a United Nations trusteeship agreement. In 1976, a covenant between the United States and the Northern Marianas established the islands as a commonwealth under the sovereignty of the United States.

Each of these areas has its own government and maintains a unique diplomatic relationship with the United States. General federal administrative responsibility for all insular areas but Puerto Rico is vested in the Department of the Interior. All departments, agencies, and officials of the executive branch treat Puerto Rico administratively "as if it were a state;" any matters concerning the fundamentals of the U.S.-Puerto Rican relationship are referred to the Office of the President.[5]

People born in Puerto Rico, Guam, CNMI, or the Virgin Islands are American citizens; those born in American Samoa are American nationals. The residents of all five of these larger insular areas enjoy many of the rights enjoyed by U.S. citizens in the 50 states.[6] But some rights that, under the Constitution, are reserved for citizens residing in the states, have not been extended to residents of the insular areas. For example, residents of the insular areas cannot vote in national elections, nor do they have voting representation in the final approval of legislation by the full Congress.

[5]Memorandum of the President, Nov. 30, 1992, 57 Fed. Reg. 57,093 (1992). For a more thorough discussion of the applicability of the provisions of the Constitution to the five insular areas, see GAO, *U.S. Insular Areas: Application of the U.S. Constitution*, GAO/OGC-98-5 (Washington, D.C.: Nov. 7, 1997).

[6]The Territorial Clause of the Constitution authorizes the Congress to "make all needful Rules and Regulations respecting the Territory or other Property" of the United States. U.S. Const. art. IV, § 3, cl. 2. Relying on the Territorial Clause, the Congress has enacted legislation making some provisions of the Constitution explicitly applicable in the insular areas. In addition to this congressional action, courts from time to time have ruled on the application of constitutional provisions to one or more of the insular areas.

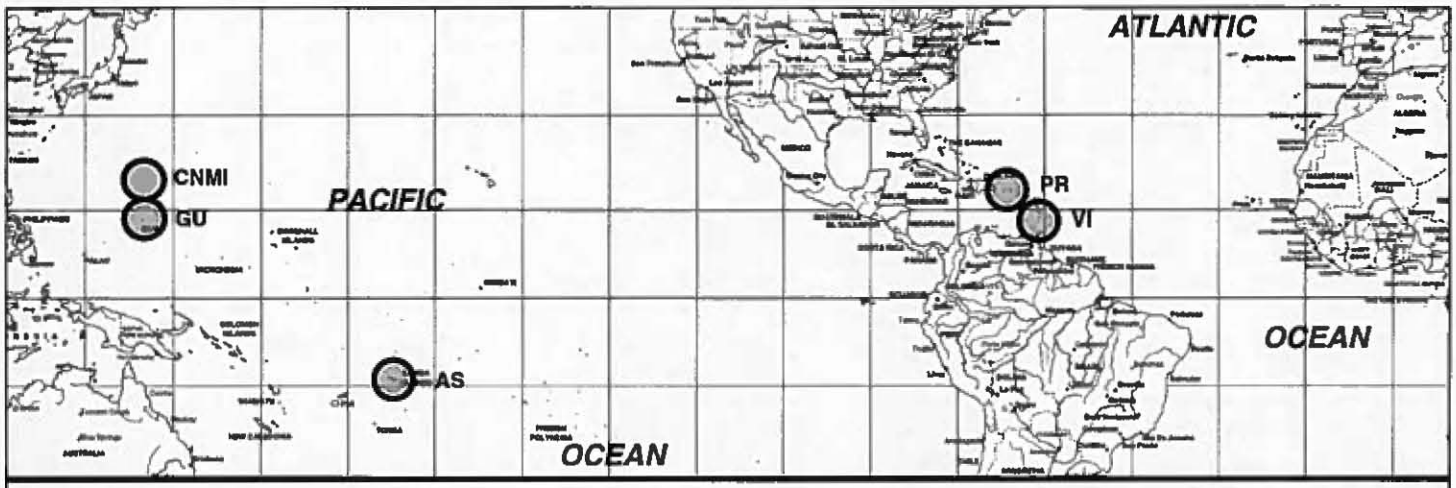
Characteristics of the Insular Areas

The insular areas—particularly those in the Pacific—are geographically isolated from the United States. For example, Hawaii, which is the closest state to the Pacific insular areas, lies 3,300 to 3,700 miles away, or up to 13 hours by air.[7] In addition, when compared to the U.S. states and each other, the insular areas have unique demographic characteristics. For example, with the exception of Puerto Rico, the populations in the insular areas are small relative to the states, and with the exception of Guam, they are significantly poorer. For example, four of the insular areas have median incomes that range from about $14,000 to about $25,000, considerably lower than the two poorest states, Mississippi and West Virginia.[8] In addition, the populations in the Pacific island areas—American Samoa, CNMI, and Guam—are younger than those of the states and Puerto Rico and the Virgin Islands. For example, nearly half of the population of American Samoa is under the age of 19 compared to about 27 percent in the United States. Similarly, while over 12 percent of the U.S. population is over 65, this age cohort represents only 1.5 to 5.3 percent of the population in the three Pacific insular areas. In terms of available health indicators, the differences are not as clear. While the insular areas have a higher mortality rate than the U.S. for certain diseases, such as diabetes, their mortality rates for cancer are lower. (See fig. 1.)

[7]By comparison, the nearest state to Hawaii is California at 2,400 miles away. The distance from Anchorage, Alaska, to Seattle, Washington, is approximately 1,400 miles. Puerto Rico and the Virgin Islands are located in the Caribbean and are both about 1,000 miles from Florida.

[8]The 1999 median household income for Mississippi and West Virginia was $31,330 and $29,696 respectively.

Figure 1: Insular Areas and United States Demographics and Health Indicators



	AS	CNMI	GU	PR	VI	US
Population	57,291	69,221	154,805	3,808,610	108,612	281,421,906
Median age	21.3	28.7	27.4	32.1	33.4	35.3
Percentage under 19 years of age	47.9	28.2	38.5	32.0	34.2	27.1
Percentage over 65 years of age	3.3	1.5	5.3	11.2	8.4	12.4
Median household income	$18,219	$22,898	$39,317	$14,412	$24,704	$41,994
Percentage high school grad or more (over age 25)	66.1	69.2	76.3	60	60.6	80.4
Percentage bachelor's degree or more (over age 25)	7.4	15.5	20	18.3	16.8	24.4
Death per 100,000 (age adjusted)	1,467.9	1,057.4	736.6	790.8	734.3	845.3
Infant mortality per 1,000 live births	13.5	*	7.3	9.4	7	6.9
Cancer death per 100,000 (age adjusted)	187.9	*	136.1	130.9	147.1	193.5
Diabetes death per 100,000 (age adjusted)	159.7	*	*	69.5	33.1	25.4
Heart disease death per 100,000 (age adjusted)	307.1	226.8	253.6	170.2	238.6	240.8

Sources: 2000 Census and Centers for Disease Control and Prevention (CDC) 2002 Mortality and Natality reports.

*CDC determined that the data did not meet reliability standards because less than 20 cases were reported.

Some insular areas do not have certain types of health care providers, and even when providers operate in these areas, their numbers per capita are lower, on average, than in the states. For example, most of the insular areas do not have Medicare-certified outpatient rehabilitation facilities, community mental health centers, or ambulatory surgical centers. In

addition, none of the Pacific insular areas has a Medicare-certified, free-standing skilled nursing facility or a Medicare-certified hospice facility.[9] Provider shortages in insular areas are often particularly acute for certain specialists.[10] For example, although Guam has a cardiac catheterization lab, it is not used because there is no cardiac surgeon. Also, although its rate of diabetes death is high, American Samoa has no resident nephrologists. Instead, the nephrologist that serves the area is based at St. Francis Medical Center in Hawaii. When providers are present, the average number per capita is usually lower than in the states, although the differences between the states and Puerto Rico are less pronounced than the differences among the states and the other four insular areas. For example, the insular areas have significantly fewer skilled nursing facilities than do the states. One notable exception is that there are more end-stage renal facilities per capita in American Samoa, Guam, and the Virgin Islands when compared to the states, perhaps due to a higher prevalence of diabetes in these areas. (See table 1.)

[9]Federally Qualified Health Centers (FQHC) are entities that receive federal grants as community health centers under section 330 of the Public Health Service Act and typically provide a variety of services, including physicians' services and services provided by physician assistants and nurse practitioners. (Codified at 42 U.S.C. § 254b (2000)).

[10]To varying degrees, each of the insular areas qualifies for one or more federal designations that are used to indicate areas with a shortage of providers—Health Professional Shortage Areas (HPSA), physician scarcity areas (PSA), and Medically Underserved Areas (MUA)—which may help them qualify for certain grants or for increased Medicare payments. A HPSA is computed based on factors including primary care physician ratio, poverty rates, and infant mortality rate, and is used as a qualifying criterion for certain federal grants and a 10 percent increase in payment rates for Medicare providers. A PSA is computed based on the ratio of primary care physicians to Medicare beneficiaries and is used to qualify Medicare providers for a 5 percent increase in payments. Providers in areas that are designated as both HPSA and PSA qualify for both payment increases. A MUA is computed based on factors including the ratio of primary care providers to the population, the percentage of the population over 65, and the poverty level, and is used as a qualifying criterion for certain federal grants.

Table 1: Medicare-Certified Healthcare Providers and Hospital Beds in Insular Areas and States, January 2005

Providers (per 100,000)	Puerto Rico	Average (four other insular areas)	States
Ambulatory surgical center	0.6	0.3	1.5
Comprehensive outpatient rehabilitation facility	0.03	0	0.2
Community mental health center	0.2	0	0.2
End stage renal disease facility	1.0	2.1	1.6
Federally qualified health center	0.2	0.8	1.0
Home health agency	1.2	1.3	2.7
Hospice	0.9	0.3	0.9
Skilled nursing facility	0.2	0.5	5.3
Hospital beds	321	265	416

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

Note: Because Puerto Rico's population represents over 90 percent of the total population of the insular areas, we separately analyzed provider data from Puerto Rico and the other four insular areas to ensure that the higher prevalence of providers in Puerto Rico did not mask the more pronounced shortages of certain providers in the other insular areas. Provider figures for Guam, Puerto Rico, and the United States include some Department of Veterans Affairs and Department of Defense facilities.

Federal Health Care Financing and Grant Programs

Each insular area participates in three major federal health care financing programs—Medicare, Medicaid, and SCHIP. In addition, each area receives health-related grant funds from a variety of HHS agencies and four of the five areas receive health-related grant funds from DOI.

Medicare covers a variety of health care services and items for more than 41 million beneficiaries—individuals who are 65 or older, have end-stage renal disease (ESRD), or are disabled—including about 600,000 in the insular areas. Medicare includes separate components or "parts" that cover different types of services. Individuals who are eligible for Medicare automatically receive Hospital Insurance, known as Part A, which helps pay for inpatient hospital care, skilled nursing facility services following a hospital stay, certain home health services, and hospice care. Beneficiaries pay no premiums for Part A but are liable for required deductibles, coinsurance, and copayments. Medicare Part A is funded through the Medicare trust fund, which is financed by state and insular area employer and employee contributions. Medicare Part B Supplemental Medical Insurance helps pay for physician, outpatient hospital care, laboratory, and other services. Beneficiaries who opt for Part B coverage must pay a

premium—about $78 per month in 2005—and are responsible for deductibles, coinsurance, and copayments.[11]

Medicare's new prescription drug program, Part D, was authorized in December 2003, and the interim phase of the program began in June 2004. Under the interim phase, all beneficiaries in the states and the insular areas who choose to enroll pay a fee to receive a discount drug card, with an expected discount of 10 to 15 percent on covered drugs.[12] In addition, certain low-income beneficiaries in the states are also entitled to assistance to subsidize drug costs in 2004 and 2005, and the amount of assistance available to each individual is generally $600 per year. Under the permanent program, to be implemented in January 2006, beneficiaries in the states and the insular areas can choose to enroll in an optional prescription drug coverage program subject to an estimated average monthly premium of about $32. Like the interim program, certain low-income participants in the states will also receive subsidies to lower their monthly premiums, deductibles, and copayments. To help offset the costs of providing coverage to individuals eligible for both Medicare and Medicaid, states must pay the federal government an amount that is roughly equal to the amount they would have paid to provide outpatient prescription drug coverage to elderly and disabled individuals previously eligible for prescription drug benefits under their Medicaid programs. Part D is otherwise financed through beneficiary premiums and general revenues.

Medicaid operates as a joint federal-state program to finance health care coverage for certain categories of low-income individuals, including children, pregnant women, and individuals who are elderly or disabled. Although state and insular area participation in Medicaid is voluntary, all states and insular areas currently participate in the program. To obtain federal matching funds, states and insular areas generally must comply with certain minimum federal requirements related to services and eligibility, including income and resource requirements. Within these

[11]Traditionally, Medicare has paid for covered services on a fee-for-service basis. Medicare Advantage, known as Part C, encompasses private managed care plans that provide Medicare-covered benefits to enrollees. Beneficiaries who opt for Medicare Advantage plans must pay the Part B premium.

[12]This fee is waived for certain low-income beneficiaries in the states. For more details on the savings provided by the discount drug card, see GAO, *Prescription Drug Discount Cards: Savings Depend on Pharmacy and Type of Card Used*, GAO-03-912 (Washington, D.C.: Sept. 3, 2003).

broad federal guidelines and under federally approved plans, states and insular areas have great discretion in setting eligibility standards and provider payment rates; determining the amount, scope, and duration of covered benefits; and developing their own administrative structures. For example, while federal law requires Medicaid programs to offer coverage to children age 5 and under if their family incomes are at or below 133 percent of the federal poverty level and to children ages 6 to 18 if their family incomes are at or below the federal poverty level, a state may decide to increase the thresholds in order to offer coverage to more people. As a result, Medicaid essentially operates as 56 separate programs: 1 in each of the 50 states, the District of Columbia, and each of the 5 largest insular areas. The federal share of states' Medicaid programs, the Federal Medical Assistance Percentage (FMAP), is determined based on state per capita income in relation to the national per capita income, with poorer states receiving higher federal matching rates than wealthier states. In 2005, the FMAP ranged from 50 percent in wealthier states, such as New York and Connecticut, to about 77 percent in Mississippi.

In 1997, the Congress enacted SCHIP to provide health care coverage to uninsured, low-income children living in families whose incomes exceed the eligibility limits for Medicaid.[13] States and insular areas have three options in designing SCHIP: expand their Medicaid programs, develop separate child health programs that function independently of the Medicaid programs, or do a combination of both. States that implement SCHIP by expanding Medicaid must use their Medicaid enrollment and benefit structure. Although SCHIP is generally targeted to families with incomes at or below 200 percent of the federal poverty level, each state or insular area may set its own income eligibility limits within certain guidelines. The FMAP for SCHIP ranges from 65 percent for the wealthiest states to about 84 percent for the poorest states.

Various HHS agencies also distribute health care grants to the insular areas. These grant funds—awarded by agencies such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA)—may be used to support health care services and outreach programs and are generally awarded to public

[13]The Balanced Budget Act of 1997 established SCHIP as Title XXI of the Social Security Act. Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-574. SCHIP is set out at 42 U.S.C. § 1397aa *et seq.* (2000).

health agencies. Similarly, DOI's Office of Insular Affairs (DOI-OIA) funds health infrastructure and provides technical assistance to all insular areas but Puerto Rico. DOI also provides the Pacific insular areas with funds to offset the cost of providing services to residents of the freely associated states.[14]

Multiple Federal Agencies Fund Health Care Services in Insular Areas

Each of the five insular areas receives funding for health care services from multiple federal sources. Federal health care financing programs—Medicare, Medicaid, and SCHIP—comprised 88 percent of aggregate federal health care funding in the insular areas in fiscal year 2003, with Medicare representing the single largest funding source (76 percent). The areas also received a significant amount of health care grant funding from certain HHS agencies and DOI. However, significant variation exists among the insular areas in terms of the distribution of funds by source, largely due to the number of Medicare beneficiaries residing in each area. For example, the Pacific insular areas have relatively young populations, and therefore receive less Medicare funding compared to other sources. From fiscal years 1999 through 2003, total federal health care funding in the insular areas increased by 37 percent, although funding increases varied considerably among the insular areas.

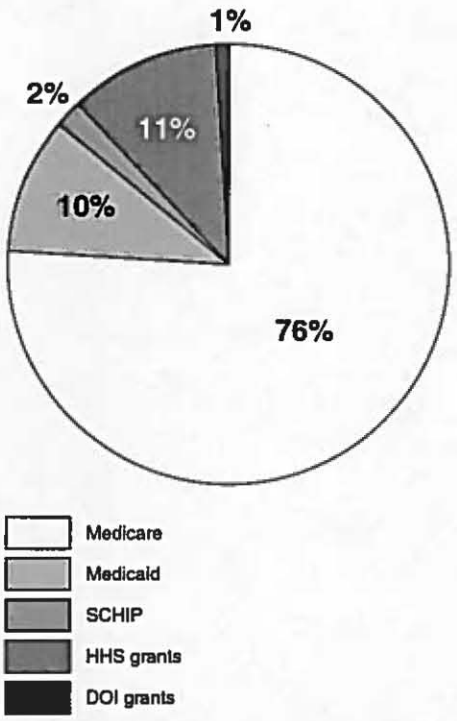
Medicare Represents the Majority of Federal Health Care Spending in Insular Areas

Federal health care financing programs—primarily Medicare—comprised the vast majority of the $2.2 billion in total federal health care spending in the five insular areas in fiscal year 2003.[15] Medicare funds alone, which are generally paid directly to health care providers for services to beneficiaries rather than directly to the insular area government, represented 76 percent—about $1.68 billion—of the aggregate funding to the insular areas. (See fig. 2.) The Medicaid program represented 10 percent of the total funding in the insular areas, about $226 million, and funding for the SCHIP program totaled about $33 million, 2 percent of total health care funding in these areas. Unlike Medicare, Medicaid and SCHIP funds are provided directly to the insular area governments.

[14]Through agreements with the U.S. government, residents of the freely associated states—the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau—may enter the United States to live and work without limitations on their length of stay. Visitors from these areas are eligible for public services, such as health care and education.

[15]The estimate for total federal health spending in the insular areas is limited to spending from key sources, as identified in appendix II.

Figure 2: Key Federal Health Care Funding Sources for Five Insular Areas, Fiscal Year 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

In addition to the federal health care financing programs, three HHS agencies—CDC, HRSA, and SAMHSA—provided health-related grants to public and private entities in the insular areas. These grants represented approximately 11 percent, more than $250 million, of total federal health care funding in the insular areas.[16] In 2003, these agencies awarded grants from 87 different programs to the insular areas, with individual awards ranging from over $9,000 to nearly $39 million. The funds may be used to support health care services and outreach programs. For example, HRSA provided grant funding to the insular areas for programs related to health care resources and services, including community health centers, human

[16]Other HHS agencies, such as the Agency for Healthcare Research and Quality (AHRQ), CMS, and the National Institutes of Health (NIH), also awarded grants to the insular areas during this time. However, we did not include grants from these agencies for a number of reasons. For example, grants from AHRQ and NIH were targeted exclusively to research. Grants from CMS, apart from Medicaid and SCHIP funding, represented less than 1 percent of HHS grant funding to the insular areas from fiscal years 1999 through 2003.

immunodeficiency virus (HIV) care and treatment, maternal and child health care, and bioterrorism preparedness.

DOI also provided a number of health-related grants to the four insular areas that were eligible for these funds.[17] In fiscal year 2003, DOI grants to the insular areas totaled about $13.6 million, 1 percent of federal health care funding in the insular areas. The grants had multiple purposes, including offsetting the costs of providing care to individuals from the freely associated states and supporting health-care-related activities, such as facility construction and information technology.

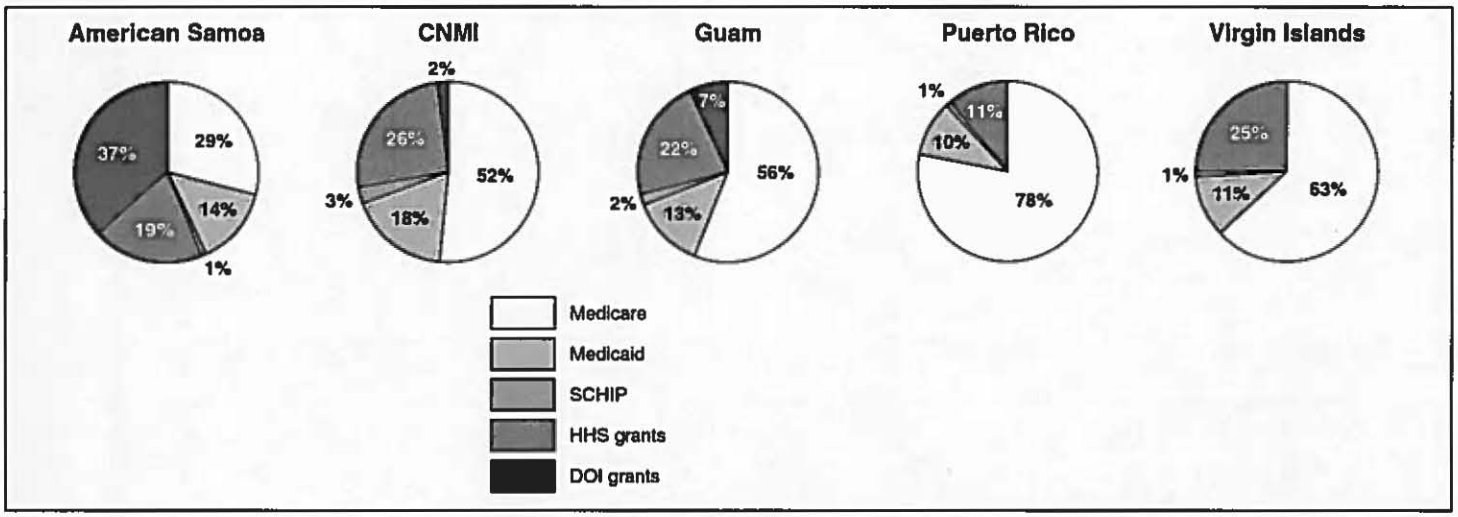
From 1999 through 2003, total federal health care funding in the insular areas increased 37 percent—from over $1.6 billion to over $2.2 billion. During this time, funding from all sources but SCHIP increased. For example, total Medicare funding increased by 41 percent, Medicaid by 21 percent, HHS grants by 73 percent, and DOI by 11 percent. Although funds from HHS had the largest percentage increase over this time, the biggest increase in dollars was seen in Medicare, with an increase of over $485 million.

Health Care Grants Represent Smaller Share of Federal Funding in Puerto Rico Compared to Other Insular Areas

Since Puerto Rico represents about 91 percent of total insular area population, the aggregate spending numbers obscure the often significant variation that exists in the sources of funding among the insular areas. For example, similar to aggregate numbers, Medicare spending represented 78 percent of spending in Puerto Rico in fiscal year 2003, whereas the Medicare share in the other areas was smaller, ranging from 29 percent in American Samoa to 63 percent in the Virgin Islands. (See fig. 3.) This variation is influenced by differences in the share of Medicare beneficiaries residing in each area relative to its overall population. For example, Medicare as a share of total spending was largest in both Puerto Rico and the Virgin Islands, whose populations of individuals 65 or older are comparatively larger than that of the Pacific insular areas and are more closely aligned with the U.S. average. Differences in the other federal health financing programs also varied, but to a lesser extent, with Medicaid and SCHIP funding combined representing between 12 and 21 percent of health care funding in each of the areas.

[17]DOI does not have jurisdiction over Puerto Rico; therefore, the island is not eligible for DOI grants.

Figure 3: Key Federal Health Care Funding Sources by Insular Area, Fiscal Year 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Note: Figures may not total to 100 percent due to rounding.

In terms of health care grants from both HHS and DOI, significant variation existed in the share of health care funding they represented among the insular areas. For example, in fiscal year 2003, these grants represented 11 percent of total health care funding in Puerto Rico; however, they represented 25 to 56 percent of total funding in the other insular areas. Variation among the insular areas in terms of DOI health grants as a share of total federal funding was more pronounced than that of HHS grants during this time. While HHS grants represented roughly the same share of total health care funding in each insular area except Puerto Rico, DOI grants represented 2 percent of total health care funding in CNMI, 7 percent in Guam, and 37 percent in American Samoa. The Virgin Islands, although eligible for these funds, received none in fiscal year 2003.

The availability of grant funds, and therefore the share they represented of health care funding, has fluctuated considerably in recent years. For example, DOI grants to CNMI, which represented 2 percent of total health care funds in 1999, increased to 26 percent of total funding in 2001 and fell

back to 2 percent in 2003.[18] Similarly, HHS grants to the Virgin Islands represented 13 percent of total federal health funding in 1999, but grew to nearly one-third of total spending in 2002. (See app. II for a detailed description of trends in federal funding sources over time for each insular area.) Such year-to-year variability can make it difficult to establish long-range budgets and to develop, manage, and staff programs funded by grant awards. In addition, according to insular area officials, capturing and retaining HHS grant funds can be labor intensive. For example, for most of the grants we reviewed, agencies require insular areas and states to complete comprehensive applications with detailed budgets and program plans. Agencies may also require periodic data reporting or local cost sharing.

When considered individually, each of the five insular areas experienced an overall increase in total federal health care funding from 1999 through 2003. Increases, however, varied considerably among the areas, ranging from 36 percent in Puerto Rico to 81 percent in CNMI.[19] The variation was largely due to differences in the annual increases specific to Medicare and HHS grant awards. For example, Medicare funding increased in all areas, but most dramatically in CNMI, largely due to changes in the way its hospital reported costs to CMS. Similarly, total HHS grant funding increased in each area, although increases were more pronounced in certain areas, such as American Samoa and Guam, due in part to the introduction of new grants related to bioterrorism.

[18]DOI grants are generally large awards of short duration—1 to 5 years—and targeted to address specific needs, thus creating significant year-to-year fluctuation. For example, the large increase in CNMI in 2001 was due to an influx of funding earmarked for specific construction projects.

[19]By comparison, federal health care funding in the states increased by 39.5 percent from fiscal years 1999 through 2003.

Notable Differences Exist in Methods Used to Allocate Federal Health Care Funds in the Insular Areas Compared to the States

The methods used to allocate federal health care funds in the insular areas differ, in some cases, from those used in the states. Although Medicare payment policy does not differ for certain providers, such as physicians, notable differences exist in the policies used to pay hospitals and for the new Part D prescription drug benefit. Similarly, differences exist in how the Medicaid and SCHIP programs are funded in the insular areas. Unlike in the states, the federal share of Medicaid and SCHIP expenditures in the insular areas—the FMAP—is limited by statute, and federal Medicaid funding is capped. In addition, allocation methods used for certain HHS grants establish separate rules for the insular areas.

Medicare Funds Are Allocated Differently for Parts A and D

The Medicare program operates similarly in the insular areas and the states in terms of eligibility for the program and beneficiaries' entitlement to benefits. For example, like their counterparts in the states, insular area residents who are eligible for Medicare are automatically enrolled in Part A and do not pay premiums for this coverage. Likewise, the policies used to determine payment for physicians under Part B are essentially the same. However, significant differences exist between the insular areas and the states regarding the methods used to determine payments to hospitals and the funding of the Medicare Part D benefit.

Unlike the states and Puerto Rico, where hospitals are paid under Medicare's PPS, hospitals in the other insular areas are paid based on their costs.[20] There are differences in the cost-based payment methods used in these areas. The hospitals in Guam and the Virgin Islands are paid using the methodology established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) for classes of hospitals not included in the PPS. Payments to these hospitals are the lesser of their average cost per discharge or a specific target amount.[21] Hospitals in American Samoa and CNMI are also paid based on their costs; however, they are not subject

[20]When Medicare's inpatient PPS was implemented in 1984, it did not include hospitals in the insular areas. Hospitals in Puerto Rico lobbied to be included in the PPS and were transitioned into the system in 1987.

[21]TEFRA established this payment methodology for classes of hospitals not included in PPS. The target amount is the PPS-exempt provider's Medicare-allowable costs per patient stay in a designated base year, inflated to the current year by an annual update factor. Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 324, 331-333.

to target amounts or a national cap.[22] We did not evaluate how payments under these cost-based methods compare to PPS payments to hospitals in the states.

Although hospitals in Puerto Rico are paid under the PPS system, the formula that CMS uses to reimburse hospitals in Puerto Rico is distinct from that used for hospitals in the states. Each of the Puerto Rico PPS payment rates is a "blended rate," which is comprised of 75 percent of a national rate used for hospitals in the states and 25 percent of a local rate, which is lower than the national rate. The rates are further adjusted for each hospital using national and local cost factors. These adjustments account for the lower costs of providing hospital services in Puerto Rico compared to the states and for differing costs among hospitals within Puerto Rico.

Differences also exist between the insular areas and the states regarding the methods used to fund Medicare's new Part D prescription drug benefit for low-income beneficiaries. For example, during the interim phase of the Part D program, certain low-income beneficiaries in the states who participate in the program are entitled to assistance to subsidize drug costs in 2004 and 2005, and the amount of assistance available to each individual is generally $600 per year. In contrast, low-income Medicare beneficiaries in the insular areas do not receive this direct subsidy. Instead, CMS provided each insular area with an allotment, which the insular areas typically used to subsidize prescription drug coverage to certain low-income Medicare beneficiaries.[23] Similarly, although the permanent Part D program, scheduled to begin in January 2006, allows for identical coverage for most beneficiaries in the insular areas and states, however, low-income beneficiaries in the insular areas will not receive direct benefits to help subsidize their premiums, deductibles, and copayments available to Medicare and Medicaid dual eligible beneficiaries in the states. Instead, CMS will again provide each of the insular areas an

[22]Hospitals in American Samoa and CNMI are not subject to the TEFRA payment methodology because they do not have the capacity to complete the full cost report required by this methodology.

[23]The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided the insular areas with $35 million, which was to be allocated among them based on their Medicare enrollment as of July 1, 2003, to assist Part D eligible individuals (as outlined in 1935(e)) with the purchase of prescription drugs. Pub. L. No. 108-173, §101, 117 Stat. 2066, 2146 (amending 42 U.S.C. § 1395w-141(j)). CMS provides these funds to the insular areas in the form of an enhanced allotment to their Medicaid program funds.

allotment, which they will use to administer the program to low-income beneficiaries based on a locally-developed plan. The extent to which the benefits in the insular areas will mirror the federal program is not clear as none of the insular areas has finalized its plan for the administration of this program.

Medicaid and SCHIP Federal Funding to the Insular Areas Is Limited by Statute

Like the states, each of the insular areas receives federal funding from the Medicaid and SCHIP programs. However, how federal funds for these programs are allocated to the insular areas differs, often significantly, from the states, and these differences are statutory in nature. For example, recognizing that states vary in their capacity to pay for Medicaid expenses, the statutory formula used to calculate the federal share of each state's expenditures—the FMAP—is based on a state's per capita income in relation to the national average per capita income. The FMAP ranges from 50 to no more than 83 percent of Medicaid expenditures, with poorer states receiving a higher federal matching rate than wealthier states.[24] In contrast, the FMAP for the insular areas does not recognize their capacity to pay for Medicaid expenses; instead, the FMAP is set at the lowest rate—50 percent—although all of the insular areas, except Guam, had a lower median household income than the poorest U.S. state.

In addition, federal Medicaid funding in states is not limited, provided the states contribute their share of program expenditures for services provided. In contrast, federal Medicaid funding in each insular area is subject to a statutory cap, which is increased annually by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers, which averaged about 4 percent per year from 1999 through 2003.[25] All five of the insular areas typically exhaust the Medicaid cap prior to the end of the fiscal year, and once the cap is exhausted, the

[24]Alaska and the District of Columbia have matching percentages that are higher than what would be calculated under the FMAP formula. Alaska's higher matching rate, which is about 58 percent, was authorized by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Pub. L. No. 106-554, App. F, § 706, 114 Stat. 2763, 2763A-577. The District of Columbia's higher matching rate, which is currently 70 percent, was authorized by the Balanced Budget Act of 1997. Pub. L. No. 105-33, § 4725 and tit. XI, 111 Stat. 251, 518 and 712.

[25]42 U.S.C. § 1308(a), (f) (2000). As a result, payments in insular areas increased about 21 percent during fiscal years 1999 through 2003, while the increase in the states, bound only by state contributions to the Medicaid program, was about 49 percent.

insular areas assume the full costs of Medicaid.[26] Due to insufficient local funds, once the Medicaid cap is met, some insular areas may suspend services or cease payments to providers until the next fiscal year.[27]

Federal statute and the Medicaid cap also affect the ability of insular areas to access certain sources of Medicaid funding. For example, insular areas are not included in the federal legislation that established the Medicaid disproportionate share hospital (DSH) program, which provides supplementary payments to hospitals that serve a large number of Medicaid and low-income uninsured patients.[28] DSH is a key source of Medicaid funding for "safety net" hospitals in the states and totaled about 5 percent of all federal Medicaid funding to the states in fiscal year 2003. In addition, although states and the insular areas are eligible for other sources of Medicaid federal matching funds, CMS officials said the federal cap prevents the insular areas from accessing these funds. For example, none of the insular areas accessed available funding for the development of immunization registries or for the update of data systems to comply with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because funds spent on these programs would count against the cap and thereby divert funds from the direct provision of care. For this same reason, none of the insular areas participates in the optional Breast and Cervical Cancer Prevention and Treatment program, which allows for expanded eligibility and an enhanced Medicaid match rate for treatment provided to women diagnosed with these cancers. All 50 states and the District of Columbia have opted to cover women under this program.

Whereas fundamental differences exist between insular areas and the states in terms of the allocation of federal Medicaid funds, the differences

[26]For example, a CNMI official told us that a single patient requiring expensive off-island care, such as a baby with congenital heart disease or a child with leukemia, can consume a large portion of the available federal Medicaid contribution.

[27]For example, CMS officials told us that each year, the Virgin Islands Medicaid program becomes further in arrears with providers and must use current cap allotments to cover past due payments to providers.

[28]See 42 U. S. C. § 1396r-4 (2000). Similarly, the Social Security Act provides for a shorter extension of transitional medical assistance eligibility for Medicaid beneficiaries who lose eligibility due to increased resources or hours of work in the insular areas, as opposed to the states. In these circumstances, beneficiaries in the insular areas are provided up to a 4 month extension of eligibility (42 U.S.C. § 1396a(e)(1)(A)) while beneficiaries in the states are provided up to a 12 month extension of eligibility (42 U.S.C. § 1396r-6(a), (b)).

that exist in the funding of their SCHIP programs are less pronounced. For example, unlike Medicaid, where federal funding to the states is open-ended, annual SCHIP allotments to both the states and the insular areas are set in statute and function like a cap. The statute specified a total annual allotment for the states and insular areas for fiscal years 1998 through 2007, with the insular areas receiving 0.25 percent of the annual nationwide SCHIP allotment, which is divided among them based on statutorily set proportions.[29] The remainder of the allotment is allocated to states based on the population of low-income uninsured children. The Congress awarded additional funds to insular areas for fiscal years 1999 through 2007 which, when combined with the original allotment, increased their portion of total SCHIP funding.[30]

Although SCHIP funding is limited for both states and insular areas, the FMAP for SCHIP, similar to Medicaid, does not consider the capacity of insular areas to pay for services. The statute provides for an "enhanced" FMAP, which is equal to each state and insular area's Medicaid matching rate plus 30 percent of the difference between the Medicaid match and 100 percent, not to exceed a federal share of 85 percent. Thus, like states that receive the minimum 50 percent Medicaid match, the insular areas receive the minimum 65 percent match available under SCHIP.

Certain HHS Grants Are Allocated Differently

Each HHS grant has a distinct funding allocation method, and although certain grants use identical allocation methods for the states and the insular areas, others treat some or all of the insular areas differently. For example, the method used to calculate HRSA's Consolidated Health Center grants, which are competitive awards made to individual qualifying health centers based upon proposed budgets and their capacity to compete for funds, is the same in the states as in the insular areas. In

[29]The disbursement proportions for the SCHIP allotment for insular areas are as follows: Puerto Rico-91.6 percent; Guam-3.5 percent; the Virgin Islands-2.6 percent; American Samoa-1.2 percent; and CNMI-1.1 percent.

[30]As a result, the insular areas received about 1 percent of the total SCHIP allotment. The Congress did not provide similar, supplemental SCHIP funds to states. In addition, for fiscal years 1998 through 2002, all the insular areas also received redistribution funds, which are available SCHIP funds not expended by states within the prior 3-year period. Insular areas are eligible for 1.05 percent of the total redistribution funds, which are allocated among them according to the percentages of the initial allotment. The amount of SCHIP funds available for redistribution has declined over time. For example, while these funds increased the insular areas' share of the total SCHIP allotment by 0.7 percent in 1999, they added only about 0.2 percent of the total SCHIP allotment in 2002.

contrast, different allocation rates are used to determine funding levels for some insular areas under HRSA's Ryan White Title II HIV Care Formula grants to States and CDC's Public Health Preparedness and Response for Bioterrorism grant. The allocation formulas for these grants have two components—a base component, which is a set dollar amount, and a variable component, which is based on population or other factors. For example, funding levels for the Ryan White Title II grant are based largely on the prevalence of AIDS in individual states as well as in Puerto Rico and the Virgin Islands. In contrast, funding of this grant for the Pacific insular areas does not consider the prevalence of AIDS; instead, these insular areas receive a lower, standard base rate.[31] Similarly, when compared to the states, the base and variable components for the CDC's Public Health Preparedness and Response to Bioterrorism grant is smaller for each of the insular areas except Puerto Rico. (See table 2.)

Table 2: Formula Components for CDC's Public Health Preparedness and Response for Bioterrorism Grant

Grant program and recipients	Base component	Variable component (dollars per person)
Public Health Preparedness and Response for Bioterrorism		
All states and Puerto Rico	$3.915 million	$2.03
Washington, D.C.	10 million	2.03
Chicago, Los Angeles County, and New York City	5 million	2.03
American Samoa, CNMI, Guam, the Virgin Islands, and the freely associated states	391,500	0.79

Source: CDC.

CDC's Immunization and Vaccines for Children grant provides another example of where the method used to allocate funds differs in the insular areas compared to the states. In this case, grant amounts to the states are based on certain rules that consider characteristics of the population as well as funding history. In contrast, these rules are not used to determine

[31]The Pacific Insular areas receive a base amount of $50,000 while Puerto Rico and the Virgin Islands are treated like states in the determination of grant funding. States with more than 90 living AIDS cases receive a base amount of $500,000; those with 90 or fewer AIDS cases receive a base rate of $200,000.

the grant amounts for insular areas. Instead, the award amounts to insular areas are determined at the discretion of the agency's project officer.[32]

Multiple Factors Explain Differences in Individual Spending Levels in Insular Areas Compared to the States

Although most of the key sources of health care funding available in the insular areas are also available in the states, individual spending levels are often lower in the insular areas. For example, Medicare spending per beneficiary is significantly lower in the insular areas, due in part to differences in methods used to pay for certain services and in beneficiaries' utilization of services. In addition, statutory limits on Medicaid funding in the insular areas contribute to lower per capita spending. In light of these statutory limits, CMS does not hold insular areas accountable for providing all the mandatory Medicaid services, including nursing home care, which makes up nearly a third of Medicaid expenditures in the states. In contrast, HHS grant funding per capita is higher in the insular areas than in the states, due, in part, to allocation formulas that result in higher payments to them as well as to states with smaller populations.

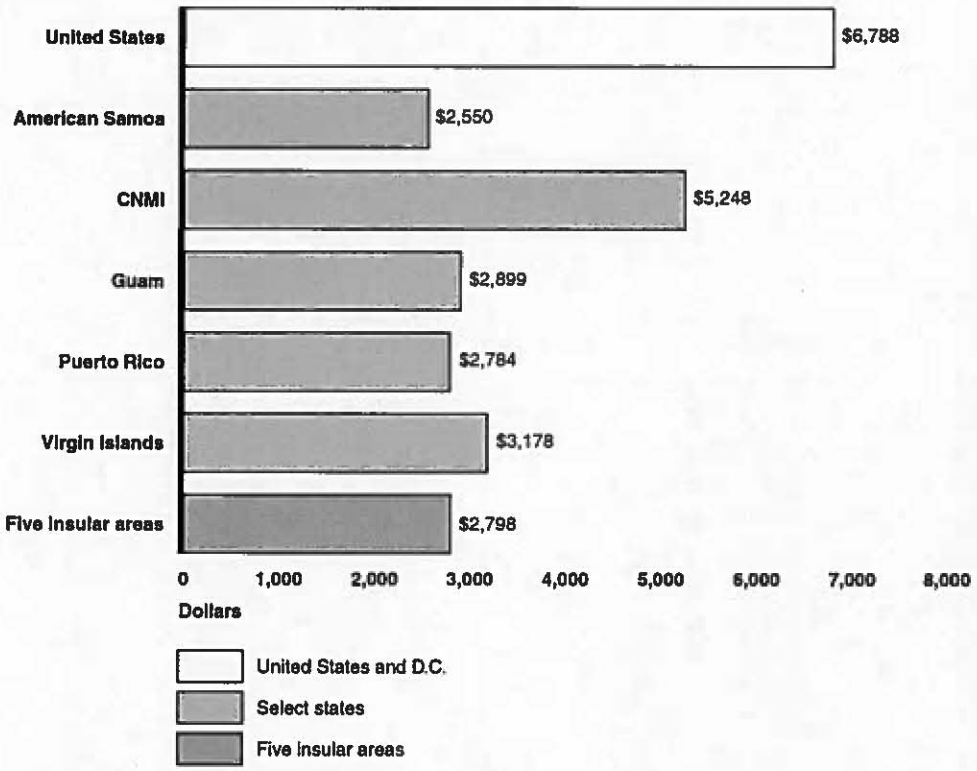
Lower Medicare Spending Per Beneficiary Explained by Payment Policy Differences and Lower Utilization

As in the insular areas, Medicare comprised the majority—over 60 percent—of federal health care funding in the states in fiscal year 2003 and, with limited exceptions, the program operates largely the same in the insular areas as in the states. However, Medicare spending per beneficiary in the insular areas in fiscal year 2003 was less than half of Medicare spending in the states—about $2,800 on average in the insular areas compared to $6,800 in the states.[33] (See fig. 4.)

[32]HHS officials stated that the Vaccines for Children grant is allocated differently to the insular areas because their public health infrastructures are so much different than the states. Therefore, the agency tailors funding to these areas to ensure that the program fulfills its statutory requirement of providing vaccines to eligible children.

[33]A small portion of the gap is attributable to cost of living differences in the insular areas compared to the states. However, even when adjusting Medicare payment rates to account for differences in the cost of providing health care in different locations, the gap in per beneficiary spending in the states versus the insular areas remained significant.

Figure 4: Medicare Spending Per Beneficiary in Five Insular Areas Compared to the States, Fiscal Year 2003



Source: GAO analysis of Medicare expenditure and enrollment data.

Differences in payment policy help explain some of the disparity in Medicare per beneficiary spending in the insular areas compared to the states. For example, the PPS methodology used to determine payments to hospitals in Puerto Rico, which includes a lower local component, contributes to lower payments. Similarly, the method used to determine supplemental PPS payments for Medicare's DSH program results in lower payments to hospitals in Puerto Rico compared to the states.[34] To qualify for Medicare DSH payments, at least 15 percent of a hospital's patient days must be attributable to certain patients receiving either Supplemental Security Income (SSI) or Medicaid benefits (which combined serve as a

[34]The Medicare DSH program provides supplementary payments to hospitals that serve a large number of low-income and uninsured patients. DSH payments are only available to hospitals that are paid based on the PPS; therefore, hospitals in the other insular areas are not eligible for these payments.

measure of the number of low-income patients treated by any single hospital). Further, the actual DSH payment is based on the number of patient days attributable to these low-income patients. Because residents of Puerto Rico are statutorily ineligible for SSI payments regardless of whether or not they meet the income thresholds required for SSI eligibility, only SSI patients visiting from the states are included in the counts for DSH. We were informed that, as a result, it is more difficult for hospitals in Puerto Rico to meet the 15 percent threshold, and those hospitals meeting the threshold receive limited DSH payments because the low-income counts do not include some poor patients.

Whether cost-based methods used to pay hospitals in the other insular areas similarly contribute to lower per beneficiary payments relative to the states is less clear. However, some of the variation in spending per beneficiary among the insular areas is likely due to the fact that statutory limits on Medicare payments apply to hospitals in some, but not all, insular areas. For example, hospital payments in CNMI are based on what the hospital claims as its actual costs. These costs are not limited, are not audited, and have increased dramatically in recent years. In contrast, under TEFRA, payments to hospitals in the Virgin Islands are limited, and according to officials with the Medicare fiscal intermediary serving the Virgin Islands, these payments may not be covering costs.[35] The different methods used to pay these hospitals likely explain, in part, why Medicare payments per beneficiary in CNMI are significantly higher than in the Virgin Islands.

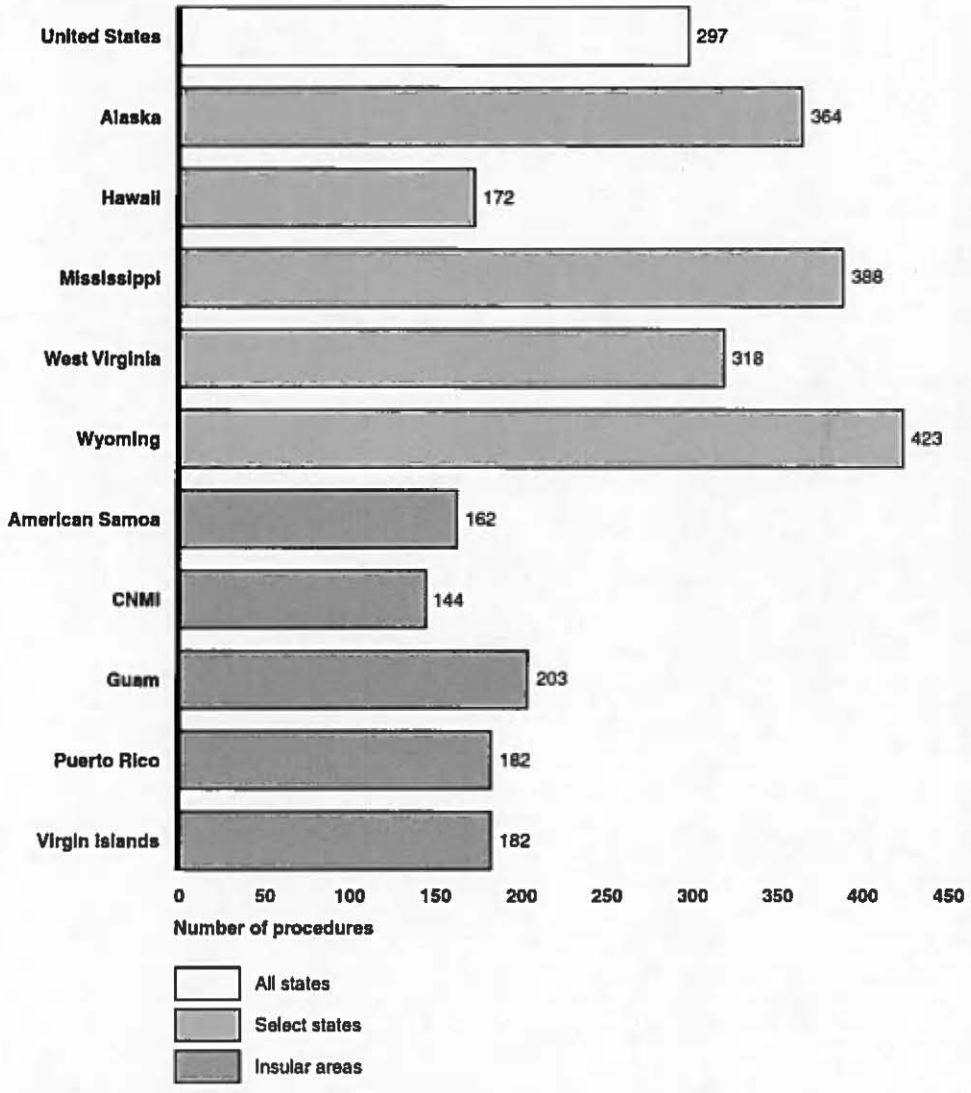
Another factor that helps explain lower Medicare per beneficiary spending in the insular areas is the extent to which Medicare beneficiaries in the insular areas use certain covered services. For example, an analysis of Medicare utilization rates for major medical procedures[36] shows that, on average, beneficiaries in the insular areas received far fewer of these

[35]Under TEFRA, the payments to hospitals in the Virgin Islands are the Medicare-allowable costs per patient stay in a designated base year, inflated to the current year by an annual update factor. A fiscal intermediary is a private company that has a contract with the Medicare program to pay Part A and some Part B bills. Cooperativa de Seguros de Vida de Puerto Rico, the fiscal intermediary serving the Virgin Islands, believes that the base-year cost estimates for facilities in the Virgin Islands may be understated, leading to costs that exceed Medicare payments.

[36]For this analysis, major medical procedures are services classified as such by the Berenson-Eggers Type of Service codes, which were developed by CMS primarily for analyzing growth in Medicare expenditures for services, including major cardiovascular procedures such as angioplasty, pacemaker insertion, and bypass surgery.

services than beneficiaries in the states—rates in the insular areas ranged from 144 to 203 per thousand beneficiaries compared to 297 per thousand in the states. Rates were similarly low in Hawaii (172 per thousand), but not in other remote or poor states studied. (See fig. 5).

Figure 5: Number of Medicare Part B Major Medical Procedures Per 1,000 Beneficiaries in Selected States and Insular Areas, Calendar Year 2003



Source: GAO analysis of allowed services in Medicare physician claims.

Notes: Utilization rates in CNMI may be understated due to hospital billing practices. According to CNMI officials, physicians in CNMI do not separately bill Medicare for services they provide in the hospital. Instead, the hospital captures these costs in its hospital cost report.

States included in the analysis were selected based on their geographic remoteness or their lower income levels relative to the U.S. average.

Several factors likely contribute to lower Medicare utilization, and therefore per beneficiary spending, in the insular areas. For example, limited access to certain specialty services, a lack of Medicare-certified physicians, and local cultural differences may contribute to lower Medicare utilization rates. A CMS official serving the Pacific insular areas reported that certain specialty services, such as chemotherapy, are not available in these areas, and it is often too expensive for beneficiaries to travel to receive such services off island. Lower utilization rates of physician services in American Samoa could also be attributable, in part, to a lack of Medicare-certified providers. According to a CMS official, many medical professionals in American Samoa who provide services to residents are not certified to receive payments under Medicare.[37] Cultural differences may also contribute to lower utilization of Medicare services in the insular areas. For example, a CMS official said that some American Samoans are less likely to seek care in Medicare-certified facilities. Similarly, reliance on nursing facilities may be less prevalent in certain insular areas, as families assume primary care responsibility for individuals who might commonly receive care in these facilities in the states.

Another factor contributing to lower per beneficiary spending is that the percentage of Medicare beneficiaries enrolled in Part B is significantly lower in most of the insular areas than in the states. On average, in 2003 about 77 percent of Medicare beneficiaries in the insular areas opted for Part B, compared to 95 percent in the states.[38] Insular area officials provided a number of reasons to explain the enrollment differences. For example, Medicare beneficiaries in the states and all insular areas but Puerto Rico are automatically enrolled in Part B, typically around their 65th birthday.[39] However, some insular area officials told us that their residents opt out of Part B coverage because they cannot afford its

[37]Medicare does not pay for services provided by noncertified providers and such services would not be captured in the Medicare data we analyzed.

[38]The percentage of Medicare beneficiaries enrolled in Part B in July 2003 ranged from 68 to 79 percent in all insular areas but the Virgin Islands, where enrollment was 91 percent.

[39]Approximately 3 months prior to their 65th birthdays, eligible individuals receive Part A enrollment information and an enrollment card for Part B. To opt out of Part B coverage, individuals must return the Part B card to the CMS contractor handling claims for services in their area.

monthly premium, which was about $78 in 2005.[40,41] Also, beneficiaries in Puerto Rico must go to a local Social Security office to enroll in Part B,[42] and according to CMS officials, this policy leads to lower enrollment. Similarly, American Samoa officials said that some of their Medicare beneficiaries may lack the incentive to purchase Part B coverage as they have access to free health coverage through the local hospital.[43]

Medicaid and SCHIP Individual Spending Levels in Insular Areas are Lower; Minimum Program Requirements Are Not Strictly Enforced

Federal Medicaid spending per capita was also lower in the insular areas compared to the states. In fiscal year 2003, federal Medicaid per capita spending in the states averaged $565 compared to between $33 and $65 for the insular areas. Poorer states with higher federal matching rates received as much as $813 in federal Medicaid per capita spending—more than 12 times the amount received by any insular area.[44] (See fig. 6.)

[40]Individuals who do not enroll in Part B when they are first eligible may sign up for coverage during specified open enrollment periods. However, in most cases, the Part B premium increases 10 percent for each 12-month period that an individual could have had Part B but did not select it.

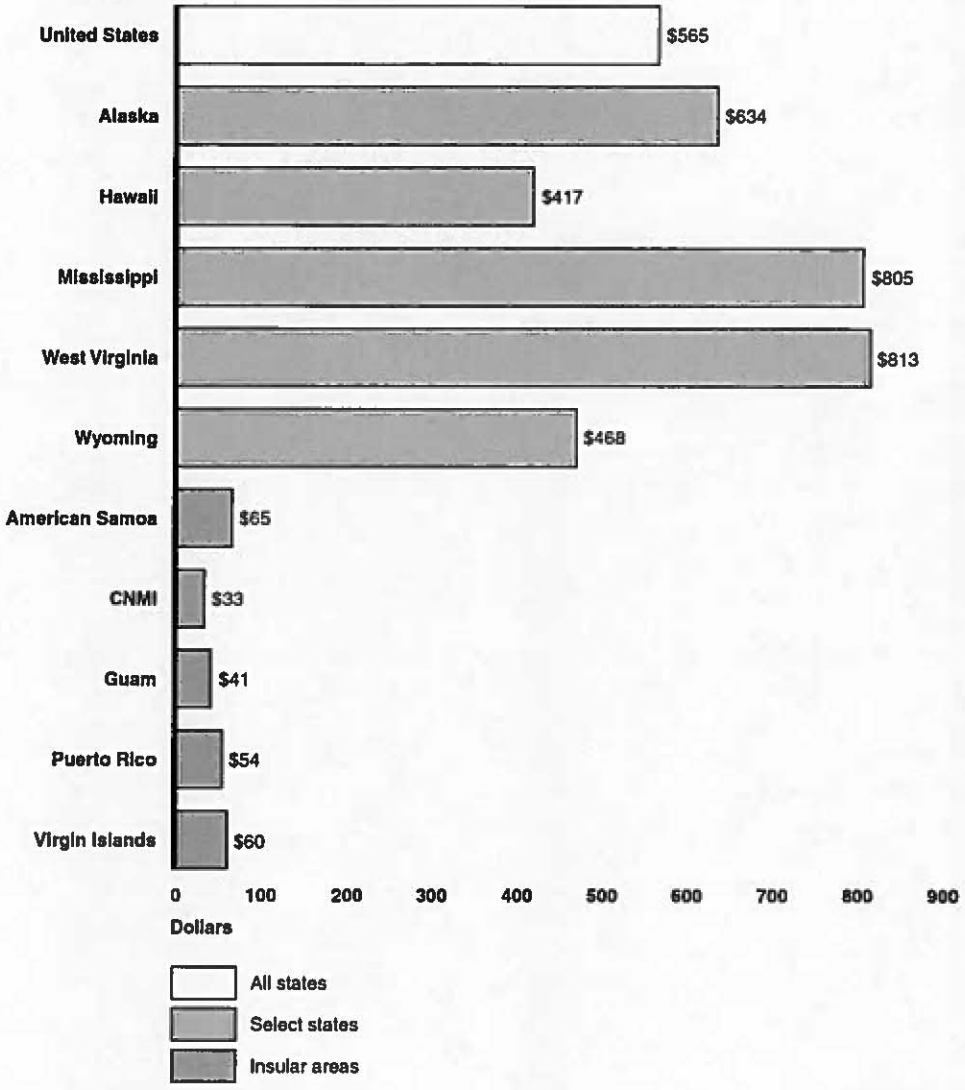
[41]State Medicaid agencies provide cost-sharing assistance to certain low-income Medicare beneficiaries. However, because of the statutory cap on federal Medicaid funding, most of the insular areas do not participate in these assistance programs, although some insular areas pay for the Part B premiums for select Medicare beneficiaries.

[42]The 1972 amendments to the Social Security Act, which created automatic enrollment procedures for Part B, specifically exempted residents of Puerto Rico. 42 U.S.C. § 1395p(f),(g).

[43]Local law requires American Samoa to provide health care free of cost to all residents, which is funded by both federal and local sources. According to an American Samoa official, this law precludes the government owned and operated hospital from charging patients adequate physician fees and also deters the development of private health care services as private facilities can not compete with the subsidized care provided by the government.

[44]Even when adjusting for differences in costs of living, the gap in per capita spending remains. Using Medicare geographic indices to account for differences in the cost of providing health care in different locations, per capita spending in the states was eight times that in the insular areas.

Figure 6: Federal Medicaid Per Capita Funding in Selected States and Insular Areas, Fiscal Year 2003



Source: GAO analysis of Medicaid expenditure data.

Note: States included in the analysis were selected based on their geographic remoteness or their lower income levels relative to the U.S. average.

The statutory limits on federal Medicaid funding in the insular areas—particularly the minimum federal matching contribution and payment cap—clearly contribute to lower federal per capita spending. However, insular areas are not required to meet all Medicaid eligibility requirements, and in light of the statutory limits on federal funding, CMS does not hold these areas accountable for covering all Medicaid benefit requirements.[45] For example, Puerto Rico and the Virgin Islands have implemented eligibility criteria that are more restrictive than the federal standards, which have resulted in lower Medicaid enrollment than would otherwise be the case.[46] In contrast, American Samoa, whose median household income is less than half that of the United States, neither uses specific categories to determine eligibility nor links eligibility to income levels that reflect local conditions. Instead, it considers every resident with an income at or below the federal poverty level—the majority of the population—as eligible for Medicaid. The different eligibility determination methods affect Medicaid enrollment in each insular area. While nationwide about 14 percent of the population is enrolled in Medicaid, Medicaid enrollment in the insular areas ranges from 12 percent in CNMI to 65 percent in American Samoa. (See app. III for a summary of the characteristics of insular areas' Medicaid programs.)

Another notable difference between states and the insular areas is the range of services covered by their respective Medicaid programs, and disparities in federal per capita spending should be considered in the context of these differences. For example, once states choose to participate in Medicaid, they are required to cover certain mandatory services, such as inpatient and outpatient hospital care; physician services; nursing facility care; and early and periodic screening, diagnostic, and treatment (EPSDT) services for children. With limited exceptions, all of

[45]Section 1902(j) of the Social Security Act allows the Secretary of HHS to waive or modify Medicaid requirements with respect to American Samoa and CNMI, except for the Medicaid cap, the statutorily set FMAP, and payment for Medicaid services described in section 1905(a), which includes all of Medicaid's mandatory services.

[46]Puerto Rico and the Virgin Islands determine Medicaid eligibility based on locally established poverty levels, which, at less than the federal poverty level, are more restrictive in terms of enrollment. According to officials in these areas, restricting eligibility allows them to target Medicaid services to fewer, albeit needier, individuals.

the states cover each of the mandatory services.[47] In contrast, none of the insular areas cover all mandatory services. For example, none of the insular areas provides full coverage for nursing facility services, which represented 32 percent of Medicaid expenditures in the states in fiscal year 2003.[48] CMS is aware that the insular areas do not provide all mandatory Medicaid services. However, according to a CMS official, the agency does not have any guidance as to how it should ensure compliance with the federal Medicaid standards regarding mandatory services, especially in light of limits on federal funding in the insular areas. Over time, CMS has allowed the insular areas to determine which Medicaid services they provide to maximize their use of federal health care funds.[49] (See table 3.)

[47]Rural health clinics (RHC) are clinics located in areas designated by the Bureau of Census as rural and by the Secretary of HHS as medically underserved or having an insufficient number of physicians. In order to be certified as a RHC, requirements under 42 C.F.R. § *491et seq.* must be met. As of June 2004, Connecticut, Delaware, D.C., Maryland, Massachusetts, New Jersey, and Rhode Island did not have RHCs that met these criteria. See GAO, *Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System*, GAO-05-452 (Washington, D.C.: June 17, 2005).

[48]According to an American Samoa official, no free-standing nursing facilities exist in American Samoa because its only major hospital, which is government owned and operated, provides long-term care as part of its inpatient services. The availability of these services within the hospital has deterred private interests from developing nursing facilities because they can not compete with government-provided care.

[49]Officials from Puerto Rico pointed out that although CMS has not enforced the provision of mandatory Medicaid services, other federal entities, including the U.S. Department of Justice and HRSA, have successfully taken or encouraged enforcement actions against Puerto Rico regarding certain Medicaid-eligible expenses.

Table 3: Mandatory Medicaid Services Covered by Insular Areas and States, Fiscal Year 2005

Service	AS	CNMI	GU	PR	VI[a]	Number of states
Inpatient hospital services	●	●	●	●	●	51
Outpatient hospital services	●	●	●	●	●	51
Physician's services	●	●	●	●	●	51
Laboratory and x-ray services	●	●	●	●	●[b]	51
Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	●	●	●	●	●	51
Family planning services and supplies	●	●	●	●	●	51
Transportation services	●	●	○	◐[c]	◐[d]	51
Certified nurse practitioner services	●	○[e]	●	○	◐[f]	50[g]
Home health services	◐[h]	●	○	○	●	51
Federally-qualified health center (FQHC) services	○	○	○	●	●	51
Nursing facility (NF) services for individuals 21 or over	○	○[e]	◐[i]	○	◐[j]	51
Nurse midwife services	●	○[e]	○	○	○	50[k]
Rural health clinic (RHC) services	○	○	○	○	○	48[l]

Sources: Insular area officials and The Kaiser Commission.

Key: ● = service covered; ◐ = service covered with limitations; ○ = service not covered

Notes: Number of states includes Washington, D.C.

The Kaiser Commission on Medicaid and the Uninsured. Medicaid Benefits: Online Database (The Henry J. Kaiser Family Foundation). http://www.kff.org/medicaid/benefits/index.jsp (downloaded Aug. 22, 2005).

[a]All services in the Virgin Islands must be provided in health department facilities (including FQHCs and referral facilities located off-island) that are pre-approved by the Medicaid program.

[b]Laboratory and x-ray services require prior approval.

[c]Ambulance services are covered when appropriate. Off-island transportation is not covered.

[d]No transportation services are covered on-island; transportation off-island must be pre-approved.

[e]Service not provided because of a lack of qualified local providers. However, these services are covered off-island when the patient is referred off-island to receive them.

[f]Certified nurse practitioner services are not covered as a separate entity, but are covered if they are provided in a Medicaid-certified facility or program.

[g]California does not cover nurse practitioner services.

[h]Long-term or transitional care provided on a case-by-case basis in hospital wards.

[i]Nursing facility care is available to Medicaid enrollees in a non-Medicaid certified facility. This coverage is a supplement to the Medicaid program and is paid for by Guam's Medically Indigent Program.

[j]The Virgin Islands has one nursing facility with 80 beds, 20 of which are Medicaid certified. No other nursing facility services are available.

[k]Illinois does not cover nurse midwife services.

'Connecticut, D.C., and New Jersey do not cover rural health clinic services.

Mandatory services may not be provided in an insular area because qualified providers or facilities do not exist.[50] For example, none of the Pacific insular areas have a Medicaid-certified, free-standing skilled nursing facility. In other cases, insular areas may not cover certain services although qualified providers are available. For example, Medicaid-qualified providers are available in Puerto Rico for nursing facility, home health, nurse midwife, and certified nurse practitioner services; however, because of the limitations of the Medicaid cap, the Medicaid program does not include them in its benefit package, according to a Puerto Rico Medicaid official. Similarly, an official associated with the Virgin Islands' Medicaid program said that although qualified providers are available, nurse midwife and nurse practitioner services are not covered due to their costs. However, the Medicaid programs of some insular areas incur additional costs that states may not. For example, several insular areas pay the costs associated with transporting enrollees off-island to receive services not available locally. The costs associated with transportation are typically high, particularly for the Pacific insular areas, and count against the Medicaid cap.[51] In addition, each insular area has chosen to add benefits, such as coverage for outpatient prescription drugs, which are optional under the statute. (See app. III for a summary of these optional benefits.)[52]

Federal SCHIP individual spending levels were also lower in the insular areas compared to the states. In fiscal year 2003, federal SCHIP spending per child under age 19 averaged $24 in the insular areas (ranging from $14 in American Samoa to about $25 in Puerto Rico) compared to an average

[50]According to a CNMI official, the federal cap on Medicaid funding has contributed to its difficulties in recruiting and retaining qualified physicians and other health care providers.

[51]For purposes of this report, we consider transportation to be a mandatory Medicaid service. Although coverage for transportation is not explicitly required under the federal Medicaid statute, several regulations indicate that states must provide transportation services as part of their Medicaid programs. 42 C.F.R. § 431.53 requires state Medicaid programs to ensure necessary transportation for beneficiaries to and from providers. 42 C.F.R. § 440.170 (a) defines transportation to include expenses for transportation and other related travel expenses determined to be necessary by the agency to secure treatment for a beneficiary. 42 C.F.R. § 441.62 requires the EPSDT program to offer assistance with transportation to program beneficiaries.

[52]Although state Medicaid programs must generally allow recipients freedom of choice among health care providers participating in Medicaid, the insular areas are exempt from this requirement.

of $41 in the states. When compared to the states, the insular areas are poorer and have a higher proportion of children under 19 years of age. Therefore, the statutory SCHIP allotment, which distributes funds to the insular areas based on their proportion of total insular population versus number of uninsured children, contributes to this disparity. However, as is the case with the Medicaid program, the operation of the SCHIP program in most of the insular areas is fundamentally different than the states. For example, while nearly 6 million children were served through SCHIP state programs in fiscal year 2003,[53] most of the insular areas do not have a unique SCHIP program that extends health insurance coverage to additional children. Instead, the insular areas primarily use SCHIP funds to continue to pay for services provided to children enrolled in the Medicaid program once the Medicaid cap is met. One exception is Puerto Rico, which uses SCHIP funding to extend Medicaid coverage to children with family incomes between 100 and 200 percent of its local poverty level.[54]

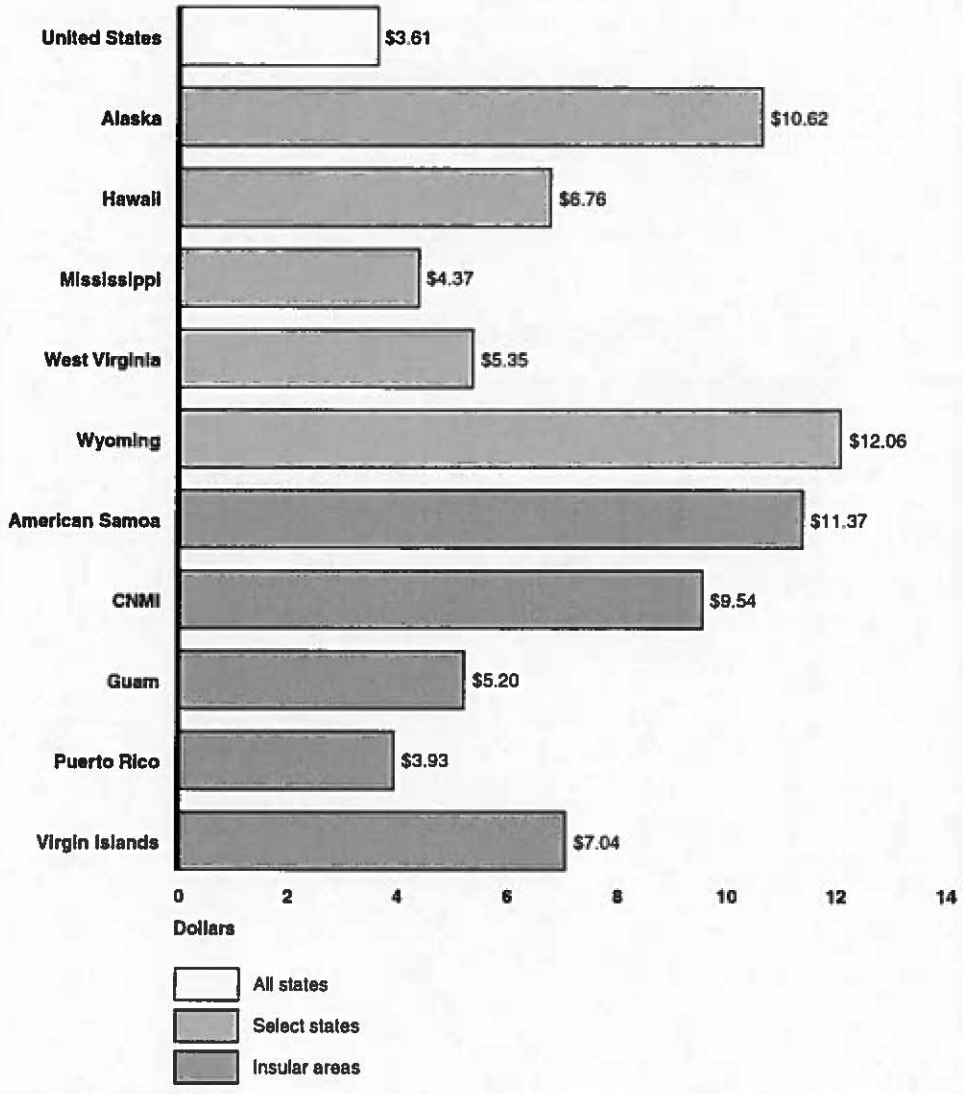
HHS Per Capita Grant Spending Is Higher in Insular Areas

In fiscal year 2003, total HHS per capita spending on health-related grants from three agencies—CDC, HRSA, and SAMHSA—was higher in the insular areas compared to the states. On average, these three agencies awarded about $60 per capita in the insular areas compared to about $48 per capita in the states. Differences in per capita spending are due in part to the methods used to allocate grant funds. For example, the base rate formula used to calculate the CDC bioterrorism grant results in higher payments to all insular areas except Puerto Rico and to states with smaller populations. In the four smaller insular areas, awards per capita for this grant range from $5.20 in Guam to $11.37 in American Samoa, and in states with small populations, such as Alaska and Wyoming, awards were $10.62 and $12.06 respectively compared to $3.61 in the states on average. (See fig 7.)

[53]An SCHIP Medicaid expansion must use Medicaid's enrollment structures, benefit packages, and provider networks, whereas SCHIP programs separate from Medicaid have greater flexibility in design and may introduce limited cost sharing or offer different benefit packages.

[54]When SCHIP funding first became available, Guam used some of these funds to pay for services provided to a group of children who previously received services through Guam's Medically Indigent Program. Remaining SCHIP funds are used to pay for services provided to children enrolled in Medicaid once the cap has been met.

Figure 7: Per Capita Funding to Insular Areas and Selected States for CDC's Bioterrorism Grant, Fiscal Year 2003



Source: Data from CDC.

Agency Comments and Our Evaluation

We provided a draft of this report for comment to HHS, DOI, and key health officials in each of the five insular areas. We received written comments from DOI, American Samoa, CNMI, and Puerto Rico, which are included in appendixes IV, V, VI and VII, respectively. Although HHS provided no general comments, it did provide technical comments, as did Puerto Rico, which we incorporated as appropriate.

DOI noted that improving health care in the insular areas is a priority for both the agency and the insular areas and commented that the report will help identify areas of disparity which may be reviewed for improvement. The insular areas expressed concern that the report did not sufficiently address certain issues, such as implications of statutory limits on federal Medicaid spending and a more comprehensive analysis of local circumstances that affect the availability and costs of health care services. The insular areas also provided a number of specific comments and suggestions.

Specifically, CNMI and Puerto Rico commented that the statutory limits on federal Medicaid spending—the Medicaid cap and minimum FMAP—result in insufficient federal Medicaid payments to the insular areas and explain the significant differences in federal Medicaid payments between them and the states. For example, CNMI noted that one patient with an expensive medical condition, such as a baby with congenital heart disease or a child with leukemia, can consume a large portion of the available federal Medicaid contribution in a given year. CNMI also commented that the federal funding limits prevent its Medicaid program from providing all Medicaid mandatory services and suggested that the report implied that this was a "satisfactory state of affairs" because the federal government does not penalize insular areas for not providing these services. We did not intend to imply that this is a satisfactory condition; rather, our purpose was to describe mandatory Medicaid services that are not provided by insular areas and to explain that, in light of the limits on federal funding, CMS does not hold these areas accountable for providing these services. We revised the report to clarify this point.

The three insular areas commented that the report did not adequately explore other implications of the statutory federal funding limits, including the impact on the local contribution to total health care costs and the local health care infrastructure. For example, Puerto Rico commented that as a result of the limits on federal Medicaid payments, it and other insular areas shoulder a larger share of financial responsibility for the Medicaid program than the states, and that the federal contribution to the program is far less than the minimum FMAP suggests. Similarly, CNMI commented

that the report failed to discuss the effect of limited federal funding on health outcomes, physician recruitment and retention, and other necessary government services. American Samoa commented that the report minimized or omitted local circumstances that affect the costs of health care services and are major factors in the analysis of federal funding. For example, a local statute requires the American Samoan government to provide medical services to qualified citizens at no cost, and its only hospital, which the government owns and operates, is the sole provider of primary, secondary, and tertiary care. In combination, these factors have deterred the development of privately-owned health care facilities and providers, which can not compete with government-level charges, and this has limited the availability of services. Where appropriate, we revised the report to include information about these local circumstances and their effect on American Samoa's ability to provide health care services. A more comprehensive analysis of insular areas' local contribution to total health care funding or their health care infrastructures, however, was beyond the scope of this report.

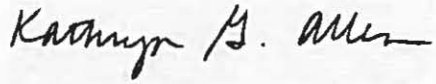
The insular areas also provided a number of specific comments or suggestions. For example, CNMI commented that the report implied that the availability of certain grant funds, including those provided to offset the cost of providing services to residents of the freely associated states, ameliorated the adverse effects of disparities in federal funding for the Medicare and Medicaid programs and added that grant funds are not enough to replace inadequate Medicaid funding. It was not our intent to imply that these grants are a substitute for other sources of federal health care funding. Rather, the report identifies major sources of federal health care funding in insular areas, of which grants are a significant portion. Puerto Rico also suggested that the report include a more thorough and substantive review of several issues it considers to be programmatic barriers to a balanced partnership between insular areas and the federal government, including the Medicaid cap, SCHIP allotment methods, and the level of the Medicare Part D low-income subsidy for insular areas. Such an analysis was beyond the scope of this report.

Finally, CNMI commented the report should include recommendations to address what it characterizes as "the outright discrimination in federal health care funding" for the insular areas and suggested that specific recommendations could include eliminating the Medicaid cap, calculating the FMAP based on actual poverty rates, and providing additional Medicare Part D pharmacy benefits. We acknowledge CNMI's views on the adequacy of current levels of federal health care funding. However, we did not include recommendations in this report because it is the Congress's

prerogative to set the overall design of the Medicaid program. Puerto Rico commented that this report describes many of the challenges and the imbalance affecting the federal and insular area health care partnership, such as the Medicaid cap, and provides the foundation for the Congress to address these issues.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Secretary of the Interior, and insular area governments. In addition, the report is available at no charge on GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7118 or allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VIII.



Kathryn G. Allen
Director, Health Care

List of Requesters

The Honorable Dan Burton
Chairman
Subcommittee on the Western Hemisphere
Committee on International Relations
House of Representatives

The Honorable Neil Abercrombie
The Honorable Madeleine Z. Bordallo
The Honorable Ed Case
The Honorable Donna Christensen
The Honorable Eni F.H. Faleomavaega
The Honorable Raúl Grijalva
The Honorable Michael M. Honda
The Honorable Robert Menendez
House of Representatives

Appendix I: Scope and Methodology

To compare characteristics of the five largest insular areas—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the Virgin Islands—we used demographic data from the Census Bureau and disease mortality data from the Centers for Disease Control and Prevention (CDC). Except for Puerto Rico, interim and supplemental censuses to the decennial census are not performed for the insular areas. Therefore, 2000 census data for all insular areas and states were used for consistency. Reliable data for the incidence of disease are not collected for all insular areas. CDC's 2002 natality and mortality report provided health indicator data except where the number of cases was too few to provide reliable estimates.

To identify key federal sources of health care funding to the insular areas we reviewed the Census Bureau's *Consolidated Federal Funds Report* and conducted interviews with representatives from insular areas, six agencies of the Department of Health and Human Services (HHS),[1] the Department of the Interior's Office of Insular Affairs (DOI-OIA), and the White House Office of Intergovernmental Affairs. We defined health care funding as federal funds provided to support directly delivered health care, health data collection, disease prevention, and other health-related activities. On the basis of the discussions, we focused our work on the following key sources of funding: Medicare, Medicaid, and SCHIP, in addition to grants from three HHS agencies—CDC, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA)—and DOI.[2]

We collected federal health expenditure data for the states and the insular areas. We selected five states for comparison to insular areas—Alaska, Hawaii, Mississippi, West Virginia, and Wyoming. States were selected on the basis of one or more criteria: geographic remoteness, low Medicare spending, and high federal Medicaid matching rate.

[1]These agencies were the Agency for Healthcare Research and Quality, CDC, the Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), National Institutes of Health, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

[2]Grants to the insular areas from other HHS agencies, such as the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH), were excluded from our analyses because they were targeted exclusively to research. Grants from CMS, apart from Medicaid and SCHIP funding, were also excluded as they represented less than 1 percent of HHS grant funding to the insular areas from fiscal years 1999 through 2003.

We analyzed data provided by each agency and by the insular areas to identify the composition of federal health care funding to insular areas and growth in the awards from fiscal year 1999 through 2003. We compared insular area data with funding to the states as a whole, and to select individual states. We also analyzed expenditures per capita or by beneficiaries of respective programs, where available and consistent.[3]

Medicare

To calculate Medicare expenditures for beneficiaries residing in the insular areas, we used Medicare's 1999-2003 claims data.[4] We supplemented the results with figures for inpatient and Part C expenditures calculated by the Centers for Medicare & Medicaid Services (CMS).[5] Expenditures for the U.S. for fiscal year 2003 were obtained from CMS.[6] Beneficiary figures for the insular areas and the U.S. were calculated using CMS's Denominator File, which contains enrollment data for Medicare beneficiaries.[7] We used the Denominator File and CMS's National Claims History File for Physician and Supplier Claims Data to calculate Medicare Part B utilization by beneficiaries in the insular areas and select states.[8]

Medicaid

We obtained insular area and state Medicaid expenditure data from CMS.[9] Medicaid enrollee figures were obtained directly from CMS and the insular areas, but were not consistently available from all insular areas in all years.

SCHIP

SCHIP funding, including the initial allotments, supplementary allocations, and redistribution funds for the insular areas and states for fiscal years

[3]Any per capita analysis is based on population from the 2000 Census.

[4]Expenditure data for the insular areas was computed using the Standard Analytic Files for institutional claims and the National Claims History File for Physician and Supplier Claims Data, extracted January 2005. Beneficiary computations used the CMS Denominator File, extracted May 2005.

[5]We received Part C expenditures for the insular areas from CMS for January 2005 and inpatient expenditures for the insular areas as of June 2005.

[6]National Health Expenditure data was calculated for the fiscal year and based on the 2005 Trustees' Report.

[7]Beneficiary computations used the CMS Denominator file, extracted May 2005.

[8]Extracted January 2005.

[9]State-reported Medicaid Form 64 data, available on the CMS Web site, were used for state expenditures.

1999 through 2003 were obtained from the *Federal Register*.[10] SCHIP enrollee figures were not consistently available for insular areas.

HHS grants

We obtained data from HHS's Tracking Accountability in Government Grants System for fiscal years 1999 through 2003.[11] For the grants provided by three HHS agencies, we evaluated the annual total and per capita award to each insular area, as well as nationally and for the selected states.

We totaled the award amounts for each grant in fiscal years 2002, 2003, and 2004 and identified eight individual grants whose 3-year aggregate comprised at least 5 percent of all HHS grant funding to any insular area and were awarded to at least three areas. We obtained the select grant award amounts from the agencies and computed the per capita award amounts for each of the insular areas, nationally, and for the selected states.[12]

For the select HHS grants, we obtained information about the application processes, allocation methods, and administrative requirements for insular areas and the states from the agencies. To identify differences in funding allocation methods, we reviewed relevant federal laws, regulations, and guidance. We augmented that work with interviews of officials at funding agencies to identify variations between programs for states and insular areas.

Department of the Interior Grants

DOI-OIA provided us with the funding totals for health-related grants provided to insular areas. Grants included funds earmarked for health care infrastructure, technical assistance, and to offset the cost of providing services to residents of the freely associated states.

Data Reliability

For the key sources identified, we obtained comprehensive health expenditure data for federal fiscal years 1999 through 2003 from the respective agencies. To assess the reliability of the program expenditure data, we reviewed relevant documentation, interviewed knowledgeable agency officials about the data, and conducted electronic data testing. To

[10]Insular area data came from *Federal Register* announcements of insular area SCHIP allocations and redistribution amounts.

[11]Data for the insular areas received December 2004, data for the states received January 2005.

[12]Any per capita analysis is based on population from the 2000 Census.

assess the reliability of HHS and DOI-OIA data, we talked with officials about data quality control procedures and reviewed relevant documentation. We determined the data were sufficiently reliable for the purposes of this report.

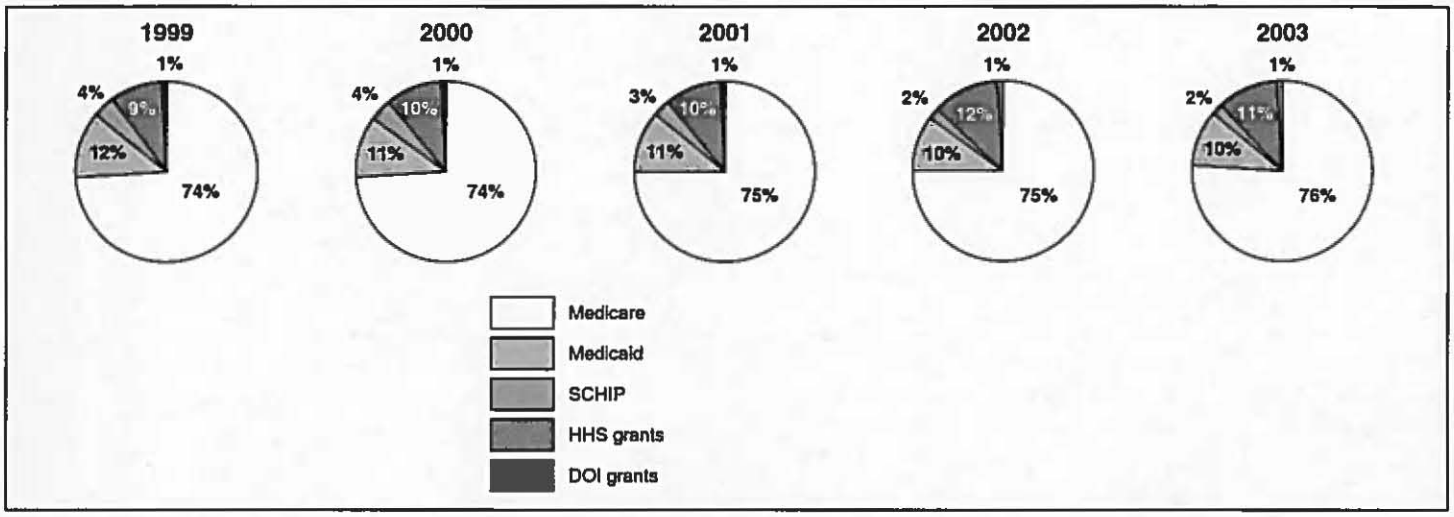
We conducted our work from October 2004 through September 2005 in accordance with generally accepted government auditing standards.

Appendix II: Changes in Insular Area Health Care Funding Proportions over Time

When considered in the aggregate, health care funding in the five largest insular areas varied little in terms of the proportion of funding attributable to various sources for fiscal years 1999 through 2003. For each of the years, Medicare represented about three-quarters of total funding, followed by Medicaid and HHS grants, which each represented about one-tenth of the total. Funding from SCHIP and DOI grants together represented 5 percent or less of total funding. However, Puerto Rico's comparatively large population masks much of the variation in funding sources that exists in the other insular areas. These areas, particularly those in the Pacific, are considerably more reliant upon grant funding, which can fluctuate from year to year. (See fig. 8 through 13 and tables 4 through 9.)[1]

[1]Fiscal year 2003 does not include SCHIP redistribution funds, which are available SCHIP funds not expended by states within the prior 3-year period.

Figure 8: Ratio of Federal Funding Sources for Five Insular Areas, Fiscal Years 1999 through 2003



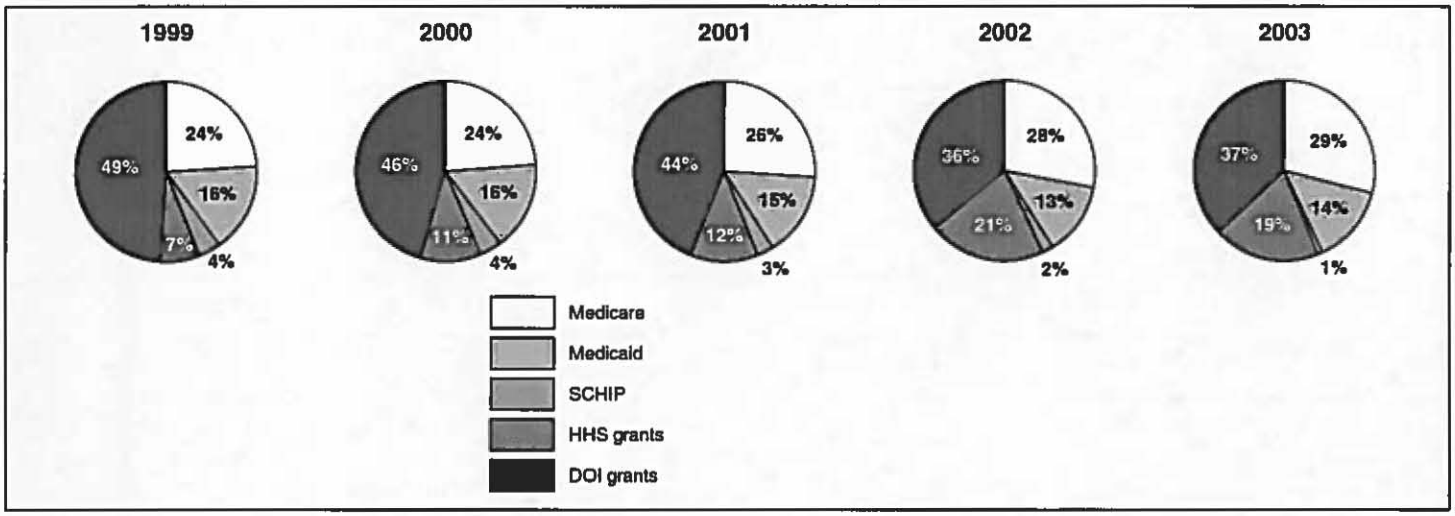
Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Table 4: Federal Health Care Spending for Five Insular Areas, Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
Medicare	$1,192,327,998	$1,266,268,455	$1,399,127,443	$1,548,352,782	$1,677,804,491
Medicaid	187,080,000	193,630,000	201,160,000	210,430,000	226,181,000
SCHIP	72,283,085	68,055,124	63,252,222	39,822,486	33,075,000
HHS grants	144,420,702	166,695,857	189,640,591	257,142,673	250,283,171
DOI grants	12,230,000	13,584,790	17,002,352	12,085,000	13,565,894
Total	**$1,608,341,785**	**$1,708,234,226**	**$1,870,182,608**	**$2,067,832,941**	**$2,200,909,556**

Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Figure 9: Ratio of Federal Health Care Funding Sources for American Samoa, Fiscal Years 1999 through 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

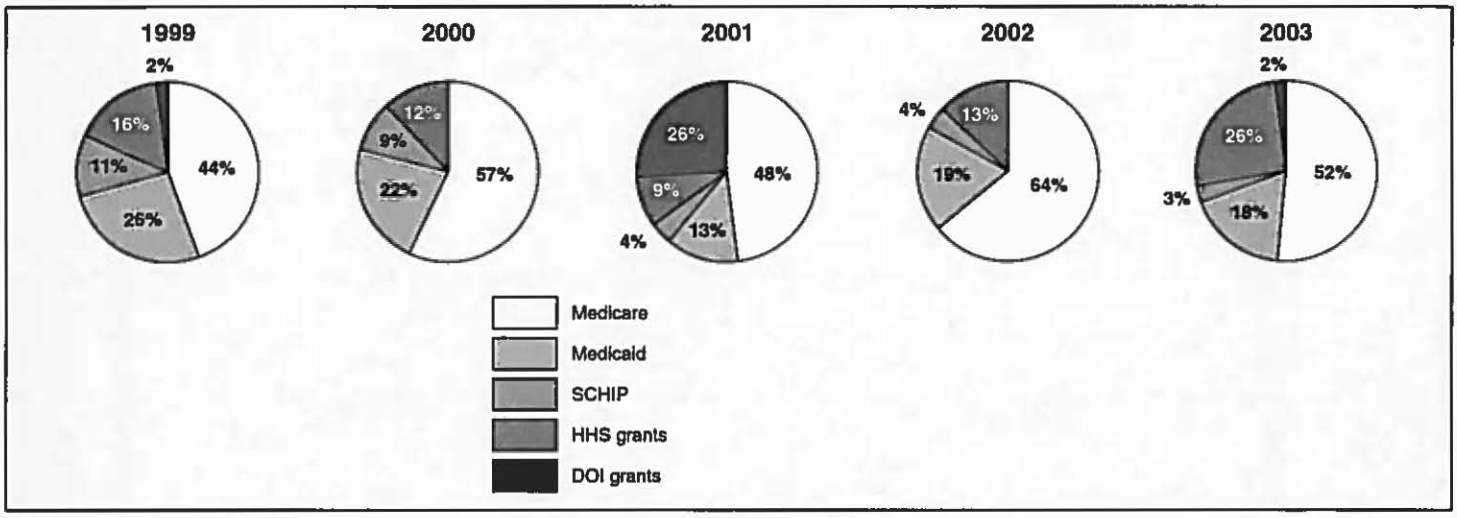
Note: Figures may not total to 100 percent due to rounding.

Table 5: Federal Health Care Spending for American Samoa, Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
Medicare	$4,629,925	$4,827,064	$5,602,888	$7,382,854	$7,666,176
Medicaid	3,090,000	3,200,000	3,320,000	3,470,000	3,727,000
SCHIP	867,397	816,661	759,027	477,870	396,900
HHS grants	1,299,877	2,178,295	2,677,466	5,554,821	5,123,934
DOI grants	9,657,000	9,389,790	9,565,502	9,392,000	9,891,947
Total	**$19,544,199**	**$20,411,810**	**$21,924,883**	**$26,277,545**	**$26,805,957**

Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Figure 10: Ratio of Federal Health Care Funding Sources for CNMI, Fiscal Years 1999 through 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

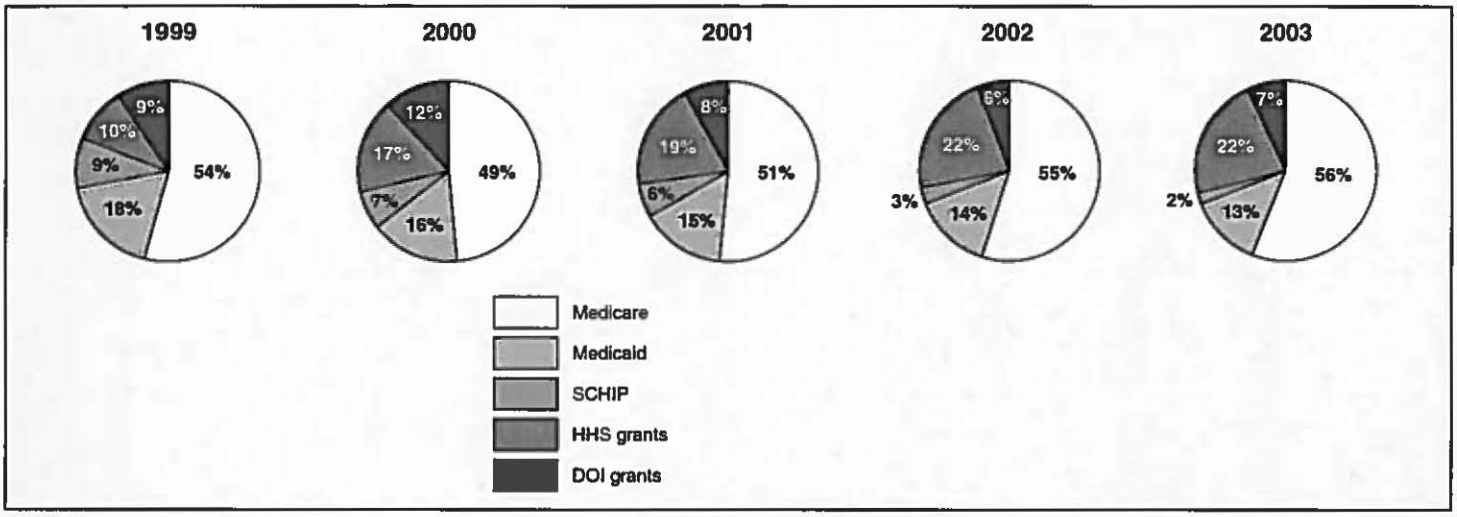
Note: Figures may not total to 100 percent due to rounding.

Table 6: Federal Health Care Spending for CNMI, Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
Medicare	$3,109,803	$4,947,156	$7,498,466	$7,050,130	$6,586,360
Medicaid	1,860,000	1,930,000	2,010,000	2,100,000	2,255,000
SCHIP	795,113	748,606	695,775	438,047	363,825
HHS grants	1,102,221	1,090,134	1,385,892	1,489,705	3,305,777
DOI grants	153,000	10,000	4,152,100	-	230,000
Total	**$7,020,137**	**$8,725,896**	**$15,742,233**	**$11,077,882**	**$12,740,962**

Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Figure 11: Ratio of Federal Health Care Funding Sources for Guam, Fiscal Years 1999 through 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

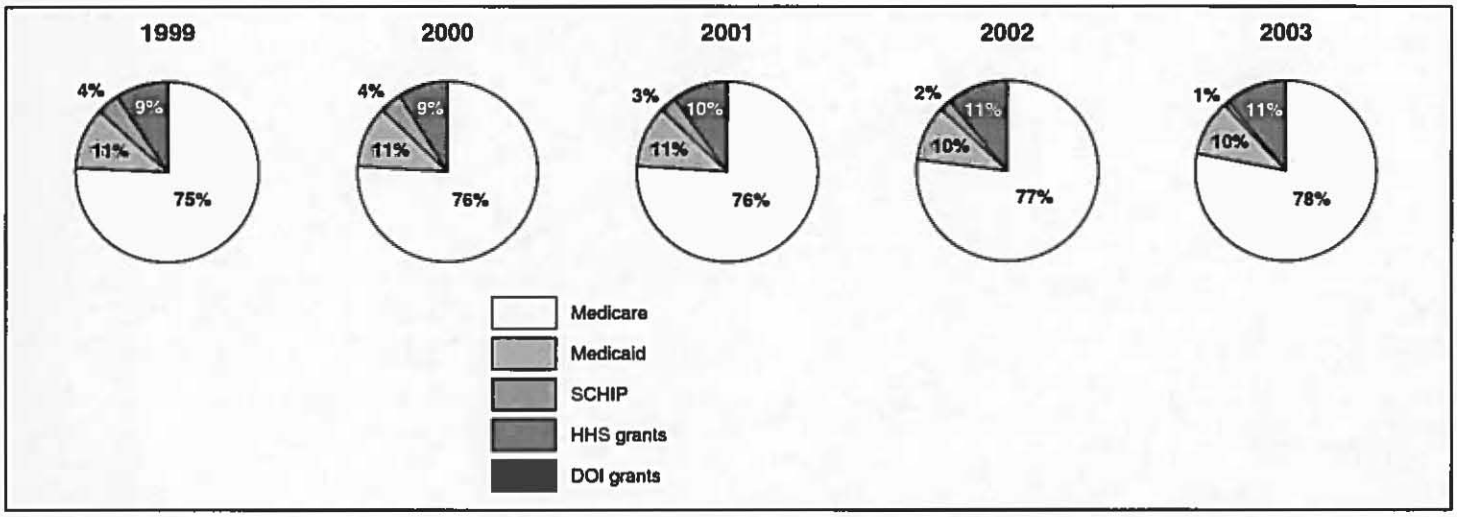
Note: Figures may not total to 100 percent due to rounding.

Table 7: Federal Health Care Spending for Guam, Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
Medicare	$15,265,639	$16,994,396	$18,636,429	$22,728,513	$26,832,745
Medicaid	5,230,000	5,410,000	5,620,000	5,880,000	6,321,000
SCHIP	2,529,909	2,381,930	2,213,827	1,393,787	1,157,625
HHS grants	2,859,071	5,795,473	7,020,535	9,108,189	10,495,714
DOI grants	2,420,000	4,185,000	2,855,000	2,633,000	3,443,947
Total	**$28,304,619**	**$34,766,799**	**$36,345,791**	**$41,743,489**	**$48,251,031**

Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Figure 12: Ratio of Federal Health Care Funding Sources for Puerto Rico, Fiscal Years 1999 through 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

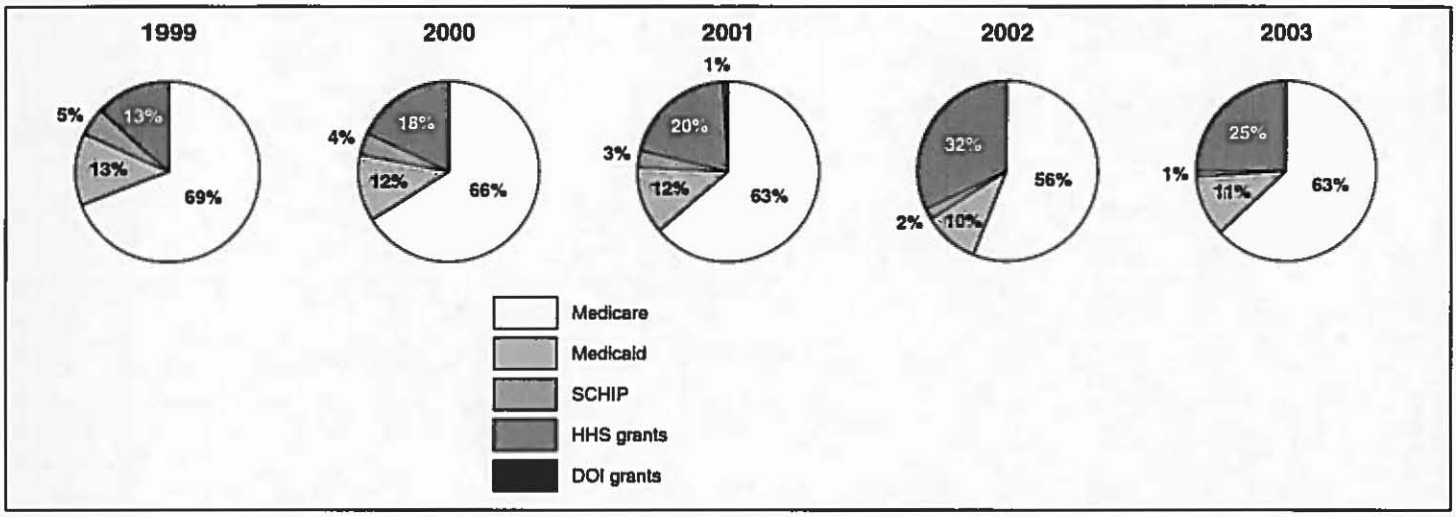
Note: Figures may not total to 100 percent due to rounding.

Table 8: Federal Health Care Spending for Puerto Rico, Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
Medicare	$1,141,552,210	$1,209,959,203	$1,337,114,946	$1,476,738,502	$1,599,351,575
Medicaid	171,500,000	177,500,000	184,400,000	192,900,000	207,341,000
SCHIP	66,211,306	62,338,494	57,939,035	36,477,397	30,296,700
HHS grants	133,820,563	149,657,652	168,783,855	221,260,544	216,598,403
DOI grants	-	-	-	-	-
Total	**$1,513,084,079**	**$1,599,455,349**	**$1,748,237,836**	**$1,921,376,443**	**$2,053,587,678**

Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Figure 13: Ratio of Federal Health Care Funding Sources for the Virgin Islands, Fiscal Years 1999 through 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Note: Figures may not total to 100 percent due to rounding.

Table 9: Federal Health Care Spending for the Virgin Islands, Fiscal Years 1999 through 2003

	1999	2000	2001	2002	2003
Medicare	$27,770,421	$29,540,636	$30,274,714	$34,452,783	$37,367,635
Medicaid	5,400,000	5,590,000	5,810,000	6,080,000	6,537,000
SCHIP	1,879,360	1,769,433	1,644,558	1,035,385	859,950
HHS grants	5,338,970	7,974,303	9,772,843	19,729,414	14,759,343
DOI grants	-	-	429,750	60,000	-
Total	**$40,388,751**	**$44,874,372**	**$47,931,865**	**$61,357,582**	**$59,523,928**

Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

Appendix III: Characteristics of Insular Areas' Medicaid Programs

To obtain Medicaid federal matching funds, state and insular area programs are to meet broad criteria related to eligibility, including categorical, income, and resource requirements. However, the insular areas vary in the extent to which their eligibility standards comply with the federal standards. For example, Guam, Puerto Rico, and the Virgin Islands use the same broad federal categories established in statute; however, the levels two of these areas use to determine income eligibility are based on locally established poverty levels rather than the federal poverty level (FPL). Table 10 compares the federal categorical and income eligibility standards to those in the insular areas.

Table 10: Comparison of Federal Medicaid Categorical and Income Eligibility Standards to Insular Area Standards, Fiscal Year 2004

Federal eligibility standards	Categories	Income level in relation to FPL	Number of enrollees (percentage of total population)
States	Five federal categories[a]	Varies by category, ranges between 100% to 185% of FPL for low income children to 133% to 185% of FPL for pregnant women	41.9 million (14%)
American Samoa	No specific categories	At or below FPL	37,504 (65%)
CNMI	Individuals whose total income does not exceed 150% of the SSI federal benefit amount and allowable resource limit	The federal benefit rate is $10,152 per year for an individual and allowable resource limit of $2,000 per year for an individual	9,758 (12%)
Guam	Five federal categories[a]	Below FPL	25,529 (15%)
Puerto Rico	Five federal categories[a]	At or below local poverty level, which was $4,800 per year for an individual	938,266 (24%)
Virgin Islands	Five federal categories[a]	At or below local poverty level, which was about $5,500 per year for an individual	16,125 (15%)

Source: GAO analysis of data from CMS, Kaiser Family Health Foundation, and insular area officials.

Note: In 2004, 100 percent of FPL for an individual was $9,310 per year, 133 percent of the FPL was $12,382 per year, and 185 percent of the FPL was $17,224 per year.

[a]The five federal categories are children, pregnant women, adults in families with children, elderly, and individuals with disabilities.

In addition to eligibility requirements, Medicaid mandates coverage for certain services. However, as shown in table 3, none of the insular areas provides coverage for all the mandatory services. Nonetheless, each insular area, like the states, has chosen to add optional benefits under the

statute, with most providing coverage for outpatient prescription drugs, clinic services, dental and eye care, and physical therapy. (See table 11.)

Table 11: Summary of Certain Optional Medicaid Services Covered by Insular Areas and States, Fiscal Year 2005

Service	AS	CNMI	GU	PR	VI	Number of states
Outpatient prescription drugs	●	●[a]	●	●	●[b]	51
Dental services	●	◐[c]	●	●	●	45
Clinic services	○	●	●	●	●	47
Prosthetic devices, eyeglasses	●	●[d]	●	○	◐[e]	48 and 41
Physical therapy and related services	●	●	○	●	○	34
Inpatient psychiatric hospital services for individuals under age 21	●	○	○	○	○	48
Personal care services	○	●	○	○	○	31
Diagnostic, screening, preventive, and rehabilitative services	○	○	○	●	○	35
Intermediate care facility for individuals with mental retardation (ICF/MR) services	○	○	○	○	○	51
Targeted case management services (home and community health)	○	○	○	○	○	50
Hospice care	○	○	○	○	○	48
Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental diseases (IMD)	○	○	○	○	○	44
Private duty nursing services	○	○	○	○	○	23

Sources: Insular area officials and The Kaiser Commission.

Key: ● = service covered; ◐ = service covered with limitations; ○ = service not covered

Notes: Number of states includes Washington, D.C.

The Kaiser Commission on Medicaid and the Uninsured. Medicaid Benefits: Online Database (The Henry J. Kaiser Family Foundation). http://www.kff.org/medicaid/benefits/index.jsp (downloaded Aug. 22, 2005).

[a]Drug coverage is limited to a 30-day supply unless a larger quantity is required for off-island travel. Any quantity larger than the 30-day supply must be pre-approved.

[b]Prior approval required for prescriptions that cost more than $200.

[c]Most dental services are covered, including fillings and extractions, and dentures are covered subject to prior approval. Orthodontics, prosthetics, and root canals are specifically not covered, and oral surgery is limited to emergencies.

[d]Prior authorization is required for prosthetic devices and eyeglasses.

[e]Eye clinic care provided to children only.

Appendix IV: Comments from the Department of the Interior

United States Department of the Interior
OFFICE OF THE ASSISTANT SECRETARY
POLICY, MANAGEMENT AND BUDGET
Washington, DC 20240

SEP 16 2005

Kathryn G. Allen
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Allen:

Now GAO-06-75.

Thank you for the opportunity to respond to the U.S. Office of Government Accountability (GAO) draft report entitled, "U.S. INSULAR AREAS: Multiple Factors Affect Federal Health Care Funding" (GAO-05-969).

We strongly support the purpose of this report and look forward to receiving it in its final form. Improving health care in the insular areas is a priority of both the insular area governments and the Department of the Interior. Although the report draws no conclusions and makes no recommendations, the information will help identify areas of disparities which may be reviewed for improvement.

If you wish to discuss the report, please contact David B. Cohen, Deputy Assistant Secretary for Insular Affairs, or Nikolao Pula, Director of the Office of Insular Affairs at (202) 208-4736.

Sincerely,

P. Lynn Scarlett
Assistant Secretary
Policy, Management and Budget

Appendix V: Comments from American Samoa

LBJ Tropical Medical Center
P.O. Box LBJ
Pago Pago, American Samoa 96799
Office of the Chief Executive Officer

"Commitment to Healthcare Excellence"

September 9, 2005

Serial#: 142-05

Ms. Kathryn G. Allen
Director, Health Care
U.S. Government Accountability Office
Washington, D.C. 20548

Dear Ms. Allen,

Per your communiqué, the LBJ Tropical Medical Center has conducted a review of the Draft Report to Congress entitled, "U.S. Insular Areas, Multiple Factors Affect Federal Health Care Funding". We thank you for the opportunity afforded to review and comment on the draft report.

The GAO report offers a "bird's eye view" of funding by the federal government to the Insular Areas. This perspective provides a context which can and does skew the information and its implications at a jurisdictional level. The LBJ Tropical Medical Center is concerned that the overview does not provide an accurate representation of primary, secondary and tertiary medical services costs and revenues, and furthermore, minimizes or omits local circumstances that in our opinion are major factors in the analysis of costs versus revenues and the allocation of federal funding thereof.

Omissions and Oversights

Due to the report's overview nature, statutory or regulatory barriers that are of enormous impact to the healthcare services and the costs of healthcare services in American Samoa are either minimized or neglected altogether in its analysis. We feel that in order for the report to provide a more accurate representation, the following factors need delineation and emphasis:

- In American Samoa, a local "statute" prescribes that medical attention will be provided "free of cost" by the government to all citizens qualified under the law. This provision precludes the LBJ Tropical Medical Center from charging patients professional physician or technician, or technologist fees. The provision further stipulates conditional parameters that severely hamper the hospital's ability to recapture costs via overhead charges. By extension, because this law directs the provision of socialized medicine, it acts a barrier to the development of privately owned and operated healthcare services for

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the simple reason that they cannot operate on a competitive basis with low cost care provided by the government for "all legal residents".

- Nowhere in the report is it mentioned that for the Pacific Insular areas, the major hospitals are government owned and operated. In many cases, certainly for American Samoa, government owned and operated hospitals are the sole providers of primary, secondary and tertiary health care in the islands. This market condition has a large impact on the availability of services and the inability to develop private healthcare interests in the territory. There are no nursing care homes/facilities in the American Samoa because 1) the LBJ Tropical Medical Center provides long term care as part of its in-patient services; 2) this deters private interests from developing independent services due to the inability to compete with government level charges.

- The report cites that American Samoa has a sizable dialysis facility yet does not have a Nephrologist. This is an erroneous statement. The LBJTMC has since it began dialysis services nearly 20 years, maintained a consultant contract with a qualified Nephrologist at the St. Francis Medical Center. This contractor provides regular patient contact and treatment orders for all the dialysis patients in the territory on a frequency and manner that has met and will continue to meet quality of care standards of the Centers for Medicaid and Medicare Services, U.S. Department of Health and Human Services.

Again we appreciate the opportunity to review the draft report and hope that our comments assist you in providing a report of meaning and substance to Congress.

Sincerely,

Taufete'e John Faumuina,
Chief Executive Officer

Appendix VI: Comments from the Commonwealth of the Northern Mariana Islands

Now GAO-06-75.

Commonwealth of the Northern Mariana Islands
Office of the Attorney General
CIVIL DIVISION

September 16, 2005 (Mainland Date)

Kathryn G. Allen, Director, Health Care
Susan T. Anthony, Assistant Director
US Government Accountability Office
Washington, DC 20548
Via Email: allenk@gao.gov; anthonys@gao.gov

Re: Draft Report Entitled U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding (GAO-05-969)

Dear Ms. Allen and Ms. Anthony:

I appreciate the opportunity to respond to GAO's draft report. Please forgive me if I am too direct, but I don't know any other way to talk about these matters.

This is an important report but a disappointing one because it fails to recommend anything to right the terrible wrong of the outright discrimination in federal health care funding against Pacific Islanders and other minorities in the insular areas.

Buried on page 30 of the report is the most important statement of fact in the report:

> **Federal Medicaid spending per capita was also lower in the insular areas compared to the states. In fiscal year 2003, federal Medicaid per capita spending in the states averaged $565 compared to between $33 and $65 for the insular areas. Poorer states with higher federal matching rates received as much as $813 in federal Medicaid per capita spending—more than 12 times the amount received by any insular area.**

The accompanying chart on page 31 shows what the CNMI received in 2003 in federal funding as compared to its sister states with the same high rates of poverty: CNMI received $33 per capita, as compared to $805 for Mississippi and $813 for West Virginia. That means CNMI Medicaid patients got 4% of what Mississippi and West Virginia Medicaid patients got in federal funding. The difference is not 12 times. It is 25 times greater in Mississippi and West Virginia than in the CNMI, though all have roughly the

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same percentage of poor people.

Shockingly absent from the GAO report is the commonsense recommendation[1] to stop the discrimination and treat Pacific Islanders and other insular minorities equally to other Americans by:

1) eliminating the Medicaid cap,
2) applying the FMAP based on actual poverty rates as in the states,
3) adjusting SCHIP and DSH payments, and,
4) providing additional pharmacy funds that mirror the amount of Medicare Part D drug benefits.

Because of the Medicaid cap and the FMAP rate, the entire federal contribution to the CNMI Medicaid program can be and usually is wiped out every year by the off island care costs of one baby with congenital heart disease or a child with leukemia, along with outpatient drug costs, including very expensive medications for hemophiliac patients. Nothing then remains to assist with preventative care and the other direct medical care costs of the many thousands of other poor, sick, elderly, and disabled Pacific Islanders.

Absent from the report is any discussion from the literature about the negative health outcomes that result when people (any people) do not receive basic, primary health care and preventative health services.

Absent is any mention of the difficulty of recruiting and retaining qualified physicians and other health care workers when the pay is so low, modern equipment and consulting specialists are generally unavailable, and the workload is so great, all due to lack of adequate federal funding for health care.

There is no discussion of the impact on other necessary government services when so much of local funds must go for health care services covered by the federal government elsewhere. What happens to schools and social services and roads and public safety when so much is drained from local sources to pay the federal government's share of health care costs?

The report notes that nursing home and transportation services[2] are not provided in most if not all of the insular areas as Medicaid benefits, though they are mandatory Medicaid services. The report then suggests that this may be a satisfactory state of affairs because the federal government does not penalize the territories for not providing them, or maybe they aren't provided because there are no providers, or maybe they do not exist because

[1] This report contains no recommendations. Other GAO reports are replete with recommendations.

[2] The cost of transporting a Medicaid patient from the CNMI to a Hawaii or California referral center, and housing costs there, are very expensive, averaging $2,000 per patient for airfare and $80 per day for housing.

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of "cultural differences." The truth is that they don't exist because there is no money to fund them due to the Medicaid cap and the low FMAP rate. Nursing home and transportation services are important and that is why they are mandatory services under Medicaid. However, there are no funds to provide them. Likewise home health care services, hospice, psychiatric care for children, intermediate care facility services for the mentally disabled, and other Medicaid benefits routinely available in the states are similarly important for good health, but they can't be provided without federal participation.

The report seems to suggest that absence of equal federal funding should be excused because some insular areas (like the CNMI) have chosen to use Medicaid funds for an optional service, i.e. outpatient prescription drugs. However, the report fails to say that such benefits are covered by Medicaid in every state and in the District of Columbia because they are critical to health. Not to cover them would be inconsistent with the purposes of the Medicaid Act, increase other health care costs, and undermine the effectiveness of other Medicaid services.

There are references to Compact Impact and other grant funds (such as bio-terrorism funds) and it is implied that these grants somehow ameliorate the adverse health effects of the discrimination in the Medicaid and Medicare[3] programs. However, the adequacy of these funds to actually cover all the needs for services caused by the migration of people from the Freely Associated States is not examined. Further, though grant funds are very important and much appreciated, they are simply are not enough to replace ongoing primary care cost reimbursement for thousands of Medicaid eligible people.[4] Bio-terrorism funds, for example, are used for preparedness and capacity building, not direct patient care.

So, I ask that you revise your report to address these issues and most importantly, that the report adopt the recommendations listed above.

Yours truly,

Debra Knapp

Debra Knapp, Assistant Attorney General

Cc: CNMI Secretary of Public Health Dr. James U. Hofschneider

[3] The report also states that Medicare spends roughly half per recipient in the insular areas than it does in the states.

[4] 12% of the people in the CNMI receive Medicaid benefits, though it has a much higher than average poverty rate. The national average is 14% of the population receiving Medicaid benefits.

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Appendix VII: Comments from the Commonwealth of Puerto Rico

COMMONWEALTH OF PUERTO RICO

ANÍBAL ACEVEDO VILÁ
GOVERNOR

September 26, 2005

Mr. David M. Walker
Comptroller General of the United States
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Walker:

Now GAO-06-75.

As Governor of the Commonwealth of Puerto Rico, I am concerned about the federal healthcare resources available to over 4 million U.S. citizens on the Island. My advisors have carefully reviewed the draft report Healthcare Funding in Insular Areas (GAO 05-969). Enclosed please find detailed comments. Yet, I would like to highlight the following points:

First, while the report describes Federal healthcare support, it is also important to review the relationship between the Federal and Commonwealth healthcare resources, and compare it to the relationship between the states and the Federal government. This is critical information in order to understand Federal healthcare policies related to Puerto Rico.

In FY '03 the Federal and Commonwealth governments invested $3.3 billion in Medicare, Medicaid and the S-Chip programs in Puerto Rico. Of this amount, the Commonwealth expended $1.3 billion or a 43 per cent share of the $3 billion. Nationwide, states and the Federal government expended $758 billion for the same programs with the states contributing $238 billion or just 29 per cent of the total expenditure.

The $2 billion of Federal healthcare funds invested in Puerto Rico is critical, and as a result the current Federal/Commonwealth healthcare partnership results in a 43

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percent contribution by the Commonwealth for these three important programs while states on average contribute 29 percent. The difference between the Federal government's 71 per cent contribution to the states and 58 percent contribution to the Commonwealth is a gap that is not stagnant but that grows each year. The impact of this gap creates significant quality of care and financial pressures on the Puerto Rico healthcare system.

Second, there are critical programmatic barriers to a balanced healthcare partnership. There are essentially four Federal policies which GAO highlights in the report that are the barriers to a more balanced partnership that would more closely resemble the current Federal/state partnership. These include:

A. Medicaid cap. The Medicaid statute calls for the Commonwealth and Federal government to share eligible expenses 50-50; however, because of the Medicaid cap the Commonwealth cannot receive more than $219 million for Medicaid expenses. The effect of the cap is that the Commonwealth finances over 80 of Medicaid costs and the Federal government supports 20 percent. If the Medicaid cap which was established in 1968 had been authorized to grow at the same rate as the Medicaid program, the cap would now approximate $1.7 billion as opposed to $219 million. The cap has effectively kept Federal per capita support for Medicaid in Puerto Rico to $50 per year as reported by GAO, and it has forced the Commonwealth to take on financial responsibility to a much greater extent than any state. Testimony has been provided to the Senate and House Committees of jurisdiction and the Department of Health and Human Services (HHS) Medicaid Commission outlining a plan for rebalancing Commonwealth/Federal healthcare partnership and a key element to address that imbalance is by authorizing critical expenditures outside of the current cap.

B. S-Chip Allocation. States receive S-Chip allocations based upon a formulation that predicts the relative number of children who need health insurance. The Commonwealth does not receive its funds based upon this formulation but receives a "seaside" that equates to less than one quarter of one percent of the funds available. However, the Commonwealth has 1.5 percent of children under 17 in the U.S. which over 50 percent of these children living in poverty received less than one-quarter of one percent of the S-Chip allocation. A significant step in rebalancing the overall Commonwealth/Federal partnership would be to include the Commonwealth in the statutory allocation of funds as opposed to the set-aside process.

C. Medicare DSH and DRG. While workers and employers pay the same Medicare taxes as other workers in the US, hospitals in Puerto Rico are not eligible to receive disproportion share payments and the DRG reimbursement rate is calculated differently than for hospitals in the states. These two critical differences in the reimbursement structure for Puerto Rico hospitals undermine the capitalization and financial vitality of hospitals and create additional barriers to providing quality healthcare services to the island's elderly.

Third, there are critical regulatory barriers to a balanced healthcare partnership. Currently, several Federal regulatory standards are imposed by a variety of agencies to states that receive some financial assistance through Medicaid. I recognize that CMS has attempted to be flexible in its enforcement of Medicaid regulatory standards --as indicated in the report-- because of the Medicaid cap in Puerto Rico. Fortunately, CMS recognizes that an attempt to mandate significant additional Federal requirements when the Commonwealth is already financing 80 percent of Medicaid is not an adequate policy.

However, I am surprised that other agencies of the Federal government within the jurisdiction of the Secretary of Health and Human Services have not adopted similar policies. For example:

- the Commonwealth Medicaid program is required to meet the standards of the Health Insurance Portability and Accountability Act (HIPPA) but with no additional Federal support.

- the Health Resources and Services Administration (HRSA) has supported legal action instituted by community health care centers in Puerto Rico to see additional Medicaid reimbursements.

- the Administration for Children and Families requires the Commonwealth to meet various requirements under the Temporary Assistance for Needy Families (TANF) program, but the Medicaid cap prevents CMS from providing persons leaving welfare in Puerto Rico to go to work with transitional medical assistance, a program used by every state.

In addition, it is quite troubling that there are other Federal agencies which have instituted legal action to force the Commonwealth to spend Commonwealth funds on Medicaid eligible expenses. For example, on April 21, 1999, the U.S. Justice

Department filed action which resulted in the Commonwealth of Puerto Rico signing a consent decree to implement provisions of the Olmstead decision. States have authority to receive additional Medicaid reimbursement for Olmstead related expenses, but the Medicaid cap precludes the additional Federal support for Puerto Rico.

A major contribution to rebalancing the Commonwealth/Federal healthcare partnership would be to align Federal policies so that regulatory requirements are more consistent with the programmatic and financial policies of the Federal government.

The GAO report provides the foundation for Congress to move forward in addressing the imbalance in the Federal/Commonwealth healthcare partnership. The report describes many of the challenges that have created the current imbalance in this partnership, such as the Medicaid cap. The efforts of the GAO in moving forward with this report are greatly appreciated and will be of great assistance to the Commonwealth in working with Congress to address the inequity of this critical healthcare partnership.

Sincerely,

Aníbal Acevedo Vilá

Appendix VIII: GAO Contact and Staff Acknowledgments

GAO Contact

Kathryn G. Allen (202) 512-7118 or allenk@gao.gov

Acknowledgments

In addition to the contact named above, Susan T. Anthony, Assistant Director, Gerardine Brennan, Richard Lipinski, Michaela M. Monaghan, Mary Reich, and Margaret J. Weber made key contributions to this report.

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