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The Honorable John D. Rockefeller IV
Chairman
Subcommittee on Health Care
Committee on Finance
United States Senate

Subject: *Medicaid and CHIP: Opportunities Exist to Improve U.S. Insular Area Demographic Data That Could Be Used to Help Determine Federal Funding*

Dear Mr. Chairman:

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—receive federal funding through Medicaid and the State Children's Health Insurance Program (CHIP), joint federal-state programs that finance health care for certain low-income individuals. These programs are administered and funded differently in the insular areas when compared to the states.[1] For example, while states must extend Medicaid eligibility to certain individuals whose incomes are at or below a percentage of the federal poverty level (FPL),[2] the insular areas are not required to cover this population. In addition, under both Medicaid and CHIP, the federal government matches state or local government spending. However, federal law establishes the federal matching rate for expenditures by the insular areas at the lowest rate available to states, while matching rates for the states are determined each year based on a formula that takes into account variations in percapita income in each state.[3] Furthermore, federal Medicaid spending in the insular areas is subject to an annual limit that does not apply to the states.[4] Finally, while CHIP funding is subject to annual limits for both states and insular areas, the formula for determining each state's CHIP allotment

[1]For purposes of Medicaid and CHIP, federal law generally defines states to include the 50 states, the District of Columbia, American Samoa, CNMI, Guam, Puerto Rico, and the U.S. Virgin Islands. 42 U.S.C. § 1301(a)(1). In this report, however, the term states refers to the 50 states and the District of Columbia, and the term insular areas only refers to American Samoa, CNMI, Guam, Puerto Rico, and the U.S. Virgin Islands.

[2]FPL refers to the federal poverty guidelines which are used to establish eligibility for certain federal assistance programs. The Department of Health and Human Services (HHS) publishes these guidelines on an annual basis, updating the guidelines to reflect changes in the cost of living and variations according to family size.

[3]42 U.S.C. §§ 1396d(b), 1397ee(a), (b).

[4]42 U.S.C. § 1308(g). Under the *American Recovery and Reinvestment Act of 2009* (Recovery Act), both states and insular areas may qualify for a temporary increase in the federal share of spending on Medicaid services—the Federal Medical Assistance Percentage (FMAP). Each insular area may choose between (1) an FMAP increase of 6.2 percentage points and a 15 percent increase in its annual federal Medicaid spending limit, or (2) a 30 percent increase in its annual federal Medicaid spending limit. Pub. L. No. 111-5, div. B, tit. V, § 5001(b), (d), 123 Stat. 115, 497-498 (2009).

differs from the formula used for allotments for the insular areas. Taken together, these differences in funding formulas have contributed to per capita federal Medicaid and CHIP spending that has been lower in the insular areas than in the states.[5]

Some insular area governors and other insular area officials contend that federal Medicaid and CHIP spending in the insular areas is not sufficient to meet the needs of the areas and have recommended that the Medicaid spending limits be removed and the federal matching rates for Medicaid and CHIP be increased.[6] However, you and others have raised concerns that limitations in Medicaid and CHIP program data and in available demographic data for the insular areas make it difficult to accurately assess the needs of the areas. For example, states are required to report all of their Medicaid and CHIP spending to the Centers for Medicare & Medicaid Services (CMS)—the agency that oversees these programs. In contrast, insular areas must report only spending up to their annual limits. Furthermore, while the Bureau of the Census (Census) collects household demographic data from the states annually, it generally only collects household demographic data for the insular areas once every 10 years as part of the decennial census.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which was enacted in February 2009,[7] modified the formula for determining federal CHIP allotments for states and insular areas for fiscal years 2009 through 2013. Under CHIPRA, increases in federal CHIP allotments to the insular areas and the states are to be based, in part, on any annual percentage increase in the population of children as determined using the most recent estimates published by Census.[8] Prior to CHIPRA, for each fiscal year, CHIP allotments for the insular areas were to be distributed based on set percentages, and for the states were to be determined based, in part, on population data derived from the Current Population Survey (CPS), a monthly survey administered by the Department of Commerce (DOC) and designed to capture national demographic trends. Because the CPS was not designed to capture state-level demographic data, some researchers were concerned about the use of CPS data to determine CHIP funding for each state. CHIPRA directs the Secretary of DOC to assess whether available data from its annual American Community Survey (ACS)—an annual household survey designed to capture community-level demographic, housing, and socioeconomic data—would provide more reliable estimates than CPS for the purpose of determining increases in federal CHIP allotments.

In light of these issues, you asked us to examine the Medicaid and CHIP programs in the insular areas and to provide information on the availability of program-related data for the areas. Specifically, we examined (1) Medicaid and CHIP income eligibility criteria used by the insular areas, (2) CMS's approach to collecting Medicaid and CHIP enrollment and spending data from the insular areas and its assessment of the reported spending data, and (3) the extent to which CPS or ACS data are available for the insular areas.

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[5]GAO, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75 (Washington, D.C.: Oct. 14, 2005).

[6]Department of the Interior, Office of Insular Affairs, *Future of Health Care in the Insular Areas Leaders Summit: Report on Health Care in the Insular Areas* (Washington, D.C.: Jan. 12, 2008).

[7]Pub. L. No. 111-3, §§ 102, 602, 123 Stat. 8, 11-15, 98-99 (2009) (codified, as amended, at 42 U.S.C. §§ 1397dd, 1397ii(b)).

[8]The estimates for fiscal year 2009 were derived from Population Estimates Program data—annual data that update the demographic data collected through the decennial census. Allotments for the insular areas were based on national estimates instead of insular areas' estimates.

To examine Medicaid and CHIP income eligibility criteria, we reviewed relevant federal laws and regulations, reviewed insular areas' approved State Medicaid Plans, and interviewed officials from CMS regional offices and from each of the insular area Medicaid offices. To examine CMS's approach to collecting Medicaid and CHIP enrollment data from the insular areas, we interviewed officials from CMS regional offices and from each insular area and obtained recent enrollment data from the insular areas. To examine CMS's approach to collecting Medicaid and CHIP spending data from the insular areas, we interviewed officials from CMS regional offices and each insular area and obtained from CMS electronic copies of summarized Medicaid spending reports from 1991 through 2008—the most recent data available at the time of our review. To examine CMS's assessment of the insular area spending data, we interviewed CMS regional officials, reviewed CMS guidance on its review of spending data, and reviewed the single audit reports available for the insular areas for fiscal years 2004 through 2007—the most recent available at the time or our review.[9] We did not independently verify the reliability of the enrollment and spending data reported to CMS by the insular areas because our analysis focused on CMS's approach to collecting and reviewing these data, not the data themselves. To examine the extent to which CPS or ACS data are available for the insular areas, we interviewed officials from the U.S. Department of Interior, which has general federal administrative authority over most insular areas, and from Census. We also reviewed related congressional testimony by a Census official.

We conducted our work from October 2008 through June 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, insular areas' Medicaid and CHIP income eligibility criteria vary, and contribute to wide variation in the estimated percent of the population covered by Medicaid in each of the insular areas. For example, two of the areas base their income eligibility criteria on the FPL, while two other areas base their income eligibility criteria on locally established income limits. In 2008, the estimated percentage of the populations covered by Medicaid in the insular areas ranged from 6 percent in the U.S. Virgin Islands to 88 percent in American Samoa, according to the Congressional Research Service (CRS). In addition, CMS provides the insular areas with flexibility in how they report Medicaid and CHIP enrollment data and requires the areas to report spending data quarterly using a standard form. Based on their review of reported spending data, CMS officials have determined that spending reports from the insular areas are sufficient to justify the federal matching payments made to them. For a number of reasons, CPS and ACS data are not available for the five insular areas in our review. However, Census updates certain data annually for Puerto Rico, including demographic, socioeconomic, and housing data collected through a tailored version of the ACS. According to Census officials, such data could be used in a CHIP allotment formula that used ACS data. Similar demographic, socioeconomic, and housing data for the other four insular areas are collected once every 10 years through the decennial census. Census officials identified two options to update demographic information for the other four insular areas between decennial censuses—the agency could implement survey programs to collect

[9]In accordance with the Single Audit Act of 1984, as amended, 31 U.S.C. §§ 7501-7505, and the Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments and Non-Profit Organizations* (June 27, 2003), nonfederal entities, including states and insular areas, that expend $500,000 or more a year in federal awards must have a single or program-specific audit conducted for that year subject to applicable requirements.

demographic, socioeconomic, and housing data or it could update certain demographic data through its Population Estimates Program. However, according to agency officials, the agency would need additional resources or would need to take additional steps to develop either of these updates, depending on the method used.

To improve the availability of the data that could be used in a CHIP allotment formula, we are recommending that the Secretary of Commerce direct Census to update, between decennial censuses, the demographic data for American Samoa, CNMI, Guam, and the U.S. Virgin Islands. In written comments on a draft of this report, DOC agreed with our recommendation.

Background

American Samoa, Guam, CNMI, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are the largest insular areas of the United States. While each insular area has its own government and maintains a unique diplomatic relationship with the United States, all areas are under the sovereignty of the United States.[10] 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.[11] Although insular area participation in Medicaid and CHIP is voluntary, all insular areas currently participate in both programs.

Medicaid

Established in 1965, Medicaid operates as a joint federal-state program to finance health care coverage for certain categories of low-income individuals. To obtain federal matching funds, the states and insular areas must operate their Medicaid programs within broad federal guidelines and under federally approved plans. Two insular areas, however, operate their Medicaid programs under federally approved waivers, which exempt them from federal eligibility requirements.[12] The remaining insular areas have some flexibility in covering their Medicaid populations.[13] Program eligibility in the insular areas is generally limited to certain categories of individuals whose incomes do not exceed certain limits.

[10]The Department of Interior has general federal administrative authority over all insular areas except Puerto Rico. All departments, agencies, and officials of the executive branch treat Puerto Rico administratively "as if it were a state" subject to few exceptions. Any matters concerning the fundamentals of the U.S.-Puerto Rican relationship are referred to the Office of the President. See Memorandum of the President, Nov. 30, 1992, 57 *Fed. Reg*. 57,093 (1992). Insular area residents are not subject to the same level of income taxes as residents of the states. For example, they pay no federal income tax on income from sources within the insular area.

[11]For example, the median household income in Puerto Rico in 1999 was $14,412 compared to $41,994 in the United States.

[12]The Secretary of HHS may waive or modify requirements with respect to Medicaid programs in American Samoa and CNMI, except for the annual limits on federal Medicaid spending, the statutorily set Federal Medical Assistance Percentage (FMAP), and the requirement that federal payments only be made for Medicaid services. 42 U.S.C. § 1396a(j).

[13]States are required to cover defined categories of individuals under their Medicaid program, including children, pregnant women, adults in families with children, the elderly, and individuals with disabilities. Guam, Puerto Rico, and the U.S. Virgin Islands, however, are not required to cover all the same categories of individuals.

The federal share of spending on services for the insular areas' Medicaid programs—the Federal Medical Assistance Percentage (FMAP)—is statutorily set at 50 percent, the lowest rate available to any state under the program.[14] In addition, total federal Medicaid spending in the insular areas is subject to an annual limit or cap.[15] As a result, the federal government will match every Medicaid dollar spent by the insular areas up to each area's limit, and any insular area spending above the limit is not matched.

Under the Balanced Budget Act of 1997, the fiscal year 1998 limits on federal Medicaid spending for the insular areas were increased by varying amounts, subject to an additional percentage increase in the medical care component of the Consumer Price Index (CPI) for all urban consumers for subsequent fiscal years.[16] The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided the insular areas with a temporary increase of 5.9 percent above each areas' annual limits for fiscal years 2003 and 2004,[17] and the Deficit Reduction Act of 2005 increased the annual limits in fiscal years 2006 and 2007 by varying amounts in each of the insular areas, and maintained these increases for subsequent fiscal years.[18] Figure 1 shows the changes in insular areas' annual federal Medicaid spending limits from 1998 through 2008. (See encl. I for more detail on federal Medicaid spending to the insular areas.) More recently, the American Recovery and Reinvestment Act of 2009 (Recovery Act), which was enacted on February 17, 2009, provides temporary increases to each insular area's FMAP and annual federal spending limits from the first quarter of fiscal year 2009 through the first quarter of fiscal year 2011.[19]

[14]In contrast, for states, the FMAP generally is determined according to a formula based on each state's per capita income in relation to the national average per capita income and may range from 50 percent to 83 percent. See 42 U.S.C. 1396d(b). As a result, poorer states receive higher federal matching rates than wealthier states. In 2009, the FMAP ranged from 50 percent in wealthier states, such as New York and Connecticut, to about 76 percent in Mississippi. The federal share for Medicaid administrative costs, however, is established under federal law at the same percent for states and the insular areas, with the percent defined by the type of administrative cost. See 42 U.S.C. § 1396b(a)(2)-(7).

[15]42 U.S.C. § 1308(f), (g). In contrast, federal Medicaid spending in the states generally is open ended, provided the states contribute their share of program expenditures.

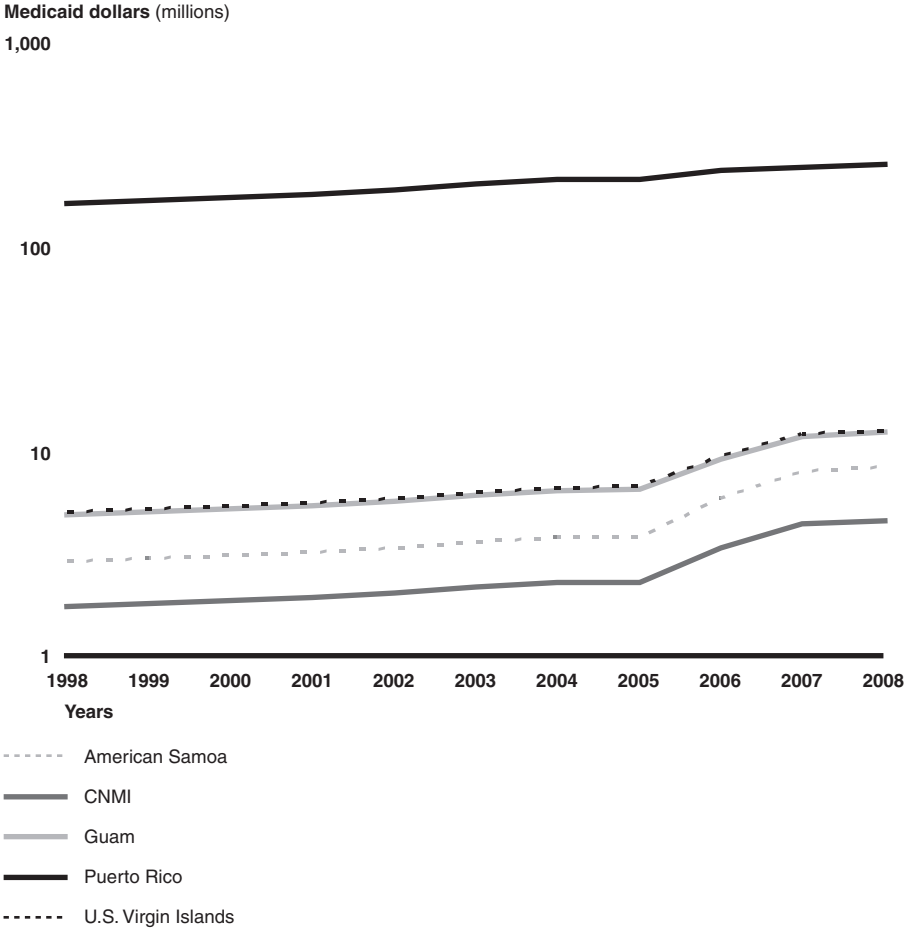
[16]Pub. L. No. 105-33, § 4726, 111 Stat. 251, 519 (1997) (codified, as amended, at 42 U.S.C. § 1308(g)).

[17]Pub. L. No.108-27, § 401, 117 Stat. 752, 764 (2003). This temporary increase only applied to the last 2 calendar quarters of fiscal year 2003 and the first 3 calendar quarters of fiscal year 2004.

[18]Pub. L. No. 109-171 § 6055, 120 Stat. 4, 96 (2006) (codified, as amended, at 42 U.S.C. § 1308(g)).

[19]Under the Recovery Act, each insular area may choose between (1) an FMAP increase of 6.2 percentage points and a 15 percent increase in its annual federal spending limit, or (2) a 30 percent increase in its annual federal spending limit. Pub. L. No. 111-5, div. B, tit. V, § 5001(b), (d), 123 Stat. 115, 497-498 (2009).

Figure 1: Insular Areas' Federal Medicaid Spending Limits, 1998 through 2008



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

Note: Figure 1 uses a logarithmic scale. A logarithmic scale can be useful when displaying data with large differences in numeric values. Logarithmic scales do not include zero.

CHIP

In 1997, Congress created CHIP, a joint federal-state program that provides health care coverage to uninsured, low-income children living in families whose incomes exceed the eligibility limits for Medicaid programs.[20] States and insular areas have three options for implementing CHIP; they can either expand their Medicaid programs, establish separate child health programs, or do a combination of both. The federal government matches insular

[20]See the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-571 (codified, as amended at 42 U.S.C. §§ 1397aa et seq.).

area CHIP spending using an enhanced FMAP, which for all five areas is at the lowest rate available for the states—65 percent.[21] Federal CHIP spending for both the insular areas and the states is limited to an annual allotment set in statute.[22]

Prior to CHIPRA, insular areas were allotted 0.25 percent of the total annual amount appropriated for CHIP allotments, which was distributed among the insular areas using statutorily set percentages,[23] and allotments to the states were to be determined based, in part, on population data derived from the CPS.[24] (See encl. II.) Under CHIPRA, increases in CHIP allotments for fiscal years 2009 through 2013 for states and the insular areas are to be determined based, in part, on any annual percentage increase in the population of children using the most recent estimates published by Census prior to the beginning of each fiscal year.[25] CHIPRA also directs the Secretary of DOC—the department responsible for collecting demographic data in the United States—to assess whether available data from the ACS would provide more reliable estimates than CPS for determining increases in these CHIP allotments.[26] Based on this assessment, the Secretary of DOC must recommend to the Secretary of HHS whether ACS data should be used in lieu of, or in combination with, CPS data, a recommendation that the Secretary of HHS may implement using a transition period.[27]

Medicaid and CHIP Program Data

Insular areas report Medicaid and CHIP enrollment and spending data to CMS, and CMS uses the spending reports to determine the amount of federal Medicaid and CHIP matching payments.[28] CMS's Region 2 office, located in New York, New York, has oversight

[21]States and insular areas qualify for an enhanced FMAP equal to their Medicaid FMAP plus 30 percent of the difference between the state's FMAP and 100 percent. Thus, because insular areas receive a 50 percent FMAP—the minimum FMAP for states—the areas' enhanced FMAP for CHIP may only be increased to 65 percent. See 42 U.S.C. § 1397ee(a), (b).

[22]42 U.S.C. § 1397dd.

[23]Of the total amount available for CHIP allotments for insular areas each fiscal year: Puerto Rico received 91.6 percent; Guam, 3.5 percent; the U.S. Virgin Islands, 2.6 percent; American Samoa, 1.2 percent; and CNMI, 1.1 percent. 42 U.S.C. § 1397dd(c).

[24]A state's CHIP allotment was to be determined, in part, based on the average number of low-income children (including those without health insurance) in the state as reported and defined in the three most recent March supplements to the CPS published by Census before the beginning of the calendar year in which the fiscal year begins. 42 U.S.C. § 1397dd(b).

[25]Pub. L. No. 111-3, § 102, 123 Stat. 8, 11-15 (2009) (codified, as amended, at 42 U.S.C. § 1397dd). The estimates for fiscal year 2009 were derived from Population Estimates Program data—national estimates were used for the insular areas and state-level estimates were used for the states.

[26]Through CHIPRA, Congress appropriated additional funds for this assessment as well as for other purposes, including the improvement of the data collected by DOC through the CPS for all states. The ACS, an annual survey that replaces the decennial census's long form, was not available when CHIP was initially authorized. Researchers have suggested that the ACS could provide better state-level population data than the CPS in part because its sample is larger than the CPS sample. Census—an agency within DOC—is responsible for collecting CPS and ACS data.

[27]Pub. L. No. 111-3, § 602, 123 Stat. 8, 98-99 (2009) (codified, as amended, at 42 U.S.C. § 1397ii(b)). According to a CMS official, CMS will work with Census to determine the appropriate data to use in determining increases in CHIP allotments for the states and insular areas for fiscal years 2010 through 2013.

[28]Medicaid spending is reported on the form known as the CMS 64. At the beginning of each program year, CMS makes the amounts of the insular areas' federal Medicaid spending limits available to the insular areas, and each area draws down its funds throughout the year based on the spending reported on the CMS 64.

responsibility for Puerto Rico and the U.S. Virgin Islands and reviews reports submitted by these areas. CMS's Region 9 office, located in San Francisco, California, has oversight responsibility for American Samoa, CNMI, and Guam and reviews the reports submitted by these areas. All five insular areas operate their CHIP programs as expansions of their Medicaid programs, and accordingly, include CHIP enrollment and spending data in their Medicaid reports. Because federal Medicaid and CHIP spending in the insular areas is limited, the areas are required to report only local spending up to that limit. However, CMS officials told us that for several years the agency has encouraged the insular areas to report actual spending, including any spending above the annual federal limits, to provide better estimates of Medicaid and CHIP costs for each area.

Insular Areas' Medicaid and CHIP Income Eligibility Criteria Vary, and Wide Variation in Covered Populations Is Reported

Each insular area relies on different income criteria to determine Medicaid and CHIP eligibility. Two of the areas explicitly base Medicaid income eligibility on the FPL: Guam extends eligibility to certain individuals earning up to 100 percent of the FPL, and American Samoa extends eligibility to individuals earning under 200 percent of the FPL. The other three areas use different income eligibility criteria for eligible individuals, such as locally established income limits.[29] As a result, the Medicaid annual income eligibility limits for individuals vary widely among the five insular areas, ranging from $4,800 in Puerto Rico to about $22,000 in American Samoa. For the CHIP program, four of the five insular areas' income eligibility criteria are the same as their Medicaid income eligibility criteria.[30] Puerto Rico is the only insular area that uses CHIP funds to extend Medicaid eligibility to children in families earning incomes that exceed its Medicaid program's income eligibility limits. See table 1 for more detailed descriptions of the Medicaid and CHIP income eligibility criteria used in each insular area.

[29]Insular areas define the income eligibility criteria in their Medicaid plans, which are approved by CMS.

[30]According to CMS officials, these insular areas may not use CHIP funds for eligible populations in any given year until they have exhausted all available federal Medicaid funds.

Table 1: Insular Area Medicaid and CHIP Income Eligibility Criteria in 2009

Insular area	Program	Income eligibility criteria[a]	2009 annual income limits for an individual[b]
American Samoa	Medicaid and CHIP	Below 200 percent of the FPL	$21,660
CNMI	Medicaid and CHIP	At or below 150 percent of the Supplemental Security Income (SSI) federal benefit amount[c]	$12,132
Guam	Medicaid and CHIP	At or below 100 percent of the FPL	$10,830
Puerto Rico	Medicaid	At or below 100 percent of the commonwealth poverty level (CPL)[d]	$4,800[e]
	CHIP	Over 100 percent and up to 200 percent of the CPL	Over $4,800 and up to $9,600
U.S. Virgin Islands	Medicaid and CHIP	At or below locally established income limits[d]	$5,500

Source: CMS and insular area officials and GAO analysis of insular area Medicaid State Plans.

[a]In addition to income eligibility requirements, some insular areas consider resources when determining Medicaid eligibility.

[b]CHIP eligibility is generally determined based on family income.

[c]SSI is a federal income supplement program designed to help aged, blind, and disabled people who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

[d]Puerto Rico and the U.S. Virgin Islands use a lower Medicaid income limit for certain groups of people. The CPL is used by Puerto Rico as a measure of poverty in lieu of the FPL.

[e]Certain aged, blind, and disabled individuals who earn up to $9,600 per year may also qualify for Medicaid in Puerto Rico. In these cases, up to $4,800 of the individual's income can be excluded when determining Medicaid eligibility.

Insular areas' rationale for determining their Medicaid and CHIP income eligibility criteria varied. For example, CNMI and Guam based income eligibility on the SSI federal benefit amount and the FPL, respectively, because these two areas used these criteria to determine eligibility for other poverty-related programs. In addition, the U.S. Virgin Islands, which is relatively poor when compared to the states, based income eligibility on a locally established income limit which is equivalent to about half the FPL because, according to a U.S. Virgin Islands Medicaid official, limits on both federal and local program spending have required the area to restrict the size of the covered population. In contrast, American Samoa, which is similarly poor, considers every resident with an income below twice the FPL—the majority of the population—eligible for Medicaid.[31] According to American Samoan officials, the area must use this relatively high income limit in order to spend all available federal funds.[32]

The differences in the income eligibility criteria used by the insular areas contribute to wide variation in the estimated percent of the population covered by Medicaid in each of the insular areas. For example, according to estimates by the CRS, in 2008 the covered populations ranged from 6 percent in the U.S. Virgin Islands to 88 percent in American Samoa. (See table 2.)

[31]American Samoan residents are not required to enroll in Medicaid or CHIP. Under the authority of its approved waiver, American Samoa annually estimates the number of residents below 200 percent of the FPL based on population estimates derived by American Samoa's Statistics Office. This number is presumed eligible for Medicaid and provides the basis for determining the federal share of Medicaid funding.

[32]Prior to 2006, American Samoa's income eligibility was limited to 100 percent of the FPL—about 65 percent of the population—but was increased to 200 percent of the FPL in 2006 when the area received an increase in its Medicaid cap. An official from the U.S. Virgin Islands told us that in response to these increased federal funds, the area is also considering increasing the program's income eligibility limits.

Table 2: Congressional Research Service Estimates of the Medicaid Populations in Each Insular Area, 2008

Insular area	Estimated enrollment	Estimated percentage of the population covered
American Samoa	60,864[a]	88
CNMI	11,292	13
Guam	29,625	17
Puerto Rico	888,370[b]	23
U.S. Virgin Islands	6,668	6

Source: CRS.

Note: Background Material and Data on the Programs within the Jurisdiction of the Committee on Ways and Means, 2008 Edition (May 5, 2008).

[a]American Samoan residents are not required to enroll in Medicaid or CHIP. Under the authority of its approved waiver, American Samoa annually estimates the number of residents below 200 percent of the FPL based on population estimates derived by American Samoa's Statistics Office. This number is presumed eligible for Medicaid and provides the basis for determining the federal share of Medicaid funding.

[b]According to Puerto Rico officials, coverage was extended to more than 100,000 additional children using CHIP funds.

CMS Provides the Insular Areas Flexibility in Reporting Enrollment, Has a Standard Requirement for Reporting Spending, and Has Determined That Reported Spending Justifies Federal Matching Payments

CMS provides the insular areas with flexibility in how they report Medicaid and CHIP enrollment data, and requires the areas to report spending data quarterly using a standard form. CMS officials told us that insular area spending reports are sufficient to justify federal matching payments provided to them, but they have concerns that reports from Puerto Rico and the U.S. Virgin Islands may not reflect the full costs of their programs.

CMS Provides Insular Areas Flexibility in Reporting Enrollment Data and Requires the Areas to Report Spending Using a Standard Form

CMS provides the insular areas with flexibility in how they report Medicaid and CHIP enrollment data because they do not use the Medicaid Statistical Information System (MSIS)—the system required for reporting Medicaid data to CMS.[33] For example, CNMI and Guam have historically provided enrollment data to CMS on their quarterly budget reports, which include certain information on enrollees, such as age.[34] Puerto Rico provides a monthly

[33]The Balanced Budget Act of 1997 required states and insular areas to participate in the MSIS beginning in 1999 to report Medicaid claims data, including enrollee encounter data, and provided states and insular areas with increased federal Medicaid funding to develop MSIS systems. Pub. L. No. 105-33, § 4753, 111 Stat. 251, 525 (1997) (codified, as amended, at 42 U.S.C. § 1396b(r)). Although insular areas could have accessed these federal Medicaid funds to develop MSIS systems, none did so because those funds would have counted against their annual Medicaid caps, according to CMS officials. Officials also stated that because the insular areas do not have this technical capability, CMS does not require the areas to report enrollment data through the MSIS. CHIPRA, Pub. L. No. 111-3 § 109, 123 Stat. 8, 25 (2009) (codified, as amended, at 42 U.S.C. § 1308(g)), has since allowed the insular areas to access federal Medicaid funding to develop MSIS systems outside of the areas' annual Medicaid caps. If the insular areas develop MSIS systems, enrollment data could become standardized.

[34]Medicaid budget reports are submitted quarterly on the form known as CMS 37.

enrollment report to CMS, which provides different information on enrollees, such as where they live and in what health plan they are enrolled.[35] American Samoa and the U.S. Virgin Islands report enrollment data to CMS less frequently than the other insular areas. American Samoa, which does not enroll individuals in Medicaid or CHIP, provides an annual estimate of eligible individuals to CMS. The U.S. Virgin Islands also reports enrollment data annually.

Unlike enrollment data, CMS requires all five insular areas to report Medicaid and CHIP spending data using a standard quarterly report that states are also required to use, and CMS uses these reported data to determine the amount of federal Medicaid and CHIP matching payments.[36] The standard report is designed to capture both aggregate spending and spending by service category, such as hospital inpatient services or laboratory and radiological services. While CNMI, Guam, and the U.S. Virgin Islands report aggregate spending as well as spending by service category, American Samoa and Puerto Rico report only aggregate spending because their programs are not designed to track spending by service.[37]

According to CMS Officials, Insular Area Spending Reports Are Sufficient to Justify Federal Matching Payments, but May Not Reflect All Insular Area Program Costs

CMS officials told us that based on their review of the insular area spending reports, they have determined that the reports are sufficient to justify the federal matching payments made to them. CMS's review is focused primarily on determining whether the areas report enough spending to reach their annual federal Medicaid limits, and if an area does not, CMS works with the area to determine why and resolve any problems.[38] In their review of insular area spending reports, CMS officials do not follow the same procedures used to review state reported spending.[39] However, CMS requires the insular areas to attest to the reliability of their data.[40] CMS officials told us that they also review the results of single audit reports for each area to identify problems with the areas' financial reporting and work with the insular areas to clear and close Medicaid-related findings from the single audits. CMS officials also told us that they do not conduct more rigorous reviews of insular area spending data because they do not think the reviews would result in changes in federal payments to the insular

[35]Puerto Rico's Medicaid program operates as a managed care system that includes several health plans. Medicaid funds are used to pay the health plans for their Medicaid enrollees.

[36]States and insular areas report, on a quarterly basis, spending on a standard report known as the CMS 64. States and insular areas that operate CHIP as an expansion of their Medicaid programs must report CHIP spending on the CMS Form 64. Expenditures related to stand-alone CHIP programs are reported quarterly on the CMS 21.

[37]Specifically, because American Samoa does not enroll individuals in Medicaid or CHIP, it cannot link spending to eligible individuals. Instead, it reports Medicaid spending in terms of a percentage of the area's total hospital expenditures. Similarly, because Puerto Rico operates Medicaid and CHIP through a managed care program, it only reports spending in terms of the total payments made for all Medicaid and CHIP enrollees.

[38]According to CMS officials, CMS 64 spending reports and associated payments may be adjusted up to 2 years after the end of the program year.

[39]CMS does not require officials that review insular area spending reports to follow the standard procedures outlined in its *Financial Review Guide for the Quarterly Statement of Expenditures (Form CMS-64 Report)*—the guide that CMS uses to ensure uniform and comprehensive reviews of state-reported Medicaid spending data.

[40]Specifically, the insular areas are required to attest to the accuracy of the Medicaid and CHIP data they report to CMS. By attesting to the data, insular areas confirm that they can readily provide documentation, such as provider payment invoices, to support the spending they report.

areas, as federal funds available to the insular areas are limited and the areas typically report spending in excess of their federal limits, according to officials.[41]

Although CMS officials have determined that the insular area spending reports are sufficient to justify the federal matching payments made to them, they have concerns that reports from the U.S. Virgin Islands and Puerto Rico may not reflect the full costs of their programs. For example, the U.S. Virgin Islands' preliminary spending reports for 2007 and 2008 indicate it spent several million dollars below the federal limit. CMS officials told us that they believe these spending reports may not reflect all of the insular area's payments for services eligible for Medicaid reimbursement, such as certain services that are provided to Medicaid beneficiaries by a U.S. Virgin Islands government department outside of Medicaid.[42] Similarly, CMS officials also noted that, despite rising costs, the area has not updated its Medicaid payment rate to hospitals in over a decade. As a result, the U.S. Virgin Islands' government currently uses non-Medicaid funds to pay hospitals the difference between the Medicaid rate and the actual cost they incur for providing services to Medicaid-eligible individuals.[43] However, according to a CMS official, the Virgin Island's Medicaid program cannot include these payments in its spending reports because they exceed the area's Medicaid hospital payment rate. Similarly, CMS officials told us that they also question the completeness of the 2009 quarterly spending reports received from Puerto Rico. While these reports show that the area spent enough to receive all federal funds up to the area's Medicaid limit, the reported spending is significantly lower than quarterly reports from previous years. CMS officials told us that, based on their examination of Medicaid enrollment data and the managed care costs for the area, they question whether these recent reports capture the cost of all payments for Puerto Rico Medicaid enrollees.

CPS and ACS Data Are Not Available for the Insular Areas, but Data Similar to ACS Data Could Be Collected

CPS and ACS data are not currently available for the five insular areas in our review. According to Census officials, CPS data are not collected from the insular areas because the CPS sampling method was designed to develop only national estimates. These officials further noted that it would not be feasible to collect CPS data from four of the five insular areas due to their small populations and that Puerto Rico was the only insular area with a large enough population from which it could draw a reliable CPS sample.

ACS data—demographic, socioeconomic, and housing data collected annually—are not available for all of the insular areas.[44] However, we found that Census currently collects similar data from Puerto Rico and could also do so in the other four insular areas. Census has conducted the Puerto Rico Community Survey (PRCS)—a tailored version of the ACS—annually since 2005, and according to agency officials, will include PRCS data when it

[41]Furthermore, officials noted that total federal spending in the insular areas accounts for a very small part of total federal spending on Medicaid and CHIP. They noted that due to the logistics of performing rigorous reviews, CMS determined there is limited value in conducting more thorough reviews of insular area data.

[42]A U.S. Virgin Islands' Medicaid official told us that the area is working with CMS to capture spending on these services in their spending reports.

[43]A U.S. Virgin Islands' Medicaid official told us that the area has hired a contractor to examine updating its Medicaid payment rates.

[44]The ACS is an annual survey that produces detailed demographic, socioeconomic, and housing data and will replace the decennial census long form survey beginning with the 2010 Census.

evaluates the ACS data for use in a CHIP allotment formula. Currently, Census collects data similar to ACS data for the other four insular areas once every 10 years through the decennial census. Census officials told us that it would be possible to collect the same type of data more frequently—that is, between decennial censuses—from the other four areas through surveys. However, to do so, agency officials told us they would first need to develop survey programs through which they would establish a sampling frame for each area.[45] Officials said the initial sampling frames could be developed during the 2010 Census and, if updated, could be used as a basis for future data collection in each of these areas. Census officials explained that the data from the insular areas that are similar to ACS data could be used in a CHIP allotment formula that uses, or is based on, ACS data. However, the officials also told us the agency would need additional resources to implement these types of survey programs for the other four areas. According to Census officials, it is also possible to estimate certain demographic data—not including socioeconomic and housing data—for the insular areas between decennial censuses through the agency's Population Estimates Program.[46] While Population Estimates Program data are available for the states, the District of Columbia, and Puerto Rico, they are not available for the four other insular areas in our review. According to Census officials, the agency would have to take additional steps to begin producing such estimates for these four areas.

Conclusions

To determine whether federal Medicaid and CHIP spending has been sufficient to meet the needs of the insular areas and whether the way this spending is determined—particularly the practice of capping federal spending—should be changed, policymakers can review program data as well as data on the insular areas' populations. Insular areas report program data—including spending data—to CMS, and officials there are working with the areas to improve the data and to ensure they provide a more complete reflection of program costs. In addition, Census has the opportunity to improve the availability of demographic data from the insular areas that could be used in a CHIP allotment formula. Census has identified two methods for collecting these data—developing survey programs to update demographic, socioeconomic, and housing data that are similar to ACS data, or updating only demographic data through the agency's Population Estimates Program. Regardless of the method, updated demographic data could be used to help determine future increases in federal CHIP allotments. Such data could also have broader value for federal programs in the insular areas, as policymakers could use these data to help assess the ongoing funding needs of Medicaid, CHIP, and other federal programs in the insular areas.

Recommendation for Executive Action

To improve the availability of the data that could be used in a CHIP allotment formula, we are recommending that the Secretary of Commerce direct Census to update, between decennial censuses, the demographic data for American Samoa, CNMI, Guam, and the U.S. Virgin Islands.

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[45]A sampling frame is a list of all members of a population used as a basis from which to draw a sample. According to Census officials, the method used to develop sampling frames in the insular areas differs from the method used in the states.

[46]Population Estimates Program data provide annual updates to the demographic data collected through the decennial census short form, specifically data on age, sex, race, and Hispanic origin. Population Estimates Program data were used in the fiscal year 2009 CHIP allotment formula. 2009 CHIP allotments for the insular areas were based on national estimates instead of insular area estimates.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from DOC and CMS, and the comments are reprinted in enclosures III and IV, respectively. In commenting on the draft report, DOC concurred with our recommendation, noting that regular updates of the demographic data for the insular areas would be beneficial. DOC also noted that as part of the 2010 Census, Census plans to collect detailed socioeconomic and demographic data from all five insular areas, and is prepared to develop methodologies for updating these data should funding become available. Commenting on behalf of HHS, CMS also stated its concurrence with our recommendation and noted that CHIPRA authorized additional funding for DOC to improve data collection. We amended our report to describe this additional funding.

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As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issue date. At that time, we will send copies to the Secretary of Commerce, the Secretary of Health and Human Services, the Secretary of Interior, insular area governments, and interested parties upon request. The report will also be available at no charge on GAO's Web site at http://www.gao.gov. If you or your staff have any questions regarding this report, please call me at (202) 512-7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Susan Anthony, Assistant Director; Rebecca Abela; Gerardine Brennan; Krister Friday; and Hemi Tewarson were major contributors to this report.

Sincerely yours,

Linda T. Kohn
Director, Health Care

Enclosure I

Insular Areas Federal Medicaid Funding Caps (Amount in dollars) 1998-2008

Year	American Samoa	CNMI	Guam	Puerto Rico	U.S. Virgin Islands
1998	3,010,000	1,810,000	5,090,000	167,000,000	5,260,000
1999	3,090,000	1,860,000	5,230,000	171,500,000	5,400,000
2000	3,200,000	1,930,000	5,410,000	177,500,000	5,590,000
2001	3,320,000	2,010,000	5,620,000	184,400,000	5,810,000
2002	3,470,000	2,100,000	5,880,000	192,900,000	6,080,000
2003[a]	3,727,000	2,255,000	6,321,000	207,341,000	6,537,000
2004[a]	3,947,000	2,381,000	6,683,000	219,397,000	6,913,000
2005	3,950,000	2,380,000	6,690,000	219,600,000	6,920,000
2006[b]	6,120,000	3,480,000	9,480,000	241,000,000	9,720,000
2007[b]	8,290,000	4,580,000	12,270,000	250,400,000	12,520,000
2008	8,620,000	4,760,000	12,760,000	260,400,000	13,020,000

Source: CMS.

[a]The federal amount includes funds made available through the Jobs and Growth Tax Relief Reconciliation Act of 2003.

[b]The federal amount includes funds made available through the Deficit Reduction Act of 2005.

Enclosure II

Insular Areas CHIP Allotments (Amount in dollars) 1998-2008

Year	American Samoa	CNMI	Guam	Puerto Rico	U.S. Virgin Islands
1998	128,850	118,113	375,812	9,835,550	279,175
1999	512,250	469,562	1,494,063	39,101,750	1,109,875
2000	538,650	493,762	1,571,063	41,116,950	1,167,075
2001	538,650	493,763	1,571,062	41,116,950	1,167,075
2002	396,900	363,825	1,157,625	30,296,700	859,950
2003	396,900	363,825	1,157,625	30,296,700	859,950
2004	396,900	363,825	1,157,625	30,296,700	859,950
2005	510,300	467,775	1,488,375	38,952,900	1,105,650
2006	510,300	467,775	1,488,375	38,952,900	1,105,650
2007	630,000	577,500	1,837,500	48,090,000	1,365,000
2008	630,000	577,500	1,837,500	48,090,000	1,365,000

Source: CMS.

Note: The allotments do not include reallocated CHIP funds.

Enclosure III

Comments from the Department of Commerce

UNITED STATES DEPARTMENT OF COMMERCE
The Secretary of Commerce
Washington, D.C. 20230

June 15, 2009

Ms. Linda R. Kohn
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Kohn:

Thank you for the opportunity to respond to the Government Accountability Office's (GAO) draft report entitled *Federal Medicaid and SCHIP Funding in the U.S. Insular Areas* (GAO-09-558R). Currently, the Census Bureau provides updated demographic data for the five Insular Areas through its International Data Base, and provides annually updated socioeconomic data for Puerto Rico through the Puerto Rican Community Survey (PRCS). Recently, the Census Bureau conducted a Compact of Free Association migrant survey in two of the Insular Areas—Guam and the Commonwealth of the Northern Mariana Islands—that provided limited socioeconomic and demographic data for residents of these islands. As part of the Census 2010 effort, the Census Bureau plans to collect detailed socioeconomic and demographic data from residents of the five Insular Areas in April 2010.

The Census Bureau concurs with the GAO recommendation that regularly updating demographic data for all five Insular Areas would be beneficial. For example, the Census Bureau could conduct specialized surveys like the PRCS in the remaining four Insular Areas, building from results of Census 2010. Should funding become available for such opportunities, the Census Bureau is prepared to develop methodologies for collecting these updated socioeconomic and demographic data in the Insular Areas.

Sincerely,

Gary Locke

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 2 2009

Linda Kohn
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Kohn:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: Medicaid and SCHIP: Opportunities Exist to Improve U.S. Insular Area Demographic Data That Could Be Used to Help Determine Federal Funding (GAO-09-558R).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 1 2009

TO: Barbara Pisaro Clark
Acting Assistant Secretary for Legislation
Office of the Secretary

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: "Medicaid and SCHIP: Opportunities Exist to Improve U.S. Insular Area Demographic Data That Could Be Used to Help Determine Federal Funding" (GAO-09-558R)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the subject draft report. As indicated in the report, Census officials identified two options to update demographic information for the four insular areas between decennial censuses: (1) the agency could implement survey programs to collect demographic, socioeconomic, and housing data or (2) it could update certain demographic adata through its Populations Estimates Program. CMS offers the following comment.

GAO Recommendation

To improve the availability of the data that could be used in a SCHIP allotment formula, we are recommending that the Secretary of Commerce direct Census to update, between decennial censuses, the demographic data for American Samoa, CNMI, Guam, and the Virgin Islands.

CMS Response

The CMS agrees with the GAO recommendation. Section 602 of the Children's Health Insurance Program Reauthorization Act of 2009 authorizes $20 million for Commerce to improve the Current Population Survey and American Community Survey data collection in order to produce more reliable estimates.

We appreciate the effort that went into this report and look forward to working with the GAO on this and other issues.

Attachment

(290742)