



April 2016

# MEDICAID AND CHIP

## Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts

## Why GAO Did This Study

Notable differences exist in the funding and operation of Medicaid and CHIP—joint federal-state health financing programs for low-income and medically needy individuals—in the territories versus the states. For example, the territories are subject to certain funding restrictions, such as capped annual federal funding, that are not applicable to the states. Further, certain federal requirements regarding eligibility, benefits, and program integrity do not apply to the territories' programs, and certain otherwise applicable requirements have not been enforced. In recent years, various laws—such as PPACA—have increased funding for Medicaid and CHIP in the territories.

This report examines (1) eligibility and benefit characteristics of the territories' Medicaid and CHIP programs, (2) Medicaid and CHIP spending in the territories, and (3) Medicaid and CHIP program integrity efforts in the territories. GAO reviewed laws and regulations, data on five territories' Medicaid and CHIP spending, and federal internal control standards. GAO also interviewed CMS and territory Medicaid officials.

## What GAO Recommends

GAO recommends that the Acting Administrator of CMS examine and select from a broad array of activities—such as establishing program oversight mechanisms, assisting in improving program information, and conducting program assessments—to develop a cost-effective approach to protecting territories' Medicaid programs from fraud, waste, and abuse. HHS concurred with GAO's recommendation.

## MEDICAID AND CHIP

### Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts

#### What GAO Found

Eligibility and benefits for Medicaid and the state Children's Health Insurance Program (CHIP) in five U.S. territories—American Samoa, Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico and the U. S. Virgin Islands—differ from one another and from the states, generally reflecting the territories' unique circumstances. For example, Guam is the only territory that covers all 17 mandatory Medicaid benefits, while American Samoa and Puerto Rico cover 10 of the 17 benefits. Officials from the territories that do not cover all mandatory benefits cited multiple reasons for not doing so, including limited funding and a lack of infrastructure, and, in some cases, exercised available flexibility to exclude certain benefits.

Temporary increases in federal funding have enabled the territories to increase Medicaid and CHIP spending. Unlike the states, whose Medicaid funding is not subject to a capped allotment—provided they contribute their share—territories are subject to a capped allotment, and historically have exhausted available federal Medicaid and CHIP funds each year. Most notably, the Patient Protection and Affordable Care Act (PPACA) provided the territories an additional \$7.3 billion through at least fiscal year 2019. Officials in four territories cited positive effects of the additional funding, such as the ability to enroll more providers and cover more services; however, some officials also expressed concerns about the temporary nature of the funding, noting that they may have to make program cuts once the funding is exhausted—and that future shortfalls remain a concern.

Despite temporary increases in Medicaid funding, GAO found little assurance that territory Medicaid funds are protected from fraud, waste, and abuse.

- **Program oversight mechanisms:** Only Puerto Rico has developed a program integrity unit, which, although not required, is tasked with identifying and recovering improper payments and is a management best practice. Additionally, no territory has established a Medicaid Fraud Control Unit—which identify and prosecute Medicaid fraud—or received an exemption from doing so, as required by federal law.
- **Program information:** Territories lack detail on the types and volume of services they provide, contrary to federal reporting requirements, resulting in limited information on how territories spend their federal Medicaid funding. Until recently, the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), exempted the territories from the requirement to implement a claims processing and information retrieval system with program integrity capabilities, although the U.S. Virgin Islands has established a partnership to use such a system.
- **Program assessments:** CMS has performed assessments on Medicaid program integrity effectiveness and compliance only for Puerto Rico.

Although not required, such assessments have been conducted on all states. CMS does provide technical assistance, with the activities of CMS officials varying across the territories. Officials from CMS noted that funding for program integrity would count against the territories' capped allotments. Nonetheless, such limited efforts by the territories and federal government are inconsistent with federal internal control standards regarding identifying and responding to risks, particularly in light of increased federal Medicaid spending in the territories as a result of PPACA.

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Figure 2: Selected Optional Medicaid Benefits Covered by U.S. Territories, Fiscal Year 2015

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**Abbreviations**

ASES	Administración de Seguros de Salud de Puerto Rico
CHIP	State Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FFS	fee-for-service
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services’ Office of Inspector General
HIT	health information technology
LPL	local poverty level
MBES/CBES	Medicaid Budget and Expenditure System/ State Children’s Health Insurance Budget and Expenditure System
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
OMB	Office of Management and Budget
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
RAC	recovery audit contractor
Recovery Act	American Recovery and Reinvestment Act of 2009

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April 8, 2016

The Honorable Orrin G. Hatch  
Chairman  
Committee on Finance  
United States Senate

The Honorable Lamar Alexander  
Chairman  
Committee on Health, Education, Labor, and Pensions  
United States Senate

The Honorable Fred Upton  
Chairman  
Committee on Energy and Commerce  
House of Representatives

The Honorable Joseph R. Pitts  
Chairman  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

Five territories of the United States receive federal funding through Medicaid and the state Children's Health Insurance Program (CHIP)—joint federal-state health financing programs for low-income and medically needy individuals.<sup>1</sup> The five U.S. territories are American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands. Notable differences exist in the funding and operation of the territories' Medicaid and CHIP programs as compared with the states. For example, federal law has historically established the federal matching rate for Medicaid expenditures by the territories at the lowest rate available to states, while matching rates for

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<sup>1</sup>The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) and states or territories jointly administer the Medicaid program, established in 1965, which finances health care for low-income and medically needy individuals, and the CHIP program, established in 1997, which finances health insurance for children whose household income exceeds limits for Medicaid eligibility.

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the states are determined each year based on a formula that takes into account variations in their per capita incomes. Furthermore, federal Medicaid spending in the territories is subject to an annual cap that does not apply to the states.<sup>2</sup> However, many federal Medicaid requirements that apply to states, including certain requirements related to eligibility and program integrity, do not apply to Medicaid in the territories.<sup>3</sup> In some cases, CMS has not enforced applicable requirements in the territories—such as coverage of certain mandatory benefits and establishment of certain program integrity efforts.<sup>4</sup>

In recent years, various laws have increased funding for Medicaid and CHIP in the territories. For example, the Patient Protection and Affordable Care Act (PPACA) increased the territories' capped allotments by \$6.3 billion and provided an additional \$1 billion in Medicaid funding outside of these annual allotments.<sup>5</sup> PPACA has also increased the territories' federal matching rates for Medicaid and CHIP.<sup>6</sup> Given these recent increases in program funding, members of Congress have expressed interest in understanding the role of Medicaid and CHIP in the territories and how these programs operate.

You asked us to provide information on the characteristics of the territories' Medicaid and CHIP programs, and oversight of these programs. In this report, we

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<sup>2</sup>GAO previously reported that all territories typically reached their annual Medicaid cap prior to the end of the fiscal year and that federal Medicaid per capita spending levels in the territories were significantly lower than in the states. See GAO, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75 (Washington, D.C.: Oct. 17, 2005).

<sup>3</sup>Program integrity efforts refer to oversight activities that seek to protect Medicaid and CHIP from fraud, waste, and abuse.

<sup>4</sup>American Samoa and CNMI operate their Medicaid programs under broad waiver authority under section 1902(j) of the Social Security Act, and are not subject to certain requirements that apply to Guam, Puerto Rico, and the U.S. Virgin Islands. See 42 U.S.C. § 1396a(j).

<sup>5</sup>Pub. L. No. 111-148, §§ 1323, 2005(a), 124 Stat. 119, 283 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1204(a)-(b), 124 Stat. 1029, 1055 (2010) (hereafter, "HCERA"). Hereafter, references to PPACA include any amendments made by HCERA.

<sup>6</sup>PPACA, § 2005(c), 124 Stat. at 284.

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1. describe the eligibility and benefit characteristics of the territories' Medicaid and CHIP programs;
  2. describe Medicaid and CHIP spending in the territories; and
  3. determine the extent to which Medicaid and CHIP program integrity efforts occur in the territories.

To describe the eligibility and benefit characteristics of territories' Medicaid and CHIP programs, we reviewed relevant laws, regulations, and policies. We also interviewed Centers for Medicare & Medicaid Services (CMS) officials and officials from all five territories regarding the rationale for any variation from federal requirements applicable to the states, including any recent changes in eligibility or benefits. From these officials, we also obtained information about the extent to which territories provided all mandatory Medicaid benefits and selected optional Medicaid benefits.<sup>7</sup> While all of the territories participate in CHIP, Puerto Rico is the only territory that has used CHIP funding to expand Medicaid to cover children in families with incomes above Medicaid eligibility. The remaining territories use their CHIP funds to pay for services provided to children up to the age of 19 in their Medicaid programs.<sup>8</sup> Therefore, because each of the territories operates a CHIP-funded Medicaid expansion or otherwise uses their CHIP funds to pay for Medicaid services, CHIP benefits are synonymous with Medicaid benefits in all five territories, as are eligibility levels with the exception of Puerto Rico, where eligibility levels are higher.<sup>9</sup>

To describe Medicaid and CHIP spending in the territories, we reviewed data we requested from CMS, including CMS-64 data, which provided information on Medicaid and CHIP spending in the territories from federal

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<sup>7</sup>We focused our review on optional benefits identified during our prior work examining federal health care funding in the territories. See [GAO-06-75](#).

<sup>8</sup>American Samoa, CNMI, Guam, and the U.S. Virgin Islands use their CHIP funds in this manner.

<sup>9</sup>We also analyzed the 2010 Decennial Census data for American Samoa, CNMI, Guam, and the U.S. Virgin Islands, and 2010 American Community Survey (ACS) Census data for Puerto Rico, to identify the sources of insurance coverage for territory residents. While more recent ACS data are available, 2010 is the most recent year for which Census data on health insurance status were available from all territories. The results of these analyses were often inconsistent with reliable information we had obtained on insurance coverage from other data sources, including interviews with CMS and territory officials, and were therefore excluded from this report.

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funding sources for fiscal years 2010 through 2014, the most recently available complete year of data at the time of our analysis.<sup>10</sup> Spending data from this time period allowed us to examine spending both before and after the additional PPACA funding became available. In addition, we interviewed CMS officials regarding territories' expenditure reporting and conducted extensive follow-up with CMS officials to clarify data gaps and inconsistencies we identified. We also interviewed CMS and territory officials to determine how the various federal funding sources have affected the territories' programs. To assess the reliability of CMS-64 data, we reviewed the data to identify missing information and discrepancies, and interviewed CMS and territory officials regarding the processes for collecting and verifying the data. Based on these efforts, we determined that these data sources were sufficiently reliable for the purposes of this report.

To determine the extent to which Medicaid and CHIP program integrity efforts occur in the territories, we reviewed federal laws, regulations, and policies regarding Medicaid program integrity requirements, and compared the efforts with federal internal control standards.<sup>11</sup> Because there are no separate CHIP programs in the territories, our review of program integrity efforts is limited to territories' Medicaid programs. In addition, we interviewed territory officials about their program integrity efforts, including those undertaken in coordination with federal agencies. We also interviewed CMS and territory officials, including officials from the regional offices with primary responsibility for overseeing the territories, about reasons for any incomplete reporting; applicable federal program integrity requirements; their activities regarding improper payments; and the rationale for any variation from these requirements. We also examined CMS-64 expenditure data to determine the extent to

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<sup>10</sup>States and territories submit enrollment and expenditure data to CMS by means of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program—also known as the CMS-64—within the Medicaid Budget and Expenditure System/State Children's Health Insurance Budget and Expenditure System (MBES/CBES). These expenditure data may be subject to adjustment by the territories or by CMS, and may not have been reviewed by CMS. Territories' CMS-64 expenditure data was provided by CMS on October 8, 2015.

<sup>11</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.; Sept. 10, 2014); and *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.; Nov. 1, 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.



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which territories reported service-level spending for covered benefits.<sup>12</sup> We also asked CMS officials about federal resources available to assist territories in their program integrity efforts and about other federal efforts that could provide insight on program integrity. To this end, we also reviewed the Office of Management and Budget's (OMB) A-133 single audits for each territory for fiscal year 2013 to identify findings, if any, related to Medicaid oversight including internal controls and compliance.<sup>13</sup> We also contacted HHS's Office of Inspector General (HHS-OIG) regarding any relevant program integrity efforts in the territories.<sup>14</sup>

We conducted this performance audit from May 2015 to April 2016 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.

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## Background

American Samoa, CNMI, Guam, Puerto Rico, and the U.S. Virgin Islands are five territories of the United States. With the exception of Puerto Rico,

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<sup>12</sup>We extracted service-level expenditure data from the CMS-64 net expenditures financial management report from MBES/CBES on October 13, 2015. CHIP expenditures for covered Medicaid benefits were not included in this analysis because they were often grouped into larger categories with other services and could not be isolated.

<sup>13</sup>The Single Audit Act requires states, territories, local governments, and nonprofit organizations expending more than \$500,000 in federal awards in a year to obtain an audit in accordance with requirements set forth in the act. 31 U.S.C. §§ 7501-7507. Under the OMB Uniform Guidance, this threshold increased to \$750,000 for audits of fiscal years beginning on or after December 26, 2014. See 2 C.F.R. § 200.501(a). A Single Audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the Schedule of Expenditures of Federal Awards; (2) gaining an understanding of and testing internal control over financial reporting, and the entity's compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain federal programs (i.e., the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain federal programs.

<sup>14</sup>According to HHS-OIG's 2015 work plan, it intended to determine whether each of the territories had sought an exemption regarding a specific program integrity requirement. As of September 2015, HHS-OIG officials told us they did not have an estimated date for beginning this work. Department of Health and Human Services, Office of Inspector General. *HHS OIG Work Plan, Fiscal Year 2015* (Washington, D.C.: Fiscal Year 2015).

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the populations in the territories are small relative to the states, and are generally poorer.<sup>15</sup>

Within broad federal guidelines and under federally approved plans, territories have some discretion in setting Medicaid and CHIP eligibility standards and provider payment rates; determining the amount, scope, and duration of covered benefits; and developing their own administrative structures. For example, similar to the states, unless they have obtained a waiver, the territories' Medicaid programs are required to cover certain benefits—known as mandatory Medicaid benefits—and can choose to cover additional benefits, known as optional benefits.<sup>16</sup> While the states also have similar discretion, the territories have been afforded greater flexibility, including the ability to set their own income eligibility levels for certain populations and determine income eligibility using a locally established poverty level instead of the federal poverty level (FPL).<sup>17</sup> Also like the states, territories can operate their CHIP programs as a separate program, include CHIP-eligible children in their Medicaid program, or use a combination of the two approaches.

Significant differences exist in how Medicaid and, to a lesser extent, CHIP are funded in the territories as compared with the states. For example, the federal matching rate for states' Medicaid programs, the Federal Medical Assistance Percentage (FMAP), is based on a state's per capita income in relation to the national per capita income, with poorer states receiving higher federal matching rates than wealthier states. In contrast, the Medicaid FMAP for the territories does not recognize their capacity to

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<sup>15</sup>For example, in 2014, the median household income in Puerto Rico (\$18,928) was lower than the median income in any U.S. state (\$39,680). See U.S. Census Bureau, "Median Household Income (in 2014 inflation-adjusted dollars)," *2014 American Community Survey*, accessed January 8, 2016,

<sup>16</sup>American Samoa and CNMI operate their Medicaid programs under broad waiver authority under section 1902(j) of the Social Security Act. See 42 U.S.C. § 1396a(j). Under this provision, the Secretary may waive or modify any Medicaid requirement except the following: the statutory cap on federal Medicaid funding for the territories under section 1108 of the act; the statutory Federal Medical Assistance Percentage (FMAP), which is the portion the federal government pays for Medicaid; and the requirement that federal Medicaid funds are only available for Medicaid-covered services under the act.

<sup>17</sup>For example, while state Medicaid programs are required to cover women, infants, and children under 6 with incomes up to 133 percent of the federal poverty level, the territories may adopt a lower income eligibility threshold for these populations. See 42 U.S.C. § 1396a(l)(4)(B).

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pay for program expenses. Although PPACA increased the territories' FMAP from 50 to 55 percent, this percentage is fixed at the lower end of the range available to states.<sup>18</sup> For the CHIP program, the federal government matches states' and territories' program spending at a rate higher than Medicaid, known as the enhanced FMAP. However, territories' matching rate for CHIP spending is similarly fixed at the lower end of the range available to the states.<sup>19</sup> Additionally, federal Medicaid funding in states is not subject to a limit, provided the states contribute their share of program expenditures for services provided. In contrast, federal Medicaid funding in each territory is subject to a statutory cap. In general, once their Medicaid and CHIP funding is exhausted, territories must assume the full costs of their programs.<sup>20</sup> These funding differences, along with differences in the costs of health care in the territories compared with the states, have contributed to lower federal and territory Medicaid program expenditures in the territories. For example, in the aggregate, total Medicaid expenditures in all five territories comprised less than one half of one percent of the total national Medicaid expenditures in fiscal year 2014. However, when examined separately, Puerto Rico had Medicaid enrollment and expenditures similar to some states. Specifically, in fiscal year 2014, Puerto Rico ranked 11th in Medicaid enrollment nationally and ranked 42nd in total Medicaid expenditures. Like the states, territories must report their quarterly program expenditures for Medicaid and CHIP on the CMS-64 no later than 30 days after the end of each quarter, which is used to reimburse them for their federal share of these expenditures.<sup>21</sup>

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<sup>18</sup>State regular Medicaid FMAPs range from 50 percent to 83 percent, and are determined annually based on a formula. In contrast, the Medicaid FMAP for the territories is statutorily set at 55 percent. Prior to July 1, 2011, the Medicaid FMAP for the territories was set at 50 percent.

<sup>19</sup>CHIP-enhanced FMAPs for the states have historically ranged from 65 percent to 85 percent, with the CHIP-enhanced FMAP for the territories set at 65 percent prior to July 1, 2011, and 68.5 percent effective July 1, 2011.

<sup>20</sup>Certain Medicaid expenditures in the territories are not subject to the capped Medicaid allotment. For example, expenditures for incentive payments to eligible Medicaid providers to adopt interoperable health information technology and qualified electronic health records and administrative costs relating to the provision of these payments are not subject to this cap. With respect to CHIP funding, the difference between states and territories is less pronounced, primarily because federal CHIP funding in both the states and territories is subject to an annual cap.

<sup>21</sup>See 42 C.F.R. § 430.30(c)(2015).

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In recent years, legislation to provide temporary increases in Medicaid and CHIP funding has been enacted. For example, the American Recovery and Reinvestment Act of 2009 (Recovery Act) provided the territories with a 30 percent increase in their Medicaid caps from fiscal year 2009 through the first quarter of fiscal year 2011, as well as federal matching funds to encourage Medicaid providers to undertake health information technology (HIT) initiatives.<sup>22</sup> Most recently, PPACA appropriated \$7.3 billion in additional Medicaid funding to the territories, the majority of which is available through fiscal year 2019. According to CMS officials, this funding can be used once territories expend their Medicaid and CHIP funding each year. PPACA also permanently increased territories' Medicaid FMAPs and CHIP enhanced FMAPs to 55 percent and 68.5 percent, respectively.<sup>23</sup>

Federal law generally requires state, territory, and federal entities to ensure program integrity by protecting the Medicaid and CHIP programs from fraud, waste, and abuse.<sup>24</sup> Like the states, territories have primary responsibility for such program integrity because they enroll providers,

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<sup>22</sup>Like the states, the territories are eligible for a 100 percent FMAP for incentive payments to providers to encourage adoption and use of certified electronic health record technology. Additionally, territories may qualify for a 90 percent FMAP for reasonable administrative expenses related to HIT planning and implementation activities, such as provider outreach and oversight. These federal matching funds are not subject to the annual caps on federal Medicaid spending in the territories.

<sup>23</sup>The additional PPACA funding was comprised of two separate allotments and is to be distributed among the territories based on each territory's population as a proportion of overall territory population. PPACA provided \$6.3 billion to the territories, which is available for expenditure from July 1, 2011, through September 30, 2019. PPACA provided another \$1 billion to territories not establishing a health benefit exchange under the law. Because none of the territories opted to establish such an exchange, all of the territories are eligible for these funds, which are available for expenditure from January 1, 2014, through December 31, 2019. The PPACA funding, which is in addition to the territories' capped Medicaid allotment, is subject to the territories' Medicaid FMAP.

PPACA made additional changes to the Medicaid FMAP and the CHIP enhanced FMAP. For example, under the law, all five territories were eligible for a 2.2 percent FMAP increase—from 55 percent to 57.2 percent—for calendar years 2014 and 2015, because they had expanded coverage to certain childless adults prior to the enactment of PPACA. With respect to CHIP, PPACA provides a temporary 23 percentage point increase in states' and territories' enhanced FMAPs from October 1, 2015, through September 30, 2019. During this period, the CHIP enhanced FMAPs for the states will range from 88 percent to 100 percent, and the CHIP enhanced FMAP for the territories will generally be set at 91.5 percent.

<sup>24</sup>See, e.g., 42 U.S.C. §§ 1396a(a)(69), 1396u-6.

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establish payment policies, process claims, and pay for services furnished to beneficiaries.<sup>25</sup> To execute this responsibility, territories may undertake a variety of efforts. For example, although not required, they can establish program integrity units, which are tasked with identifying and recovering improper payments. Territories, like the states, are also required to implement certain program integrity mechanisms or receive an exemption from CMS for doing so. For example, territories must establish Medicaid Fraud Control Units (MFCU), which are tasked with investigating Medicaid fraud and other health care law violations, or receive an exemption from CMS from establishing one.<sup>26</sup> The territories are also required to implement a Medicaid Management Information System (MMIS), which is a claims processing and information retrieval system that includes capabilities for reporting claims data, enrollee encounter data, and conducting pre- and post-payment review.<sup>27</sup> Such information can assist in identifying improper payments. Federal mechanisms are also available to assist in program oversight. For example, CMS can conduct comprehensive or focused program integrity reviews, which assess the effectiveness of state and territory program integrity efforts, including compliance with federal statutory and regulatory requirements. Further, through the Payment Error Rate Measurement (PERM) program, CMS requires states to estimate improper payments in the Medicaid and CHIP program to identify program vulnerabilities and actions to reduce improper payments; however, the agency has excluded the territories from this program.<sup>28</sup> Additionally, OMB's annual A-133 single audits examine internal controls and compliance deficiencies in

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<sup>25</sup>In Puerto Rico, managed care plans are responsible for enrolling providers.

<sup>26</sup>An exemption from the requirement to establish a MFCU is available if the state or territory can demonstrate to the satisfaction of the Secretary that the operation of a MFCU would not be cost effective because minimal fraud exists in the state's or territory's Medicaid program, and that beneficiaries in the state or territory will be protected from abuse and neglect without a MFCU. See 42 U.S.C § 1396a(a)(61).

<sup>27</sup>See 42 U.S.C § 1396b(r). CNMI and American Samoa have not implemented an MMIS, which is allowed under their section 1902(j) waivers.

<sup>28</sup>The PERM program was established in response to the Improper Payments Information Act of 2002. According to CMS, it has excluded the territories from the PERM program because funding for Medicaid and CHIP in the territories is "minimal," is subject to a cap, and inclusion of improper payment estimates for the territories would not have an impact on the national error rate estimates for these programs. See 69 Fed. Reg. 52620, 52623 (Aug. 27, 2014).

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certain federal programs, including Medicaid and CHIP, and can be a resource to inform program oversight.

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## Medicaid and CHIP Eligibility and Benefits Reflect the Territories' Unique Circumstances

Due to the flexibility territories have in administering their Medicaid and CHIP programs, the territories' program eligibility and benefits not only reflect their unique circumstances, but also differ from one another and from the states. For example, a notable distinction among territories' program eligibility is that Puerto Rico is the only territory that uses its CHIP funds to cover additional children in its Medicaid programs whose income levels exceed Medicaid eligibility levels. The other four territories use their CHIP funds to pay for services provided to children up to the age of 19 in their Medicaid programs. Additionally, Guam, Puerto Rico and the U.S. Virgin Islands base program eligibility on local poverty levels (LPL) that are more restrictive than federal standards, which has resulted in lower program enrollment than would otherwise be the case.<sup>29</sup>

Additionally, unlike the states and other territories, American Samoa does not determine eligibility for its Medicaid program on an individual basis. Instead, it presumes that all individuals with incomes at or below 200 percent of the FPL are eligible.<sup>30</sup> The different methods territories use to determine eligibility affect Medicaid enrollment in each territory, with the estimated percentage of territories' populations enrolled in Medicaid in fiscal year 2015 ranging from about 17 percent in the U.S. Virgin Islands to 88 percent in American Samoa. (See table 1.)

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<sup>29</sup>The 2015 LPL for an individual in Puerto Rico and the U.S. Virgin Islands was \$4,962 and \$6,581, respectively, comparatively lower than the 2015 FPL, which was \$11,770 for an individual.

<sup>30</sup>American Samoa annually estimates the number of individuals with incomes below 200 percent FPL, removing from this calculation ineligible qualified and non-qualified non-citizens who are not eligible for Medicaid, and adjusting to account for Medicare beneficiaries, to develop Medicaid and CHIP claiming percentages. These percentages are applied to all Medicaid- and CHIP-eligible services provided by the Lyndon B. Johnson Tropic Medical Center, American Samoa's only Medicaid provider.

**Table 1: Comparison of Eligibility Standards, and Enrollment for U.S. Territory Medicaid and State Children’s Health Insurance Program (CHIP), Fiscal Year 2015**

Program	American Samoa Medicaid	Commonwealth of the Northern Mariana Islands Medicaid	Guam Medicaid	Puerto Rico Medicaid	Puerto Rico CHIP	U. S. Virgin Islands Medicaid
Basis of income eligibility determination	At or below 200 percent of the federal poverty level (FPL)	At or below 150 percent of the Supplemental Security Income benefit amount	At or below 133 percent of the local poverty level (LPL)	At or below 133 percent of the LPL <sup>a</sup>	Greater than 133 percent and below 266 percent of the LPL	At or below 133 percent of the LPL <sup>b</sup>
Maximum annual income amount for an individual	\$23,540	\$13,194	\$12,369	\$6,600	\$13,200	\$8,753 and \$11,770 <sup>c</sup>
Number of enrollees <sup>d</sup>	40,515	19,076	38,482	1,322,136	88,107	23,506
Estimated percentage of total population enrolled in program	88 <sup>e</sup>	40	20		46 <sup>f</sup>	17 <sup>g</sup>

Source: GAO analysis of information from the U.S. territories and the Centers for Medicare & Medicaid Services (CMS) officials, CMS website, and Central Intelligence Agency World Factbook. | GAO-16-324

Notes: Puerto Rico is the only territory that elected to use CHIP funding to expand Medicaid to cover children in families with incomes above Medicaid eligibility. The remaining four territories use their CHIP funds to pay for services provided to children up to the age of 19 in their Medicaid programs. Therefore, we provide separate eligibility standards for Puerto Rico only.

Puerto Rico and the U. S. Virgin Islands extended Medicaid eligibility to non-elderly adults without children with incomes at or below 133 percent of the local poverty level (LPL) in January 2014 and June 2015, respectively. Given the timing of their expansions, Puerto Rico’s estimated percentage of total population enrolled in Medicaid likely reflects the expansion, while the estimated percentage in the U.S. Virgin Islands likely does not.

<sup>a</sup>Children, parents, pregnant women, and other non-elderly adults with incomes at or below 133 percent of the LPL are eligible for Medicaid. Puerto Rico also has a separate income eligibility determination process for aged and disabled individuals.

<sup>b</sup>Children, parents, and pregnant women in the U.S. Virgin Islands with incomes at or below 133 percent of the LPL are eligible for Medicaid; in contrast, residents who are aged and disabled must have incomes at or below 179 percent of the LPL to be eligible for the program.

<sup>c</sup>These are the maximum annual income amounts for children, parents, and pregnant women (at or below 133 percent of the LPL), and aged and disabled individuals (at or below 179 percent of the LPL) in the U. S. Virgin Islands, respectively.

<sup>d</sup>Dates for territory enrollment numbers vary. Specifically, enrollment data for American Samoa, CNMI, and Guam are from January 2015; data for Puerto Rico and the U.S. Virgin Islands are from December 2015. See <http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html>, accessed January 14, 2016, for the source of American Samoa, CNMI, and Guam data.

<sup>e</sup>American Samoa annually estimates the number of individuals with income below 200 percent FPL, removing from this calculation ineligible qualified and non-qualified non-citizens who are not eligible for Medicaid, to develop Medicaid and CHIP claiming percentages.

<sup>f</sup>This estimated percentage includes both Medicaid and CHIP enrollment.

<sup>g</sup>Data from the World Factbook was used to estimate the percentage of the U.S. Virgin Islands’ population enrolled in Medicaid.

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Territories also vary in terms of the range of benefits covered by their respective Medicaid programs. Specifically, Guam covers all of the 17 mandatory Medicaid benefits; CNMI and the U.S. Virgin Islands cover nearly all of the benefits; and American Samoa and Puerto Rico cover 10 of the 17 benefits.<sup>31</sup> American Samoa and CNMI operate their Medicaid programs under broad waiver authority under section 1902(j) of the Social Security Act and, therefore, are not required to cover all mandatory benefits. While the other territories do not operate under this broad waiver authority, CMS acknowledged that the agency has not required them to cover all mandatory Medicaid benefits, citing limited federal Medicaid funding and the unavailability of certain services.<sup>32</sup> Examples of the mandatory benefits most commonly covered by all five territories include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under 21; inpatient hospital services; outpatient hospital services; and physician services. In contrast, the territories' coverage of other benefits, such as nursing facility and rural health clinic services, was less widespread, and only Guam covered freestanding birth center services.<sup>33</sup> (See fig. 1.)

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<sup>31</sup>Similar to the states, territories have some discretion regarding the amount, duration, and scope of benefits covered in their Medicaid programs. For example, in some cases, territories may limit the number of services covered within a specified period of time, such as limiting eyeglasses to one pair of eyeglasses every two years and repair or replacement of broken eyeglasses to once every two years.

<sup>32</sup>See 42 U.S.C. § 1396a(j). In at least one case—coverage of freestanding birth centers in Puerto Rico—CMS approved a state plan amendment documenting that there are no licensed or approved freestanding birth centers in the territory to provide services to Medicaid beneficiaries. In addition, according to a CMS official, taking a compliance action against the territories for not covering all mandatory benefits could put the territories' federal Medicaid funding at risk.

<sup>33</sup>CNMI, Guam, Puerto Rico, and the U.S. Virgin Islands covered more mandatory Medicaid benefits in 2015 than in 2005. See [GAO-06-75](#).



**Figure 1: Mandatory Medicaid Benefits Covered by U.S. Territories, Fiscal Year 2015**

<b>Mandatory Medicaid benefit</b>	<b>Territory</b>				
	American Samoa	Commonwealth of the Northern Mariana Islands	Guam	Puerto Rico	U.S. Virgin Islands
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under 21	●	●	●	●	●
Inpatient hospital services	●	●	●	●	●
Laboratory and X-ray services	●	●	●	●	●
Medical or surgical services by a dentist	●	●	●	●	●
Outpatient hospital services	●	●	●	●	●
Physician services	●	●	●	●	●
Tobacco cessation for pregnant women	●	●	●	●	●
Family planning services	○	●	●	●	●
Federally-qualified health center services	○	●	●	●	●
Home health services for those entitled to nursing facility services	●	●	●	○	●
Non-emergency transportation to medical care	●	●	●	○	●
Certified pediatric and family nurse practitioner services	○	●	●	○	●
Nurse midwife services	○	●	●	○	●
Nursing facility services for individuals 21 or over	○	●	●	○	●
Rural health clinic services	○	●	●	●	○
Emergency services for certain legalized aliens and undocumented aliens	●	●	●	○	●
Freestanding Birth Center services	○	○	●	○	○

● Benefit covered by territory      ○ Benefit not covered by territory

Source: GAO analysis of data from territory and CMS officials. | GAO-16-324

Note: American Samoa and CNMI operate their Medicaid programs under broad waiver authority under section 1902(j) of the Social Security Act and, therefore, are not required to cover all mandatory benefits. 42 U.S.C. § 1396a(j). However, the Centers for Medicare & Medicaid Services (CMS) has not waived these requirements for Puerto Rico and the U.S. Virgin Islands. Similar to the states, territories have some discretion regarding the amount, duration, and scope of benefits covered in their Medicaid programs. For example, the U.S. Virgin Islands limits its coverage of nursing facility

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services to 25 beds. Similarly, territories may limit the number of services covered within a specified period of time.

Officials from the four territories that do not cover all mandatory Medicaid benefits cited multiple reasons for not doing so, including limited funding and a lack of infrastructure.<sup>34</sup> In particular,

- officials from Puerto Rico and American Samoa said that their programs do not cover nursing facility services due to insufficient funding and because they do not have nursing homes;<sup>35</sup>
- CNMI officials noted that its program does not cover freestanding birth center services because there are no such facilities in the territory; and
- due to the lack of available providers, certain specialty services covered by American Samoa, CNMI, and Guam are only available off-island. For example, in CNMI, most cardiac, orthopedic, chemotherapy, and radiation services are only available off-island; in Guam, pediatric oncology, hematology, dermatology, and procedures such as cardiac bypass surgery, are only available off-island.

In addition to mandatory Medicaid benefits, each territory has chosen to cover optional benefits, with all five territories providing coverage for outpatient prescription drugs, clinic services, dental and eyeglasses, prosthetics, physical therapy, and rehabilitative services. Optional services commonly covered by states—such as targeted case management, personal care services, and intermediate care facilities for individuals with intellectual disabilities—are not covered by any of the five territories. (See fig. 2.)

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<sup>34</sup>We previously reported that reliance on nursing facilities may be less prevalent in certain territories, as families assume primary care responsibility for individuals who might commonly receive care in these facilities in the states. See [GAO-06-75](#).

<sup>35</sup>In addition, according to CMS, Puerto Rico law does not regulate freestanding birth centers or nurse midwife services and, therefore, these services are not available to Medicaid beneficiaries in Puerto Rico.

**Figure 2: Selected Optional Medicaid Benefits Covered by U.S. Territories, Fiscal Year 2015**

Optional Medicaid benefit	Territory				
	American Samoa	Commonwealth of the Northern Mariana Islands	Guam	Puerto Rico	U.S. Virgin Islands
Clinic services	●	●	●	●	●
Dental services	●	●	●	●	●
Eyeglasses and prosthetics	●	●	●	● <sup>a</sup>	●
Outpatient prescription drugs	●	●	●	●	●
Physical therapy and related services	●	●	●	●	●
Diagnostic, screening, preventive and rehabilitative services	●	○	●	●	●
Hospice care	○	●	●	○	○
Inpatient psychiatric hospital services for individuals under age 21	○	○	○	●	●
Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental diseases	○	○	○	● <sup>b</sup>	●
Private duty nursing services	●	○	○	○	○
Intermediate care facility for individuals with intellectual disabilities	○	○	○	○	○
Personal care services	○	○	○	○	○
Targeted case management services	○	○	○	○	○

● Benefit covered by territory      ○ Benefit not covered by territory

Source: GAO analysis of data from territory and Centers for Medicare & Medicaid Services (CMS) officials. | GAO-16-324

Note: Similar to the states, territories have discretion regarding the amount, duration, and scope of benefits covered in their Medicaid programs. For example, territories may limit the number of services covered within a specified period of time.

<sup>a</sup>Eyeglass benefits are currently available only to children up to age 21 through the Early and Periodic Screening, Diagnostic, and Treatment benefit in Puerto Rico.

<sup>b</sup>This benefit is limited to inpatient hospital services.

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## Temporary Funding Has Enabled the Territories to Increase Medicaid and CHIP Spending, although Future Shortfalls Remain a Concern

The recent temporary increases in federal funding have enabled the territories to increase Medicaid and CHIP spending, and avoid federal funding shortfalls. Most notably, PPACA's appropriation of an additional \$7.3 billion in Medicaid funding for the territories—available for expenditure through at least fiscal year 2019—provided them flexibility in terms of when they choose to draw down the additional funds.<sup>36</sup> For example, between fiscal year 2010 when PPACA funds were not available and fiscal year 2014 when they were, the average annual percentage change in total Medicaid and CHIP spending in CNMI and Guam was 23 percent and 19 percent, respectively, with total spending in these territories more than double in fiscal year 2014 compared to fiscal year 2010.<sup>37</sup> (See table 2.)

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<sup>36</sup>The additional PPACA funding was comprised of two separate allotments and is to be distributed among the territories based on each territory's population as a proportion of overall territory population. PPACA provided \$6.3 billion to the territories, which is available for expenditure from July 1, 2011, through September 30, 2019. PPACA provided another \$1 billion to territories not establishing a health benefit exchange under the law. Because none of the territories opted to establish such an exchange, all of the territories are eligible for these funds, which are available for expenditure from January 1, 2014, through December 31, 2019. The PPACA funding, which is in addition to the territories' capped Medicaid allotments, is subject to the territories' Medicaid FMAP.

Prior to PPACA, the Recovery Act also increased Medicaid funding to the territories. From fiscal year 2010 to fiscal year 2014, Recovery Act spending on the territories' Medicaid programs totaled \$431 million, an amount significantly lower than the \$4 billion in PPACA spending the territories received during the same time period.

<sup>37</sup>Total spending amounts include federal and territory spending. Average annual percent changes are based on these amounts adjusted for inflation using the gross domestic product price index to fiscal year 2014 dollars. The increase in program spending in American Samoa and the U.S. Virgin Islands lags significantly behind that in the other territories. According to officials from both territories, the territories have accessed fewer PPACA funds, in part, because they have not been able to generate the local match to access more of these funds. Additionally, the U.S. Virgin Islands officials said because the territory did not have an electronic claims system until fiscal year 2013, they couldn't process claims fast enough to access PPACA funds until fiscal year 2014.

**Table 2: Federal and U.S. Territory Medicaid and CHIP Spending, and Average Annual Percentage Change Between Fiscal Years 2010 and 2014**

Dollars in millions						
	2010	2011	2012	2013	2014	Average annual percentage change (%)
American Samoa	\$28	33	33	28	28	-1%
Commonwealth of the Northern Mariana Islands	15	29	27	32	36	23
Guam	40	42	50	71	86	19
Puerto Rico	1,155	1,509	1,784	2,105	2,155	15
U.S. Virgin Islands	36	41	40	28	46	4

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-324

Notes: Dollar amounts presented in the table are nominal values; average annual percent changes are based on these amounts adjusted for inflation using the gross domestic product price index to fiscal year 2014 dollars.

Figures for fiscal years 2010 through 2014 include Recovery Act spending. Figures for fiscal years 2011 through 2014 include both Recovery Act and Patient Protection and Affordable Care Act spending

Prior to the availability of these temporary funds, the territories often exhausted their Medicaid funds anywhere from the first through the third quarter of each fiscal year, and generally utilized all of their CHIP funding each year. The territories used various strategies to address these federal funding shortfalls. For example, Puerto Rico officials said that prior to the PPACA funding, the federal Medicaid funds covered only 16 percent of their planned annual expenditures and were expended during the first quarter of the federal fiscal year, after which time the territory had to rely entirely on local funding to cover program spending. Further, a CNMI official said it was normal for their providers to provide services in one year and be paid the following year.<sup>38</sup> In addition to all five territories avoiding federal funding shortfalls, officials in three of the territories noted that these temporary funds have allowed them to improve their programs by covering more benefits, enrolling more providers, or both. For example, American Samoa officials said they plan to use some of their PPACA funds to pay for services provided by new providers, thereby expanding access to services beyond the island's only hospital. Puerto

<sup>38</sup>The territories have flexibility regarding when to make payments to providers as long as the territories comply with provider prompt pay requirements. According to CMS officials, in the instances when territories have been out of compliance in payment, the CMS regional offices closely monitor the situation and work with the territory to assure the delay in payments is temporary.

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Rico officials said they used some of their PPACA funds to add coverage for certain organ transplants, which, according to CMS officials, the territory must cover due to other changes in law enacted under PPACA.

Despite the influx of temporary PPACA funding, territories may nonetheless experience funding shortfalls in the near future, according to CMS and territory officials. Specifically, certain territories may exhaust their PPACA funding before the end of fiscal year 2019, as there are no restrictions on the rate at which territories may access their allotted funds. For example, CNMI and Puerto Rico, which used 49 percent and 56 percent of their allotments between fiscal years 2011 and 2015, respectively, are spending these temporary funds at a rate that could deplete their allotments early, as the amount they have spent has increased each year. (See table 3.) While the rate of expenditures to date may not reflect future spending rates, some territory officials expressed concerns about the temporary availability of the PPACA funds and the fact that their capped allotments will be reduced to pre-PPACA levels beginning in fiscal year 2019, or earlier if they expend the PPACA funds before 2019. As a result, the territory officials noted that the territories may run out of the temporary funding early, have to make program cuts once the funding is exhausted, or both. For example, Puerto Rico Medicaid officials said they determined they could exhaust their entire PPACA allotment as early as fiscal year 2017. Additionally, officials from Puerto Rico and Guam expressed concern that they may need to restrict eligibility or reduce benefits once the PPACA funding is exhausted.<sup>39</sup>

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<sup>39</sup>Under PPACA's maintenance of effort provision, to receive federal Medicaid funds, states and territories cannot impose eligibility and enrollment policies that are more restrictive than those in place at the time PPACA was enacted until 2014 for adults and until 2019 for children in Medicaid.

**Table 3: Patient Protection and Affordable Care Act (PPACA) Allotments and Expenditures in Five U.S. Territories through Fiscal Year 2015**

Dollars in millions

Territory	Total allotment	Expenditures	Percent expended (%)
American Samoa	\$198	23	12%
Commonwealth of the Northern Mariana Islands (CNMI)	109	53	49
Guam	293	87	30
Puerto Rico	6,401	3,580	56
U.S. Virgin Islands	299	32	11

Source: GAO analysis of data from Centers for Medicare & Medicaid Service officials. | GAO-16-324

Note: There are no restrictions on the rate at which territories may access their PPACA allotments, and these funds are available until at least September 30, 2019.

### Limited Territory and Federal Oversight Efforts Provide Little Assurance of Medicaid and CHIP Program Integrity

Territory and federal oversight efforts provide little assurance that the territories' Medicaid and CHIP funds are protected from fraud, waste, and abuse. Citing limited resources, territory officials acknowledge a general lack of program integrity efforts. Further, federal officials cite the territories' smaller Medicaid expenditures in limiting their program integrity efforts to technical assistance.

### Federal and Territory Officials Cite Resource Constraints as Contributing to Territories' Limited Program Integrity Efforts

Although the territories have primary responsibility for Medicaid program oversight, limited assurance exists that they are identifying and recovering improper payments or investigating fraud in their Medicaid programs. With the exception of Puerto Rico, the territories have not established program integrity units, which are dedicated to identifying and reducing improper payments. Although Medicaid agencies are not required to establish program integrity units, the lack of a separate entity is counter to internal controls standards regarding segregation of key

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duties and responsibilities for reducing the risk of error and fraud.<sup>40</sup> Specifically, in four of the territories, the Medicaid Director is responsible for program oversight, including program integrity efforts, according to CMS officials. This lack of segregation of key duties and responsibilities could be remedied through the establishment of a program integrity unit or other division of labor. According to CMS officials, the territories have not established separate program integrity units because they lack adequate funding and personnel to do so, and funds spent on such an oversight effort would reduce the amount of funds available for the provision of health care services. Further, an American Samoa official said the territory is very interested in undertaking program integrity efforts, but is unable to hire additional staff to do so because of budgetary constraints.

Although Puerto Rico has a program integrity unit, according to Puerto Rico officials, this unit's responsibilities are limited to eligibility fraud and acting as a liaison regarding concerns of provider fraud with the Administración de Seguros de Salud de Puerto Rico (ASES), the Puerto Rico government entity that manages managed care organization (MCO) contracts.<sup>41</sup> ASES delegates primary responsibility for program integrity efforts to the MCOs and requires them to have policies and procedures for the identification, investigation, and referral of suspected fraud.<sup>42</sup> Both we and the HHS-OIG have previously reported concerns that MCOs might not have an incentive to identify and recover improper payments.<sup>43</sup>

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<sup>40</sup>See, e.g., [GAO/AIMD-00-21.3.1](#) and [GAO-14-704G](#). Further, a designated entity within an organization is a leading practice for managing fraud risks. See GAO, *A Framework for Managing Fraud Risks in Federal Programs*, [GAO-15-593SP](#) (Washington, D.C.; July 28, 2015).

<sup>41</sup>Puerto Rico is the only territory of the five that uses a managed care delivery system for its Medicaid program, where payments are made to a managed care organization, typically on a pre-determined, per person, per month basis. The other four territories use a fee-for-service delivery system, where health care providers are paid for each service.

<sup>42</sup>ASES has developed *Guidelines for the Development of Program Integrity Plan*, which lists the minimum criteria for compliance with program integrity policies and procedures for MCOs. See Puerto Rico Health Insurance Administration, *Guidelines for the Development of Program Integrity Plan*, 2014-2015.

<sup>43</sup>See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, [GAO-14-341](#) (Washington, D.C.; May 19, 2014). The HHS-OIG also noted concerns from MFCUs that MCOs lacked the incentive to refer potential fraud. See also HHS-OIG, *General Medicaid Fraud Control Units Fiscal Year 2013 Annual Report*, OEI-06-13-00340 (March 2014).



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For example, as we previously reported, officials from state program integrity units noted that they believed MCOs were not consistently reporting improper payments in order to avoid appearing vulnerable to fraud and abuse.<sup>44</sup> In this same report, state program integrity unit officials also noted a potential conflict of interest for MCOs because reporting improper payments could reduce their future federal funding.

In addition to the general absence of program integrity units, none of the territories has established a MFCU—units that investigate and prosecute Medicaid fraud and other health care law violations—or obtained an exemption from the requirement to establish one from CMS.<sup>45</sup> According to CMS officials, territories have not established MFCUs because the costs associated with establishing them count against the territories' capped Medicaid allotment and would reduce the funds available for providing services. Further, Puerto Rico officials told us they had considered developing a MFCU, but decided against it after learning that the funds used to develop it would reduce funds for services. These officials said they made this decision despite knowing that a MFCU could eventually be cost effective because they believed they could not afford the initial investment.<sup>46</sup> While the establishment of a MFCU may not make sense, given the size and spending of the territories, the territories are required to demonstrate that minimal fraud exists in their programs if they do not have a MFCU.

The territories' incomplete service-level expenditure reporting also contributes to limited assurance of Medicaid program integrity in the

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<sup>44</sup>See [GAO-14-341](#).

<sup>45</sup>An exemption from the requirement to establish a MFCU is available if the state or territory can demonstrate to the satisfaction of the Secretary that the operation of a MFCU would not be cost effective because minimal fraud exists in the state's or territory's Medicaid program, and beneficiaries in the state or territory will be protected from abuse and neglect without a MFCU. See 42 U.S.C § 1396a(a)(5), (a)(61). Forty-nine states and the District of Columbia currently have MFCUs. North Dakota has received an exemption from this requirement. Officials from the U.S. Virgin Islands told us they have developed a preliminary plan to establish a MFCU.

<sup>46</sup>Although the FMAP for costs associated with establishing a MFCU is 90 percent for 3 years, any expenditures relating to the establishment and operation of a MFCU would count against the territories' capped Medicaid allotment. In the absence of a MFCU, both HHS-OIG and the Department of Justice have assisted Puerto Rico in prosecuting fraud cases, according to Puerto Rico officials; however, they noted challenges to these departments' availability in processing cases.

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territories. Specifically, the limited detail on the types and volume of services provided in the territories can hinder program integrity efforts, including making it difficult to identify potential fraud, waste, and abuse. As with states, different reporting requirements exist for fee-for-service and managed care spending in the territories. According to CMS officials, the health care delivery systems in American Samoa, CNMI, Guam, and the U.S. Virgin Islands are entirely fee-for-service, and therefore these territories are required to report service-level spending on the CMS-64. CMS officials cited the CMS-64 as the only data source for Medicaid and CHIP spending in these territories, underscoring the importance of accurate service-level expenditure reporting for territories' program integrity efforts. However, we reviewed the territories' Medicaid spending for fiscal year 2014 and found that none of the territories had reported service-level spending for all the Medicaid benefits they covered.<sup>47</sup> Specifically, for the benefits we reviewed, American Samoa, CNMI, and Guam reported service-level spending for 24 percent, 55 percent, and 63 percent, respectively, of the Medicaid benefits they covered. (See table 4.) This limited reporting is the result of various circumstances. For example, Medicaid enrollees in American Samoa are serviced by a single hospital that reports costs by only three mandatory benefits—inpatient hospital services, outpatient hospital services, and emergency services for certain legalized aliens and undocumented aliens.<sup>48</sup>

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<sup>47</sup>We also reviewed territories' reported spending for mandatory Medicaid benefits for fiscal years 2010 through 2013 and found that none of the territories reported expenditures for all covered services during this time. We extracted CMS-64 net expenditures financial management reports for fiscal years 2010 through 2014 from CMS's MBES/CBES on October 13, 2015. CHIP expenditures for covered Medicaid benefits were not included in this analysis, because they were often grouped into larger categories with other services and could not be isolated.

<sup>48</sup>American Samoa has also reported expenditures for prescription drugs for individuals enrolled in both Medicaid and Medicare—an optional benefit—on its CMS-64. According to CMS officials, although territories reported accurate aggregate expenditures in fiscal year 2014, they often included expenditures for certain covered benefits with reported expenditures for other benefits. In addition, CMS officials and a territory official cited other reasons why expenditures might not be reported for certain benefits, such as if they were not utilized in a territory in a given year.

**Table 4: Number of Covered Mandatory and Selected Optional Medicaid Benefits with Reported Service-Level Expenditures for Four U.S. Territories, Fiscal Year 2014**

Territory	Mandatory benefits (17)		Selected optional benefits (13)	
	Number of mandatory benefits covered	Number of mandatory benefits with reported service-level expenditures	Number of selected optional benefits covered	Number of selected optional benefits with reported service-level expenditures
American Samoa	10	3	7	1
Commonwealth of the Northern Mariana Islands	16	7	6	5
Guam	17	12	7	3
U. S. Virgin Islands	15	13	8	8

Source: GAO analysis of information and data from the Centers for Medicare & Medicaid Services (CMS) and the territories. | GAO-16-324

Notes: These four territories are required to report service level expenditures for non-managed care organization providers on the CMS-64. Because Puerto Rico’s Medicaid program is entirely managed care, the territory is not required to report service-level expenditures.

Medicaid enrollees in American Samoa are serviced by a single hospital that, consistent with the territory’s approved state plan, reports costs by only three mandatory benefits—inpatient hospital services, outpatient hospital services, and emergency services for certain legalized aliens and undocumented aliens.

CHIP expenditures for covered Medicaid benefits were not included in this analysis, because they were often grouped into larger categories with other services and could not be isolated.

With regard to managed care, Puerto Rico’s Medicaid managed care program, which provides coverage to all Medicaid and CHIP enrollees, is not subject to service-level reporting requirements. However, under their contracts with Puerto Rico Medicaid, the MCOs in Puerto Rico are required to submit encounter data to ASES. Although these data could provide insight on service-level utilization, CMS officials told us they do not collect or review these data on a regular basis.

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## Federal Officials Reported Making Limited Program Integrity Efforts, Citing the Small Amount of Medicaid Spending in the Territories

With regard to program oversight, CMS's general practice has been to conduct comprehensive program integrity reviews in all of the states; however, of the five territories, it has conducted such reviews only in Puerto Rico, the most recent of which was released in January 2012 and produced multiple findings.<sup>49</sup> CMS officials told us they are switching from comprehensive and more focused program integrity reviews in the states and plan to conduct such a review for Puerto Rico in 2016. Citing the other territories' smaller Medicaid expenditures, however, CMS has neither conducted similar reviews of their Medicaid programs, nor does it plan to conduct more focused program reviews. While Medicaid spending in the territories is small as a proportion of total Medicaid spending, such limited federal oversight efforts provide little assurance that Medicaid is protected from fraud, waste, and abuse, and are inconsistent with federal internal control standards regarding the identification, analysis, and response to relevant risks as part of achieving program objectives.<sup>50</sup> Given that governmental, economic, industry, regulatory, and operating conditions continually change—such as when PPACA significantly increased territory Medicaid funding—mechanisms should be provided to identify and manage any special risks prompted by such changes in program conditions.

Additionally, other factors—such as the lack of enforcement of program integrity mechanisms and information systems—have contributed to the limited federal program integrity efforts in the territories. For example, CMS has neither required the territories to establish MFCUs, nor has the agency granted them an exemption, because agency officials were unclear whether they had the authority to grant such exemptions. Additionally, until recently, CMS regulations exempted territories from the requirement to develop an MMIS, which could provide more detail on the territories' Medicaid and CHIP spending, including increasing the level of

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<sup>49</sup>In contrast, from fiscal year 2007 through fiscal year 2013, CMS has completed at least two comprehensive program integrity reviews in all states, Washington, D.C., and Puerto Rico, according to CMS officials.

Puerto Rico's 2012 review included significant findings, such as a lack of methods for identifying, investigating, and referring suspected fraud cases. Puerto Rico developed a corrective action plan in response to CMS's recommendations from this comprehensive program integrity review, and, according to CMS officials, has taken sufficient action regarding these recommendations. CMS performed a previous comprehensive program integrity review on Puerto Rico's Medicaid program in 2009.

<sup>50</sup>See [GAO/AIMD-00-21.3.1](#) and [GAO-14-704G](#).

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detail on the territories' CMS-64 reporting.<sup>51</sup> In December 2015, CMS amended its regulations to eliminate the MMIS exemptions for the territories, effective January 1, 2016.<sup>52</sup> Despite the fact that an exemption had been in place, the U.S. Virgin Islands established a partnership with West Virginia, which allowed territory officials to make use of the state's MMIS beginning in 2013.<sup>53</sup> This has improved the level of detail on the U.S. Virgin Islands' CMS-64 reporting. Specifically, in fiscal year 2012, prior to the implementation of its MMIS, the U.S. Virgin Islands reported service-level expenditures for 30 percent of the Medicaid benefits they covered; after the implementation, this percentage increased to 91 percent in fiscal year 2014.<sup>54</sup> According to Puerto Rico Medicaid officials, the territory's Medicaid agency is in the process of establishing a similar partnership with Florida and anticipates implementation by the end of 2016. Having additional details on program spending could strengthen CMS's and territories' program oversight.<sup>55</sup>

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<sup>51</sup>See 42 C.F.R. § 433.110 (2015).

CMS officials said that developing an MMIS is costly and the size of the Pacific territories' Medicaid programs may be too small to justify such an expense. Therefore, they would like to see the territories implement smaller systems instead, such as data warehouses, that would allow them to handle claims processing and provider enrollment, and identify examples of improper payments.

<sup>52</sup>See 80 Fed. Reg. 75817, 75841 (Dec. 4, 2015) (amending 42 C.F.R. § 433.110).

<sup>53</sup>According to CMS, MMIS implementation in the U.S. Virgin Islands was made possible by the Children's Health Insurance Program Reauthorization Act of 2009, which allowed for MMIS funding outside the territories' capped Medicaid allotment.

<sup>54</sup>CHIP expenditures for covered Medicaid benefits were not included in this analysis, because they were often grouped into larger categories with other services and could not be isolated.

<sup>55</sup>In addition, four of the five territories do not have access to a key federal resource that could help their program integrity efforts. Specifically, CMS's Medicaid Integrity Institute offers training and technical assistance regarding multiple aspects of program integrity—including fraud investigation, data mining, and analysis—to assist states and territories in such efforts at no cost to them. Instructors at the Medicaid Integrity Institute include state Medicaid program administrators and subject matter experts, federal and state law enforcement officers, and private consultants. According to CMS officials, the institute is intended for use by states and territories with a program integrity unit. As a result, the four territories that do not have a program integrity unit have not accessed this resource. Puerto Rico officials told us they send an individual from either Puerto Rico's Medicaid program or ASES to the institute each year.

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According to agency officials, CMS has assigned officials to the five territories to assist in program integrity efforts, and their role is generally focused on providing technical assistance.<sup>56</sup> The activities of these officials vary across the territories, ranging from resolving complaints to more proactive efforts to identify trends indicating fraud, waste, and abuse.<sup>57</sup> In addition, CMS officials reported that Puerto Rico and the U.S. Virgin Islands requested and received on-site training on the proper reporting of federal expenditures.

Other federal oversight efforts provide insight on Medicaid program integrity needs in the territories, and CMS has reported making use of these efforts. Specifically, OMB's annual A-133 single audits—conducted by contracted independent auditors—examine internal controls and compliance in the territories' programs, and have identified deficiencies in each of the territories. Examples of the findings from the 2013 single audits are listed below.<sup>58</sup>

- CNMI – the single audit found a significant deficiency in internal control over compliance. Specifically, the payments for certain Medicaid services and medications exceeded permissible amounts. This finding was resolved and closed in September 2015.
- Guam – the single audit found a material weakness in internal control over compliance. Specifically, the single audit found that no documentation was provided to show that eligibility specialists used

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<sup>56</sup>There is one official assigned to American Samoa, Guam, and CNMI, and one official assigned to Puerto Rico and the U.S. Virgin Islands.

<sup>57</sup>In addition, similar to the PERM program, according to CMS officials, CMS exempts the territories from the Recovery Audit Contractor (RAC) program, in which program under- and over-payments are identified and over-payments are recovered. See 42 U.S.C. § 1396a(a)(42)(B). According to CMS, as of September 2015, 47 states and Washington, D.C. had implemented RAC programs, but one of these states ended its RAC program when CMS approved an exception due to high managed care penetration. At the end of fiscal year 2015, four states have such exceptions due to small beneficiary populations or high managed care penetration.

<sup>58</sup>These findings included material weaknesses and significant deficiencies in internal control over compliance. A material weakness in internal control over compliance indicates there is a reasonable possibility that material noncompliance with a federal requirement will not be prevented, or detected and corrected, on a timely basis. A significant deficiency in internal control over compliance is less severe, yet important enough to merit attention by those charged with governance.

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the available income and eligibility verification system to determine eligibility. This finding was resolved and closed in February 2015.

- U.S. Virgin Islands – the single audit found a material weakness in internal control over compliance. Specifically, the audit revealed that sufficient controls did not exist for the required investigation of Medicaid utilization related to fraud. As a result, there may be prolonged, ongoing cases of fraud, which may be unreported. As of March 2015, according to CMS officials, the status of this finding was cleared, meaning that the next step is for the U.S. Virgin Islands to develop a corrective action plan for approval by CMS.

CMS has a single audit coordinator that receives the single audit reports and notifies CMS's regional offices, which are then responsible for working with the territories to correct any deficiencies that were identified.<sup>59</sup> For example, CMS regional office officials help the territories develop corrective action plans, if required. However, CMS officials noted that it is not uncommon for territories to take multiple years to resolve certain deficiencies.<sup>60</sup> CMS officials told us that the limited funding and staff created particular challenges for the territories when responding to single audit findings. For example, CNMI officials reported to CMS that the territory lacked sufficient staff to perform post-payment reviews in response to a finding from a single audit that found the territory incorrectly paid certain Medicaid claims.

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## Conclusions

The Medicaid and CHIP programs provide critical financial support to the U.S. territories' health care systems. However, citing the territories' limited resources and the relatively small size of their programs, CMS has not required the territories to follow certain program requirements. In particular, this includes requirements for complete service-level expenditure reporting and the establishment of a MFCU or the receipt of an exemption—obtained by demonstrating that the operation of such a unit would not be cost effective, because minimal fraud exists in a territory's Medicaid program. Although American Samoa and CNMI's

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<sup>59</sup>The CMS Regional Office in New York oversees Puerto Rico and the U.S. Virgin Islands, while the CMS Regional Office in San Francisco oversees American Samoa, CNMI, and Guam.

<sup>60</sup>CMS officials told us that states may also take multiple years to resolve certain deficiencies identified in single audits.

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Medicaid programs operate under broad waivers that exempt them from many of these requirements, this is not the case for Guam, Puerto Rico, and the U.S. Virgin Islands, which have not received exemptions or waivers from these requirements. Despite acknowledging the territories' limited resources, CMS provides limited assurance and oversight to support program integrity efforts in the territories, and undertakes limited efforts of its own in this regard. Such limited federal efforts in the territories are inconsistent with federal internal control standards regarding identifying and responding to relevant risks when conditions change, such as when PPACA significantly increased territories' federal Medicaid funding. Without additional efforts by CMS, there is limited assurance that territories have the capacity to identify fraud, recover improper payments, or provide complete information on program spending. While Medicaid funding to the territories represents a small share of national program expenditures and may not warrant the same level of program integrity oversight as the states, additional actions are needed by CMS to ensure an appropriate level of program integrity in these areas.

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## Recommendation for Executive Action

To ensure the appropriate level of Medicaid program integrity oversight in the territories, we recommend that the Acting Administrator of CMS reexamine CMS's program integrity strategy and develop a cost-effective approach to enhancing Medicaid program integrity in the territories. Such an approach could select from a broad array of activities, including—but not limited to—establishing program oversight mechanisms, such as requiring territories to establish a MFCU or working with them to obtain necessary exemptions or waivers from applicable program oversight requirements; assisting territories in improving their information on Medicaid and CHIP program spending; and conducting additional program assessments of program integrity as warranted.

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## Agency Comments and Our Evaluation

We provided a draft of this report to the HHS and the Department of the Interior (DOI) for comment. In its written comments, HHS concurred with our recommendation and acknowledged that many territories face challenges in addressing program integrity and finding a balance between applying funds towards providing services and program integrity efforts. Further, HHS noted that it will work with territory Medicaid officials to determine the feasibility of enhancing program integrity activities, including, but not limited to, establishing MFCUs or obtaining the necessary exemptions when MFCUs are not warranted. HHS also provided technical comments, which we incorporated as appropriate. In




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its written comments, DOI noted the financial and infrastructure challenges related to health care faced by all territories, despite the additional funding under PPACA, which is temporary, and raised concerns about future reductions in Medicaid once PPACA funds are depleted. HHS's and DOI's comments are reproduced in appendices I and II.

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As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution 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 and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions, please contact me at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix II.



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

MAR 0 4 2016

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

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts*" (GAO-16-324).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID AND CHIP: INCREASED FUNDING IN U.S. TERRITORIES MERIT IMPROVED PROGRAM INTEGRITY EFFORTS (16-324).**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS takes seriously its responsibility for the accountability, fiscal integrity, and funding of the Medicaid program.

Five territories 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 the Medicaid program and the Children's Health Insurance Program (CHIP). As the GAO noted in their report, notable differences exist in the funding and operation of the territories' Medicaid and CHIP programs as compared with the states. Federal law establishes the federal matching rate for expenditures by the territories at 55%, while matching rates for the states are determined each year based on a formula that takes into account variations in state per capita income. In addition, federal Medicaid funding in each territory is subject to a statutory cap, and once their Medicaid funding is exhausted, the territories must assume full responsibility of costs for their programs. The Affordable Care Act (ACA) increased funding for the territories; however, this increase in federal funding is set to expire in Fiscal Year (FY) 2019. To further strengthen the Medicaid program in the territories, the President's FY 2017 budget would (1) lift the cap on federal Medicaid matching payments to the territories, (2) raise the federal matching rate for Medicaid expenditures for the territories from 55% by applying the same statutory formula that applies to the States, and (3) provide additional financial incentives to modernize Medicaid programs in the territories. As the GAO also notes, total Medicaid expenditures in all five territories comprised less than one half of one percent of the total Medicaid expenditures in FY 2014.

Like states, within broad federal guidelines and under federally approved plans, territories have discretion in determining Medicaid and CHIP eligibility requirements, provider payment rates, and covered benefits. HHS works collaboratively with each territory to support a Medicaid and CHIP program that meets their unique needs and circumstances. HHS continues to identify opportunities for improving care and reducing costs for beneficiaries living in the territories. HHS recently published a final regulation providing the territories access to the Medicaid Drug Rebate program, which will help to lower prescription drug costs in Medicaid. In addition, HHS has provided technical assistance to the territories on federal funding reimbursement; developing a data system to help reduce fraud and abuse; and providing guidance on eligibility requirements, coverage of services, and reimbursement methodologies. In addition, HHS provides ongoing guidance on Medicaid program operations in the territories and assistance on implementing provisions of the ACA.

HHS also collaborates with the territories to eliminate fraud, waste, and abuse. However, given the limited funding and personnel, many territories still face challenges in addressing Medicaid program integrity. In order to assist territories, HHS assigns officials to the territories to assist in program integrity efforts. The activities of the HHS officials vary across the territories depending on needs and range from resolving complaints to identifying trends indicating fraud, waste and abuse. Territories are also required to conduct single audits, and HHS works with the territories to help them resolve the audit findings that are related to HHS programs.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID AND CHIP: INCREASED FUNDING IN U.S. TERRITORIES MERIT IMPROVED PROGRAM INTEGRITY EFFORTS (16-324).**

**GAO Recommendation:**

To ensure the appropriate level of Medicaid program integrity oversight in the territories, GAO recommends that the Acting Administrator of CMS reexamine CMS' program integrity strategy and develop a cost-effective approach to enhancing Medicaid program integrity in the territories. Such an approach could select from a broad array of activities, including – but not limited to – establishing program oversight mechanisms such as requiring territories to establish a Medicaid Fraud Control Unit or working with them to obtain the necessary exemptions or waivers from the applicable program oversight requirements; assisting territories in improving their information on Medicaid and CHIP program spending; and conducting additional program assessments of program integrity where warranted.

**HHS Response:**

HHS concurs with this recommendation. Given the limited funding and personnel, many territories still face challenges in addressing Medicaid program integrity and they must work to find a balance between applying funds to providing services and program integrity efforts. However, HHS is actively working with territories to strengthen program integrity. HHS will work with Medicaid officials in the territories to determine the feasibility and potential effectiveness of enhancing program integrity activities, including but not limited to, establishing Medicaid Fraud Control Units (MFCU) or by obtaining the necessary justifications from the territory that a MFCU is not warranted. We appreciate the effort that went into this report and look forward to working with the GAO on this and other issues.

# Appendix II: Comments from the Department of the Interior



United States Department of the Interior

OFFICE OF THE SECRETARY  
Washington, DC 20240



MAR - 2 2016

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

Dear Ms. Yocom:

Thank you for providing the Department of the Interior (Department) the opportunity to review and comment on the draft Government Accountability Office (GAO) report entitled, *MEDICAID AND CHIP Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts* (GAO-16-324). The Department's Office of Insular Affairs (OIA) carries out its administrative responsibilities for coordinating Federal policies within four U.S. territories, namely American Samoa, Commonwealth of the Northern Mariana Islands, Guam and the U.S. Virgin Islands. The OIA has reviewed the report and makes the following comments.

The report contains useful information about the Department of Health and Human Services' (HHS) programs and the oversight responsibilities of the programs by the Centers for Medicare and Medicaid Services (CMS). Moreover, the report highlights the financial and infrastructure challenges related to health care faced by all five of the U.S. territories, despite the temporary boost in funding provided by the Patient Protection and Affordable Care Act (PPACA). However, without a more permanent increase in the financial assistance levels through Federal programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), health services programs in the territories will likely be reduced when the PPACA funds are depleted.

The OIA has been in discussion with leadership of the four U.S. territories and HHS regarding Federal assistance for Medicaid and Medicare programs and is aware that HHS is also holding discussions with the leadership of Puerto Rico. We are hopeful that solutions to address the severe challenges to providing basic and critical health services for the U.S. territories will be found. The solutions to the challenges will include improvements in fiscal and operational management in the U.S. territories, acceptable alternatives on how the programs are administered in line with HHS' policies and applicable Federal regulations and, as necessary, pursuing amendments to existing law or new legislation.

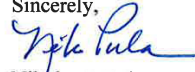
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**Appendix II: Comments from the Department  
of the Interior**

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If you have any questions, please feel free to communicate with me directly at (202) 208-4709 or with Mr. Basil Ottley, Director of Policy for OIA at (202) 208-5655.

Sincerely,



Nikolao I. Pula  
Director  
Office of Insular Affairs

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# Appendix III: GAO Contact and Staff Acknowledgements

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## GAO Contact

Carolyn L. Yocom, (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff Acknowledgements

In addition to the contact named above, Susan Anthony, Assistant Director; Manuel Buentello; Sandra George; Giselle Hicks; Drew Long; Amber Sinclair; and Teresa Tam made key contributions to this report.

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