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September 24, 2021

The Honorable Patty Murray
Chair
The Honorable Roy Blunt
Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Rosa L. DeLauro
Chair
The Honorable Tom Cole
Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
House of Representatives

Medicare Physician Services: Payment Rates, Utilization, and Expenditures of Selected Services in Alaska, Hawaii, and the U.S. Territories

Medicare eligibility is the same across the United States, including the noncontiguous states—Alaska and Hawaii—and the U.S. territories—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands. Individuals can be eligible for Medicare under several circumstances, including being age 65 and older, having a disability, or having certain conditions, such as end-stage renal disease (ESRD). Medicare's traditional fee-for-service (FFS) program, within Part B, covers such services as office visits, surgical procedures, and a broad range of diagnostic and therapeutic procedures performed by physicians and other health care professionals such as nurse practitioners, physician assistants, and physical therapists.[1] In 2019, approximately 38.6 million beneficiaries were enrolled in the Medicare FFS program.

The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), pays for such services under the Medicare Physician Fee Schedule. CMS determines payment rates for these services based on estimates that the agency assigns to each service. These estimates reflect the time and intensity of provider work, practice expenses (e.g., cost of non-provider labor or office rent), and malpractice premiums needed to provide one service relative to other services. To account for a provider's geographic location, which affects the cost of providing care, CMS separately adjusts the estimates for each Medicare payment locality.[2]

[1]Other parts of the Medicare program cover other services. Specifically, Medicare Part A covers services such as inpatient care, such as hospital admissions. Medicare Part C—known as Medicare Advantage (MA), Medicare's private health insurance alternative—covers services of Part A, Part B, and Part D, which covers prescription drug benefits. The Medicare Part B program also covers other services such as durable medical equipment, and it pays hospitals for certain drugs that beneficiaries receive as part of their treatment in hospital outpatient departments.

[2]Localities are the geographic areas defined by CMS that the agency uses to adjust payments under the Medicare Physician Fee Schedule. Currently there are 112 payment localities, which include 34 statewide areas (that is, one

Certain state and territory stakeholders have raised questions about payment rates under the Medicare Physician Fee Schedule for Alaska, Hawaii, and the U.S. territories. Specifically, they have noted that payment rates might not take into account the unique characteristics of these states and territories. For example, Alaska has large rural areas, while Hawaii and the U.S. territories are islands—geographic characteristics that may affect the delivery and cost of health care. Although eligibility for Medicare does not vary across the United States, the proportion of Medicare beneficiaries by reason for eligibility may vary.

House Report 116-62 includes a provision for us to examine Medicare funding for Alaska, Hawaii, and the U.S. territories.[3] In this report, we describe

1) demographic and other key characteristics of Medicare Part B FFS beneficiaries in Alaska, Hawaii, and the U.S. territories; and
2) payment rates, utilization, and expenditures under the Physician Fee Schedule across these states and territories.

To describe demographic and other key characteristics of Medicare Part B FFS beneficiaries in Alaska, Hawaii, and the U.S. territories, we analyzed CMS's Master Beneficiary Summary File data from calendar year 2019—the most recent year of data available at the time of our review—to determine the number of beneficiaries who were enrolled in Medicare Part B FFS at any time in 2019. We used these data to describe Medicare beneficiaries in these states and territories by characteristics such as reason for Medicare eligibility and prevalence of the 10 most common chronic conditions nationally.[4] (For more detail on our data and methods, see enclosure I.)

To describe payment rates, expenditures, and utilization under the Physician Fee Schedule for Alaska, Hawaii, and the U.S. territories, we selected 12 services that each accounted for at least $950 million in Medicare expenditures in 2019.[5] Collectively, these 12 services accounted for about $26.5 billion in Medicare Physician Fee Schedule expenditures in 2019.[6] We used the Medicare Physician Fee Schedule Search Tool to determine payment rates that reflect adjustments for our states and territories for the 12 selected services and compared them to the

locality for the entire state). Four localities exist across Alaska, Hawaii, and the U.S. territories: one locality each for Alaska, Puerto Rico, and the U.S. Virgin Islands and another locality that comprises Hawaii, American Samoa, CNMI, and Guam.

[3]H.R. Rep. No. 116-62, at 140 (2019). This House report was to accompany the bill providing appropriations for the Department of Health and Human Services for fiscal year 2020. See H.R. 2740, 116th Cong. (2019).

[4]The 10 most common chronic conditions among beneficiaries enrolled in Part A and Part B FFS beneficiaries nationally in 2017 were high blood pressure, high cholesterol, arthritis, coronary artery disease, diabetes, depression, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and Alzheimer's disease/dementia.

[5]Providers bill Medicare for their services using various five-digit billing codes, based in part on codes developed by an American Medical Association (AMA) panel. Specifically, the AMA's Current Procedural Terminology panel maintains and updates a list of billing codes that CMS adopts for use. CMS refers to these codes as Level I Healthcare Common Procedure Coding System (HCPCS) codes. CMS also develops codes for other services or items for which Medicare reimburses providers, such as ambulance services, medical equipment, and supplies; CMS refers to these codes as Level II HCPCS codes.

[6]The 12 services represented approximately 35.7 percent of the $74.2 billion in Medicare Physician Fee Schedule expenditures in 2019. We selected the 12 services with the most expenditures for which we could determine Medicare expenditures paid under the Physician Fee Schedule.

national payment amount—the amount with no geographic adjustment. [7] Medicare pays a different rate for certain services based on the setting in which they are provided (facility setting, such as a hospital, or a non-facility setting, such as a provider's office). For the six selected services that have two payment rates—facility and non-facility—we compared non-facility rates to the national payment rate, as non-facility settings are the most common setting for these services. We then calculated per beneficiary Medicare utilization and expenditures for these selected services in Alaska, Hawaii, and each territory and compared them to national per beneficiary utilization and expenditures. We examined the reliability of the claims data used in this report by performing appropriate electronic checks and checks for obvious errors such as values outside of expected ranges. We determined that these data were sufficiently reliable for the purposes of our analyses.

We conducted this performance audit from July 2020 to September 2021 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.

Background

Alaska, Hawaii, and the U.S. territories are distinctive from one another and the remaining U.S. states in terms of geography, population, and income levels. Each of these states and territories is geographically remote—both far from each other and the U.S mainland, and travel within each may be hampered by a lack of roads or the need to travel by airplane or boat to reach health care providers. The populations of these states and territories varied considerably in 2019, ranging from nearly 50,000 in CNMI, to about 3.2 million in Puerto Rico. While Alaska and Hawaii had median household incomes above the national median, the U.S. territories were generally poorer.[8] Additionally, the U.S. territories are vulnerable to national disasters such as hurricanes, typhoons, and earthquakes, which can cause long-term damage to infrastructure.[9] Together, these differences can present challenges in the delivery of health care to residents of Alaska, Hawaii, and the U.S. territories.

Across Alaska, Hawaii, and the U.S. territories the number of beneficiaries enrolled in Medicare Part B—including Part B FFS and MA—at any time during 2019 ranged from 2,104 beneficiaries in CNMI to 665,665 beneficiaries in Puerto Rico. Medicare Part B beneficiaries may enroll in Part B FFS or MA. Almost all beneficiaries in Alaska, American Samoa, CNMI, Guam, and the

[7]Centers for Medicare & Medicaid Services, *Overview of the Medicare Physician Fee Schedule Search*, accessed May 18, 2021, https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

[8]In 2019, the median household income nationally was $65,712, while Hawaii and Alaska had higher median household incomes—$83,102 and $75,463, respectively. In contrast, Puerto Rico's median household income in 2019 ($20,474) was significantly lower than any U.S. state (the lowest median income of any state was Mississippi, $45,792). See U.S. Census Bureau, *Household Income: 2019*, American Community Survey Briefs, ACSBR/20-03 (Washington, D.C.: September 2020).

[9]In September 2017, Hurricanes Irma and Maria struck Puerto Rico and the U.S. Virgin Islands, severely damaging the territories' infrastructure. Additionally, American Samoa, CNMI, and Guam have experienced natural disasters that caused significant destruction. Tropical Cyclone Gita hit American Samoa in February 2018, Super Typhoon Mangkhut struck Guam and CNMI in September 2018, and Super Typhoon Yutu made landfall in CNMI in October 2018.

U.S. Virgin Islands were enrolled in Part B FFS, while Puerto Rico and Hawaii have considerable MA populations.[10] For additional information, see enclosure II.

Medicare Part B Fee-For-Service Populations in Alaska, Hawaii, and the U.S. Territories

Our analysis of CMS data shows that Medicare Part B FFS populations in Alaska, Hawaii, and the U.S. territories varied considerably in comparison with each other and the national Part B FFS population in terms of size, the number of beneficiaries dually eligible for Medicaid, and key demographics, including Medicare eligibility category, age, and race and ethnicity.[11] Considerable variation also existed in prevalence rates for select chronic conditions among these states and territories. For additional information, see enclosure II.

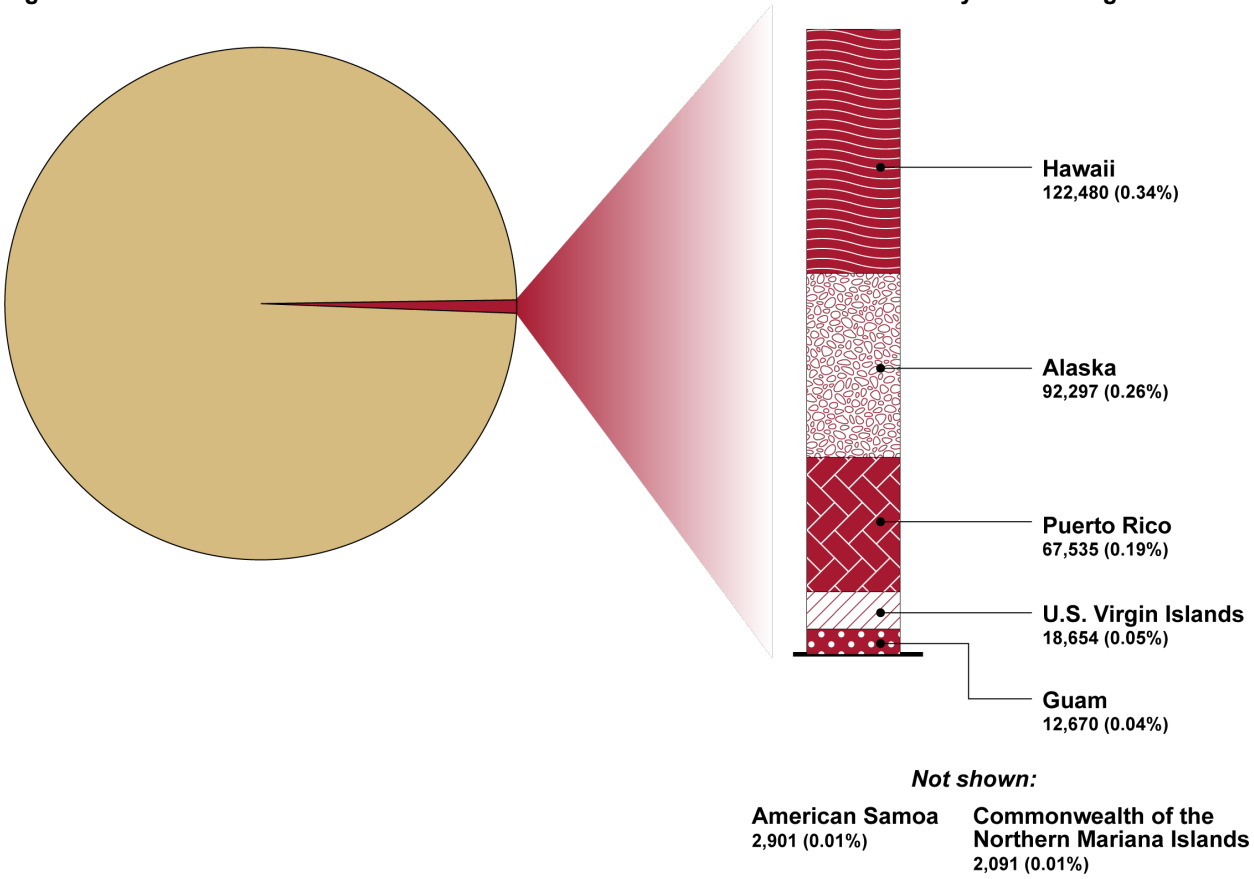
Medicare Part B FFS beneficiaries. CMS data show that nearly 36 million beneficiaries were enrolled in Medicare Part B FFS nationally at any time during 2019.[12] Of these beneficiaries, less than 1 percent (0.9 percent; 318,628 beneficiaries) resided in Alaska, Hawaii, and the U.S. territories, ranging from 2,091 in CNMI to 122,480 beneficiaries in Hawaii. (See fig. 1.)

[10]No MA plans operate in Alaska, American Samoa, CNMI, Guam, or the U.S. Virgin Islands.

[11]Dual-eligible beneficiaries are Medicare beneficiaries also enrolled in the Medicaid program in their state or territory.

[12]Enrollment status may change during the year; for example, a beneficiary may change from FFS to MA. Medicare Part B FFS enrollment includes beneficiaries enrolled in Part B FFS for at least 1 month during 2019.

Figure 1: Number of Beneficiaries Enrolled in Medicare Part B Fee-For-Service at Any Time during 2019



Source: GAO analysis of Centers for Medicare & Medicaid Services' Master Beneficiary Summary File data. | GAO-21-607R

Nationally, 21.1 percent (7,592,454) of beneficiaries enrolled in Medicare Part B FFS at any time during 2019 were dually eligible for Medicaid. In contrast, among Hawaii and the U.S. territories, the proportion of beneficiaries enrolled in Medicare Part B FFS and dually eligible for Medicaid at any time during 2019 ranged from 0.9 percent (108 beneficiaries) in Guam, to 13.6 percent (16,717) in Hawaii. Alaska had a higher proportion with nearly 22.5 percent (20,792) of beneficiaries enrolled in Medicare Part B FFS and dually eligible for Medicaid at any time during 2019.

Medicare eligibility categories. In 2019, most Part B FFS beneficiaries nationally were eligible because they were age 65 or older (85.1 percent), followed by beneficiaries eligible due to a disability (14.6 percent), and beneficiaries with ESRD (0.3 percent). Across Alaska, Hawaii, and the U.S. territories, the proportion of Part B FFS beneficiaries

- eligible because they were age 65 or older ranged from 71.9 percent in American Samoa to 92.4 percent in the U.S. Virgin Islands;
- eligible due to a disability ranged from just over half the national rate in the U.S. Virgin Islands (7.4 percent) to 26.3 percent in American Samoa; and

- eligible due to ESRD in Guam was over eight times (2.5 percent) the national proportion of 0.3 percent. Alaska had a proportion of 0.2 percent, and Puerto Rico's proportion was 1.4 percent.

Age. Nationally, in 2019, 14.9 percent of Medicare Part B FFS beneficiaries were age 64 and under, 47.5 percent were age 65 through 74, and 37.5 percent were age 75 and above.[13] Among Alaska, Hawaii, and the U.S. territories, the proportion of Medicare Part B FFS beneficiaries

- age 64 and under ranged from 7.6 percent in the U.S. Virgin Islands to 28.1 percent in American Samoa;
- age 65 through 74 ranged from 42.8 percent in Puerto Rico to 57.7 percent in CNMI; and
- age 75 and above ranged from 23.3 percent in American Samoa to 41.1 percent in the U.S. Virgin Islands.

Race and ethnicity. Nationally, 77.6 percent of Part B FFS beneficiaries were non-Hispanic White, which is similar to Alaska where 74.1 percent of beneficiaries were non-Hispanic White. In contrast, nearly all of Puerto Rico's Medicare Part B FFS beneficiaries were Hispanic (98.3 percent), the largest proportion of Medicare Part B FFS beneficiaries in American Samoa were Asian/Pacific Islanders (78.3 percent), and in the U.S. Virgin Islands, the largest proportion of Medicare Part B FFS beneficiaries were Black (71.8 percent).

Prevalence of selected chronic conditions. For this analysis, we selected the 10 most common chronic conditions nationally in 2017 based on the percentage of beneficiaries enrolled in both Part A and Part B FFS with the chronic condition.[14] While Alaska and Hawaii's prevalence rates were largely lower than the national rate for each of the chronic conditions we examined, in some cases the territories had prevalence rates that were considerably higher relative to national rates. For example, for diabetes, the national prevalence rate was 33.5 percent, while the territories' prevalence rates ranged from 42.8 percent in the U.S. Virgin Islands to 55.6 percent in Puerto Rico. Alaska, Hawaii, and the U.S. territories had lower prevalence rates for four of the 10 chronic conditions, compared to the national rates: high blood pressure, arthritis, depression, and chronic obstructive pulmonary disease. In some instances the prevalence rates were considerably lower than the national rates. For example, for depression, American Samoa's rate was the lowest (4.8 percent), followed by Guam (6.2 percent), CNMI (7.6 percent), and the U.S. Virgin Islands (9.8 percent). The national prevalence rate was 34.3 percent.

[13]Certain individuals under age 65 can qualify for Medicare based on a disability.

[14]The 10 most common chronic conditions among beneficiaries enrolled in Part A and Part B FFS nationally in 2017 were high blood pressure, high cholesterol, arthritis, coronary artery disease, diabetes, depression, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and Alzheimer's disease/dementia. A Medicare beneficiary is considered to have a chronic condition if CMS's data include a claim indicating that the beneficiary received a service or treatment for the specific condition. Chronic conditions are identified by diagnosis codes on the Medicare claims, and beneficiaries may have more than one chronic condition.

Alaska, Hawaii, and U.S. Territories' Medicare Payment Rates Were Higher for Selected Services than National Rates, while Utilization and Expenditures Were Generally Lower

Our analysis of CMS data shows that payment rates for 12 selected services under the Medicare Physician Fee Schedule varied considerably across Alaska, Hawaii, and the U.S. territories but they were consistently higher than national payment rates in 2019.[15] (See tables 1 and 2.) Specifically, payment rates in Alaska were considerably greater—from about 28 percent to about 39 percent—than the national payment rates. Payment rates in Hawaii and the U.S. territories were largely somewhat greater—from less than 1 percent to about 6 percent—than the national payment rates for services with one payment rate we examined.[16] These results were consistent across the six of the 12 selected services, which have one payment rate for either facility or non-facility settings. For further information on payment rates, see enclosure III.

Table 1: Comparison of Payment Rates in Alaska, Hawaii, and U.S. Territories to National Payment Rates for Selected Services with One Rate under the Medicare Physician Fee Schedule, 2019

Description and Healthcare Common Procedure Coding System Codes	National payment amount	Percent difference from national payment amount			
		Alaska	Hawaii, Am. Samoa, CNMI, Guam	Puerto Rico	U.S. Virgin Islands
Initial hospital care—high complexity (99223)	$205.42	35.6	2.2	0.1	0.1
Emergency department visit—high complexity (99285)	$176.23	38.5	-0.5	0.03	0.03
Annual wellness, subsequent visit (G0439)	$118.21	28.0	6.3	0.3	0.3
Subsequent inpatient hospital care—high complexity (99233)	$105.60	35.9	2.2	0.1	0.1
Subsequent inpatient hospital care—moderate complexity (99232)	$73.88	35.7	2.2	0.1	0.1
Therapeutic exercises (97110)	$31.35	30.6	5.9	0.3	0.3

Legend: Am. Samoa and CNMI = American Samoa and the Commonwealth of the Northern Mariana Islands.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule payment rates in 2019. | GAO-21-607R

Note: For the above services, Medicare has a payment rate for either facility settings (such as hospitals) or non-facility settings such as physicians' offices. CMS determines payment rates for Physician Fee Schedule services based on estimates of the cost to provide a service relative to other services, including the time and intensity of provider work, practice expenses (e.g., cost of non-provider labor or office rent), and malpractice premiums. CMS separately adjusts these estimates to account for providers' geographic location for each Medicare payment locality. The national payment amount does not reflect any geographic adjustments. Centers for Medicare & Medicaid Services, *Overview of the Medicare Physician Fee Schedule Search*, accessed May 18, 2021, https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

Medicare payment rates for our remaining selected services also varied considerably for Alaska, Hawaii, and the U.S. territories and were also consistently higher than national payment rates in 2019. The remaining six services in our review have different rates, depending on the setting in which the service is performed, and we focused on non-facility payment rates because these services were primarily delivered in non-facility settings in 2019. Specifically, non-facility payment rates in Alaska ranged from about 26 percent to 30 percent greater than the national

[15]"National payment rates" refers to the national payment amount—the Medicare payment rate with no geographic adjustment. We compared payment rates in Alaska, Hawaii, and the U.S. territories that reflect locality adjustments to national payment rates.

[16]For one service—emergency department visit, high complexity—the payment rate for American Samoa, CNMI, Guam, and Hawaii was 0.5 percent below the national payment rate (see table 1).

payment amount across five of these services. (See table 2.) In contrast, non-facility payment rates in Hawaii and the U.S. territories were slightly higher than the national payment amount.

Table 2: Comparison of Non-facility Payment Rates in Alaska, Hawaii, and the U.S. Territories to National Payment Rates for Selected Services under the Medicare Physician Fee Schedule, 2019

Description and Healthcare Common Procedure Coding System Codes	National payment amount	Percent difference from national payment amount			
		Alaska	Hawaii, Am. Samoa, CNMI, Guam	Puerto Rico	U.S. Virgin Islands
Office/outpatient evaluation and management visit, new patient—moderate complexity (99204)	$166.86	29.9	4.6	0.3	0.3
Office/outpatient evaluation and management visit, established patient—high complexity (99215)	$147.76	29.9	5.2	0.3	0.3
Eye exam and treatment, established patient (92014)	$128.66	26.2	7.9	0.4	0.4
Office/outpatient evaluation and management visit, established patient—moderate complexity (99214)	$110.28	29.1	5.8	0.3	0.3
Office/outpatient evaluation and management visit, established patient—low complexity (99213)	$75.32	28.1	6.1	0.3	0.3

Legend: Am. Samoa and CNMI = American Samoa and the Commonwealth of the Northern Mariana Islands.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule payment rates in 2019. | GAO-21-607R

Notes: CMS determines payment rates for Physician Fee Schedule services based on estimates of the cost to provide a service relative to other services, including the time and intensity of provider work, practice expenses (e.g., cost of non-provider labor or office rent), and malpractice premiums. CMS separately adjusts these estimates to account for providers' geographic location for each Medicare payment locality. The national payment amount does not reflect any geographic adjustments. Centers for Medicare & Medicaid Services, *Overview of the Medicare Physician Fee Schedule Search*, accessed May 18, 2021, https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

For the above five services, Medicare has different payment rates for facility settings (such as hospitals), and non-facility settings such as physicians' offices. At least 79 percent of the above services were performed in non-facility settings across these states and territories in 2019. In contrast, at least 96 percent of critical care, first hour services—the remaining selected service with two payment rates—were performed in facility settings across states and territories. Comparisons of this service's facility payment rates to national payment rates were similar to the above results.

Per beneficiary utilization rates for selected services were typically lower in Alaska, Hawaii, and the U.S. territories than national per beneficiary utilization rates (see table 3).[17]

- Office/outpatient evaluation and management visits: Alaska, Hawaii, and the territories all had lower utilization than the national rate of 6.1, ranging from 1.1 services per beneficiary in American Samoa to 5.6 in Hawaii.
- Inpatient evaluation and management hospital care: these states and territories had lower per beneficiary utilization compared to the national per beneficiary utilization of 2.2 services per beneficiary, ranging from 0.8 in American Samoa to 1.5 in Puerto Rico.

[17]Some differences in per beneficiary utilization may be attributable to differences in population demographics and access to certain services.

Table 3: Per Beneficiary Utilization of Selected Services under the Medicare Physician Fee Schedule, National, Alaska, Hawaii, and U.S. Territories, in 2019

Services	United States, DC, U.S territories	Alaska	American Samoa	Commonwealth of the Northern Mariana Islands	Guam	Hawaii	Puerto Rico	U.S. Virgin Islands
Office/outpatient evaluation and management services[a]	6.1	4.6	1.1	2.6	3.9	5.6	4.7	3. 7
Inpatient evaluation and management hospital care[a]	2.2	1.2	0.8	0.9	1.2	1.2	1.5	1.3
Eye exam and treatment, established patient	0.4	0.2	0.1	0.3	0.3	0.5	0.1	0.6
Emergency department visit—high complexity	0.3	0.3	0.1	0.0	0.1	0.3	0.0	0.1
Critical care, first hour	0.2	0.1	0.1	0.1	0.1	0.2	0.1	0.1
Therapeutic exercises	1.0	0.9	0.1	0.4	0.2	1.0	0.6	1.0
Annual wellness, subsequent visit	0.2	0.1	0.0	0.0	0.1	0.1	0.0	0.1

Source: GAO analysis of Centers for Medicare & Medicaid Services claims data. | GAO-21-607R

Notes: We selected 12 Physician Fee Schedule services each totaling at least $950 million in Medicare expenditures in 2019.

Some differences in per beneficiary utilization may be attributable to differences in demographics and access to certain services.

[a]Evaluation and management services generally include patient consultations, examinations, and coordination of care among providers. Office/outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS, 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

Our analysis of CMS data shows that expenditures associated with selected Physician Fee Schedule services varied widely across Alaska, Hawaii, and the territories. All had lower—in certain territories, considerably lower—per beneficiary expenditures compared to national per beneficiary expenditures in 2019.[18] Specifically, per beneficiary expenditures for all 12 selected services in the states and territories we examined ranged from approximately $183 per beneficiary in American Samoa to about $627 per beneficiary in Alaska, compared to $735 in national per beneficiary expenditures. (See table 4.)

- Of selected services, office/outpatient evaluation and management services had the highest per beneficiary expenditures for states, U.S. territories, and nationally in 2019. Specifically, they ranged from about $74 per beneficiary in American Samoa to about $364 per beneficiary in Alaska.
- Per beneficiary expenditures were lower for inpatient evaluation and management services in Alaska, Hawaii, and U.S. territories than national per beneficiary expenditures. In contrast, per beneficiary expenditures for therapeutic exercises were higher than national per beneficiary expenditures in Alaska, Hawaii, and the U.S. Virgin Islands.

[18]Selected services represented a range of Part B FFS expenditures for Alaska, Hawaii, and U.S territories in 2019, from about 23.1 percent in Alaska and CNMI to about 28.9 percent in Hawaii. Some differences in per beneficiary expenditures may be attributable to differences in population demographics and access to certain services.

Table 4: Per Beneficiary Expenditures for Selected Services under the Medicare Physician Fee Schedule, National, Alaska, Hawaii, and U.S. Territories, in 2019 (in dollars)

Services	United States, DC, U.S territories	Alaska	American Samoa	CNMI	Guam	Hawaii	Puerto Rico	U.S. Virgin Islands
Office/outpatient evaluation and management services[a]	399.63	363.75	73.86	145.92	254.94	348.10	267.98	246.68
Inpatient evaluation and management care[a]	174.25	110.71	66.44	101.71	95.36	98.22	147.88	109.03
Eye exam and treatment, established patient	29.77	17.90	5.44	21.15	21.68	43.53	9.39	46.72
Emergency department visit—high complexity	42.47	52.68	13.96	4.23	9.23	31.53	4.64	12.33
Critical care, first hour	28.95	21.85	14.71	18.00	25.33	29.29	19.16	23.27
Therapeutic exercises	33.53	48.34	4.20	12.71	9.89	45.14	15.30	41.39
Annual wellness, subsequent visit	26.40	12.22	4.71	1.62	6.38	14.34	2.66	14.90
Total per beneficiary expenditures for select services	**735.00**	**627.45**	**183.33**	**305.35**	**422.80**	**610.16**	**467.02**	**494.32**

Source: GAO analysis of Centers for Medicare & Medicaid Services claims data. | GAO-21-607R

Note: We selected 12 Physician Fee Schedule services each totaling at least $950 million in Medicare expenditures in 2019.

[a]Evaluation and management services generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services above include four selected services: new patient services (Healthcare Common Procedure Coding System—HCPCS, 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include three selected services: initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

Agency Comments:

We provided a draft of this report to HHS for review and comment. HHS provided us with technical comments, which we incorporated as appropriate.

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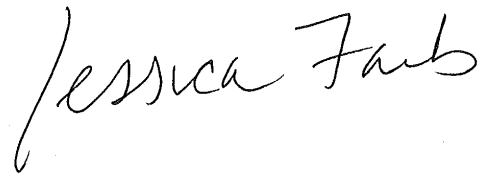
We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this information, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to

this report were Raymond Sendejas, Assistant Director; Manuel Buentello, Analyst-in-Charge; and Dawn Nelson. Also contributing were Cathleen Hamann, Cynthia Khan, Richard Lipinski, Vikki Porter, Jennifer Rudisill, and Caitlin Scoville.



Jessica Farb
Managing Director, Health Care

Enclosures – 4

Enclosure I: Scope and Methodology

To describe demographic and other key characteristics of Medicare fee-for-service (FFS) beneficiaries in Alaska, Hawaii, and the U.S. territories, we analyzed the Centers for Medicare & Medicaid Services' (CMS) Master Beneficiary Summary File data from calendar year 2019—the most recent year of data available at the time of our review—to determine the number of beneficiaries who were enrolled in Medicare Part B FFS at any time in these states and territories. We used these data to describe Medicare beneficiaries for each state and territory by characteristics such as reason for Medicare eligibility, race, gender, age, and prevalence of the 10 most common chronic conditions nationally in 2017.[1] We also spoke with health officials in the states and territories and examined key documents from CMS.

To describe Medicare payment rates, utilization, and expenditures under the Physician Fee Schedule for Alaska, Hawaii, and U.S. territories, we focused on 12 selected services based on Medicare spending. To select these services, we first examined Medicare spending in 2019 for services that had the highest Medicare allowed charges—charges for services that providers submit to CMS. Of these services with the highest allowed charges, we selected 12 services that each accounted for at least $950 million in Medicare expenditures in 2019.[2] Collectively, these 12 services accounted for about $26.5 billion—approximately 35.7 percent—of the $74.2 billion in Medicare Physician Fee Schedule expenditures in 2019. See table 5 for the list of the 12 selected services that were the focus of our analyses and associated Medicare expenditures in 2019.

[1]The 10 most common chronic conditions among beneficiaries enrolled in Part A and Part B FFS nationally in 2017 were high blood pressure, high cholesterol, arthritis, coronary artery disease, diabetes, depression, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and Alzheimer's disease/dementia.

[2]We selected the 12 services with the most expenditures for which we could determine Medicare expenditures paid under the Physician Fee Schedule.

Table 5: National Medicare Expenditures for Selected Services under the Physician Fee Schedule, 2019

Service description	HCPCS	Expenditures (in millions of dollars)
Office/outpatient evaluation and management visit, established patient—moderate complexity	99214	7,647.5
Office/outpatient evaluation and management visit, established patient—low complexity	99213	4,500.5
Subsequent hospital care—moderate complexity	99232	2,563.4
Subsequent hospital care—high complexity	99233	2,028.3
Initial hospital care—high complexity	99223	1,680.8
Emergency department visit—high complexity	99285	1,528.7
Therapeutic exercises	97110	1,207.0
Office/outpatient evaluation and management visit, new patient—moderate complexity	99204	1,201.3
Eye exam and treatment, established patient	92014	1,071.6
Critical care, first hour	99291	1,042.0
Office/outpatient evaluation and management visit, established patient—high complexity	99215	1,036.1
Annual wellness, personalized prevention plan of service, subsequent visit	G0439	950.2

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) 2019 Medicare claims data. | GAO-21-607R

Note: Providers bill Medicare for their services using various five-digit billing codes, based in part on codes developed by an American Medical Association (AMA) panel. Specifically, the AMA's Current Procedural Terminology panel maintains and updates a list of billing codes that CMS adopts for use. CMS refers to these codes as Level I Healthcare Common Procedure Coding System (HCPCS) codes. CMS also develops codes for other services or items for which Medicare reimburses providers, such as ambulance services, medical equipment, and supplies; CMS refers to these codes as Level II HCPCS codes.

To describe payment rates for the selected services, we used the Medicare Physician Fee Schedule Search Tool to determine payment rates that reflect adjustments for our states and territories for the 12 selected services.[3] We compared these payment rates to the national payment amount—the amount with no geographic adjustment. Because the payment rates for six of these services vary by setting (facility setting, such as a hospital, or a non-facility setting, such as a provider's office), we examined the extent to which these services were performed in facility or non-facility settings in these states and territories. We determined that five of these services were largely performed in non-facility settings, while the remaining service was largely performed in facility settings.[4] Consequently, we compared the non-facility payment rates to national non-facility payment rates for these services. We also examined documents such as CMS' 2019 final rule on Physician Fee Schedule services.

[3]Centers for Medicare & Medicaid Services, *Overview of the Medicare Physician Fee Schedule Search*, accessed May 18, 2021, https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

[4]We determined that eye exam and treatment and office/outpatient evaluation and management services—Healthcare Common Procedure Coding System (HCPCS) codes 92014, 99204, 99213, 99214, and 99215—were largely performed in non-facility settings. Specifically, the percentages for these services performed in non-facility settings ranged from 79 percent to 96 percent in Alaska and from 85 percent to 96 percent in Hawaii. The percentages of these services performed in non-facility settings were largely greater in Guam, Puerto Rico, and the U.S. Virgin Islands. In contrast, almost all critical care, first hour services (HCPCS code 99291) with allowable charges were performed in facility settings, ranging from 96 percent to 100 percent across these states and territories.

To describe Medicare utilization and expenditures, we calculated aggregate and per beneficiary utilization and expenditures for these 12 selected services for Alaska, Hawaii, and each territory. We compared per beneficiary utilization and expenditures for these states and territories to national Part B FFS per beneficiary utilization and expenditures.[5] We examined the reliability of the Master Beneficiary Summary File and claims data used in this report by performing appropriate electronic checks and checks for obvious errors such as values outside of expected ranges. We determined that the data we used were sufficiently reliable for the purposes of our analysis.

[5]For simplicity in reporting, we combined outpatient evaluation and management services and inpatient evaluation and management services.

Enclosure II: Demographic and Key Characteristics of Medicare Part B Fee-For-Service (FFS) Beneficiaries in Alaska, Hawaii, and the U.S. Territories, 2019

Our analysis of Centers for Medicare & Medicaid Services data shows that Medicare Part B FFS beneficiaries in Alaska, Hawaii, and the U.S. territories varied considerably in comparison with each other and the national Part B FFS population in terms of size, the number of beneficiaries dually eligible for Medicaid, and key demographics, including Medicare eligibility category, age, race and ethnicity, and prevalence rates for selected chronic conditions.[1]

Table 6: Number of Beneficiaries Enrolled in Medicare at Any Time during 2019

State or territory	Part A	Part B	Part B Fee-for-service	Medicare Advantage[a]
United States, DC, and U.S territories	63,550,165	58,851,128	35,996,541	24,517,248
Alaska	105,568	93,865	92,297	1,999
American Samoa	4,665	3,196	2,901	393
Commonwealth of the Northern Mariana Islands	2,668	2,104	2,091	21
Guam	18,033	12,749	12,670	146
Hawaii	286,236	248,842	122,480	133,588
Puerto Rico	771,035	665,665	67,535	613,206
U.S. Virgin Islands	20,541	19,031	18,654	573

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Master Beneficiary Summary File data. | GAO-21-607R

[a]No Medicare Advantage plans operate in Alaska, American Samoa, CNMI, Guam, and the U.S. Virgin Islands. CMS determines a beneficiary's residence based on where the beneficiary resided at the end of the year; therefore, these Medicare Advantage beneficiaries likely relocated earlier in 2019 from jurisdictions where such plans operate.

Table 7: Number of Beneficiaries Enrolled in Medicare Part B Fee-For-Service (FFS) and Dually Eligible for Medicaid at Any Time during 2019

	Part B FFS	Part B FFS and Dual Eligible	
State or territory		Number	Percent
United States, DC, and U.S. territories	35,996,541	7,592,454	21.1
Alaska	92,297	20,792	22.5
American Samoa	2,901	289	10.0
Commonwealth of the Northern Mariana Islands	2,091	22	1.1
Guam	12,670	108	0.9
Hawaii	122,480	16,717	13.6
Puerto Rico	67,535	3,378	5.0
U.S. Virgin Islands	18,654	413	2.2

Source: GAO analysis of Centers for Medicare & Medicaid Services Master Beneficiary Summary File data. | GAO-21-607R

[1]Dual-eligible beneficiaries are Medicare beneficiaries also enrolled in the Medicaid program in their state or territory.

Table 8: Eligibility Category of Beneficiaries Enrolled in Medicare Part B Fee-For-Service at Any Time during 2019

	Aged		Disabled		End stage renal disease (ESRD)		Both Disabled and ESRD	
State or territory	Number	Percent	Number	Percent	Number	Percent	Number	Percent
United States, DC, and U.S. territories	30,624,110	85.1	5,255,249	14.6	94,672	0.3	22,510	0.1
Alaska	80,552	87.3	11,493	12.5	206	0.2	46	0.1
American Samoa	2,087	71.9	762	26.3	37	1.3	15	0.5
Commonwealth of the Northern Mariana Islands	1,705	81.5	269	12.9	*	*	*	*
Guam	11,008	86.9	1,316	10.4	321	2.5	25	0.2
Hawaii	110,908	90.6	10,682	8.7	789	0.6	101	0.1
Puerto Rico	54,914	81.3	11,510	17.0	913	1.4	198	0.3
U.S. Virgin Islands	17,244	92.4	1,373	7.4	*	*	*	*

Legend: * = Values between 1 and 10 were omitted to protect the privacy of beneficiaries and prevent the recalculation of such values.

Source: GAO analysis of Centers for Medicare & Medicaid Services Master Beneficiary Summary File data. | GAO-21-607R.

Table 9: Age of Beneficiaries Enrolled in Medicare Part B Fee-For-Service at Any Time during 2019

	64 and under		65 through 74		75 and above	
State or territory	Number	Percent	Number	Percent	Number	Percent
United States, DC, and U.S. territories	5,377,907	14.9	17,114,097	47.5	13,504,537	37.5
Alaska	11,757	12.7	51,831	56.2	28,709	31.1
American Samoa	816	28.1	1,410	48.6	675	23.3
Commonwealth of the Northern Mariana Islands	381	18.2	1,206	57.7	504	24.1
Guam	1,651	13.0	6,572	51.9	4,447	35.1
Hawaii	11,574	9.5	62,774	51.3	48,132	39.3
Puerto Rico	12,629	18.7	28,872	42.8	26,034	38.6
U.S. Virgin Islands	1,413	7.6	9,580	51.4	7,661	41.1

Source: GAO analysis of Centers for Medicare & Medicaid Services Master Beneficiary Summary File data. | GAO-21-607R

Note: The data reflect beneficiaries' age at the end of 2019; for beneficiaries who died during 2019, the data reflects their age as of the date of death.

Table 10: Race and Ethnicity of Beneficiaries Enrolled in Medicare Part B Fee-For-Service at Any Time during 2019

Race and Ethnicity		United States, DC, and U.S. territories	Alaska	American Samoa	Commonwealth of the Northern Mariana Islands	Guam	Hawaii	Puerto Rico	U.S. Virgin Islands
American Indian/Alaska Native	Number	200,570	11,770	*	0	*	151	*	12
	Percent	0.6	12.8	*	0	*	0.1	*	0.1
Asian/Pacific Islander	Number	1,097,566	3,877	2,271	1,020	6,066	58,290	*	177
	Percent	3.1	4.2	78.3	48.8	47.9	47.6	*	1.0
Black	Number	3,403,321	2,409	*	12	83	1,471	35	13,398
	Percent	9.5	2.6	*	0.6	0.7	1.2	0.1	71.8
Hispanic	Number	2,376,134	2,547	37	636	3,715	7,588	66,396	1,837
	Percent	6.6	2.8	1.3	30.4	29.3	6.2	98.3	9.9
Non-Hispanic White	Number	27,934,508	68,358	256	189	1,116	39,149	1,041	2,728
	Percent	77.6	74.1	8.8	9.0	8.8	32.0	1.5	14.6
Other	Number	285,503	1,376	320	214	1,568	14,105	38	292
	Percent	0.8	1.5	11.0	10.2	12.4	11.5	0.1	1.6
Unknown	Number	698,939	1,960	*	20	*	1,726	13	210
	Percent	1.9	2.1	*	1.0	*	1.4	0.02	1.1

Legend: * = Values between 1 and 10 were omitted to protect the privacy of beneficiaries and prevent the recalculation of such values.

Source: GAO analysis of Centers for Medicare & Medicaid Services Master Beneficiary Summary File data. | GAO-21-607R

Table 11: Chronic Condition Prevalence in Beneficiaries Enrolled in Medicare Part B Fee-For-Service (FFS) at Any Time during 2019, by Percent

Chronic condition	United States, DC, and U.S. territories	Alaska	American Samoa	Commonwealth of the Northern Mariana Islands	Guam	Hawaii	Puerto Rico	U.S. Virgin Islands
High blood pressure	70.7	60.0	61.7	61.0	66.6	67.1	68.7	70.0
High cholesterol	69.4	53.2	45.2	43.0	63.0	71.8	64.1	55.8
Arthritis	51.5	43.2	27.4	27.5	27.4	37.0	46.1	34.7
Coronary artery disease	38.5	26.3	16.8	26.9	28.9	29.6	45.3	24.3
Diabetes	33.5	24.4	44.0	43.2	48.0	33.1	55.6	42.8
Depression	34.3	25.6	4.8	7.6	6.2	19.5	27.5	9.8
Chronic kidney disease	32.2	24.0	31.6	33.0	35.6	32.8	36.6	27.3
Chronic obstructive pulmonary disease	22.4	17.2	11.2	13.0	12.8	15.0	18.0	6.2
Congestive heart failure	21.3	14.4	20.2	18.3	21.0	16.0	29.3	14.2
Alzheimer's disease/ dementia	12.8	9.3	4.1	6.2	6.1	11.8	17.5	9.5

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Master Beneficiary Summary File data. | GAO-21-607R

Note: For this analysis we first identified the 10 most common chronic conditions nationally using CMS's 2017 chronic conditions data for beneficiaries enrolled in Part A and Part B FFS. Next, we determined the prevalence rates for each of these 10 chronic conditions for beneficiaries enrolled in Medicare Part B FFS at any time during 2019. A Medicare beneficiary is considered to have a chronic condition if CMS's data include a claim indicating that the beneficiary received a service or treatment for the specific condition. Chronic conditions are identified by diagnosis codes on the Medicare claims. Beneficiaries may have more than one chronic condition. We used the 2017 data because they were the most recently available data at the time of our review. Centers for Medicare & Medicaid Services, *County Level Chronic Conditions Table: Prevalence, Medicare Utilization and Spending,* accessed January 4, 2021, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/CC_Prev_State_County_Age.zip.

Enclosure III: Payment Rates for Selected Services in Alaska, Hawaii, and the U.S. Territories and Comparison to the National Payment Rate

See tables 12 and 13 for payment rates and comparisons to the national payment rate for 12 selected services that each accounted for at least $950 million in Medicare expenditures in 2019. We used the Centers for Medicare & Medicaid Services Physician Fee Schedule Search Tool to determine payment rates that reflect adjustments for Alaska, Hawaii, and the U.S territories and compared them to the national payment amount—the amount with no geographic adjustment. Collectively, these selected services accounted for about $26.5 billion in Medicare Physician Fee Schedule expenditures in 2019.[1]

Table 12: Comparison of Payment Rates in Alaska, Hawaii, and U.S. Territories to National Payment Rates for Selected Services with One Rate under the Medicare Physician Fee Schedule, 2019

Description and HCPCS Codes		National payment amount	Alaska	Hawaii, Am. Samoa, CNMI, Guam	Puerto Rico	U.S. Virgin Islands
Initial hospital care—high complexity (99223)	Payment rate	205.42	278.61	209.88	205.72	205.72
	Percent difference	N/A	35.6	2.2	0.1	0.1
Emergency department visit—high complexity (99285)	Payment rate	176.23	244.14	175.39	176.29	176.29
	Percent difference	N/A	38.5	-0.5	0.03	0.03
Annual wellness, subsequent visit (G0439)	Payment rate	118.21	151.27	125.71	118.60	118.60
	Percent difference	N/A	28.0	6.3	0.3	0.3
Subsequent inpatient hospital care—high complexity (99233)	Payment rate	105.60	143.49	107.88	105.74	105.74
	Percent difference	N/A	35.9	2.2	0.1	0.1
Subsequent inpatient hospital care—moderate complexity (99232)	Payment rate	73.88	100.24	75.49	73.99	73.99
	Percent difference	N/A	35.7	2.2	0.1	0.1
Therapeutic exercises (97110)	Payment rate	31.35	40.94	33.20	31.45	31.45
	Percent difference	N/A	30.6	5.9	0.3	0.3

Legend: N/A = not applicable. Am. Samoa and CNMI = American Samoa and the Commonwealth of the Northern Mariana Islands.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule payment rates in 2019. | GAO-21-607R

Note: For the above services, Medicare has a payment rate for either facility settings (such as hospitals) or non-facility settings such as physicians' offices. CMS determines payment rates for Physician Fee Schedule services based on estimates of the cost to provide a service relative to other services, including the time and intensity of provider work, practice expenses (e.g., cost of non-provider labor, office rent, etc.), and malpractice premiums. CMS separately adjusts these estimates to account for providers' geographic location for each Medicare payment locality. The national payment amount does not reflect any geographic adjustments. Centers for Medicare & Medicaid Services, *Overview of the Medicare Physician Fee Schedule Search*, accessed May 18, 2021, https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

[1]The 12 services accounted for approximately 35.7 percent of the $74.2 billion in Medicare Physician Fee Schedule expenditures in 2019.

Table 13: Non-facility Payment Rates in Alaska, Hawaii, and the U.S. Territories and Comparison to National Payment Rates for Selected Services under the Medicare Physician Fee Schedule, 2019

Description and HCPCS		National payment amount	Alaska	Hawaii, Am. Samoa, CNMI, Guam	Puerto Rico	U.S. Virgin Islands
Office/outpatient evaluation and management visit, new patient—moderate complexity (99204)	Payment rate	166.86	216.83	174.40	167.29	167.29
	Percent difference	N/A	29.9	4.6	0.3	0.3
Office/outpatient evaluation and management visit, established patient—high complexity (99215)	Payment rate	147.76	191.96	155.43	148.17	148.17
	Percent difference	N/A	29.9	5.2	0.3	0.3
Eye exam and treatment, established patient (92014)	Payment rate	128.66	162.43	138.87	129.17	129.17
	Percent difference	N/A	26.2	7.9	0.4	0.4
Office/outpatient evaluation and management visit, established patient—moderate complexity (99214)	Payment rate	110.28	142.41	116.63	110.61	110.61
	Percent difference	N/A	29.1	5.8	0.3	0.3
Office/outpatient evaluation and management visit, established patient—low complexity (99213)	Payment rate	75.32	96.49	79.91	75.56	75.56
	Percent difference	N/A	28.1	6.1	0.3	0.3

Legend: N/A = applicable. Am. Samoa and CNMI = American Samoa and the Commonwealth of the Northern Mariana Islands.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule payment rates in 2019. | GAO-21-607R

Notes: CMS determines payment rates for Physician Fee Schedule services based on estimates of the cost to provide a service relative to other services, including the time and intensity of provider work, practice expenses (cost of non-provider labor, office rent, etc.), and malpractice premiums. CMS separately adjusts these estimates to account for providers' geographic location for each Medicare payment locality. The national payment amount does not reflect any geographic adjustments. Centers for Medicare & Medicaid Services, *Overview of the Medicare Physician Fee Schedule Search*, accessed May 18, 2021, https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

For the above five services, Medicare has different payment rates for facility settings (such as hospitals), and non-facility settings such as physicians' offices. At least 79 percent of the above services were performed in non-facility settings across these states and territories. In contrast, in the case of the last service we reviewed—critical care, first hour services—at least 95 percent of these services were performed in facility settings across states and territories in 2019. Comparisons of the service's facility payment rates to national payment rates were similar to the above results. Specifically, percentages of this service performed in facility settings ranged from about 95 percent to 100 percent.

Enclosure IV: Additional Information on Medicare and Beneficiaries in Alaska, Hawaii, and the U.S. Territories

See the following pages for additional information on Medicare and beneficiaries in Alaska, Hawaii, and the U.S. territories.

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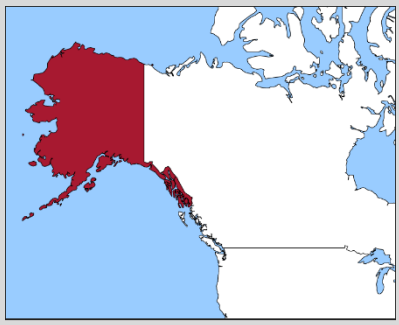
State Overview



Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: Northwest part of the North America continent, the state's largest city—Anchorage—is about 1,400 miles from Seattle, Washington.

PHYSICAL SIZE: 570,641 square miles; state with large frontier and rural areas and low-population density.

POPULATION IN 2019: 731,545

PEOPLE AGE 65 YEARS AND OVER IN 2019: 91,443 (12.5 percent)

HEALTH CARE DELIVERY: Alaska has community health centers, the majority of which are federally qualified health centers. It also has Tribal Health organizations, which are members of the Alaska Native Tribal Health Consortium. Tribal Health organizations are funded through the Indian Health Service (IHS), and provide care to Medicare beneficiaries, regardless of IHS eligibility, according to Alaska state officials. There were also 24 hospitals of which 18 were designated as trauma centers as of February 2019.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: According to Department of Health and Human Services (HHS) officials, through Medicare Savings Programs, Alaska is responsible for the Medicare premiums, and often cost-sharing, for certain low-income Medicare beneficiaries.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP): Alaska has a SHIP to help Medicare-eligible individuals or caregivers select and enroll in Medicare coverage, including Part B.

Alaska

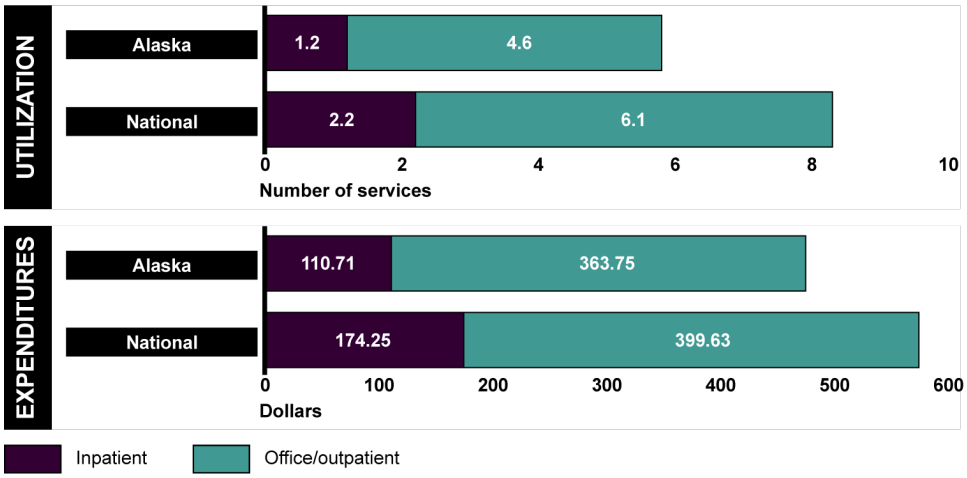
Medicare Part B Fee-For-Service (FFS) Beneficiaries

According to Centers for Medicare & Medicaid Services (CMS) data, there were 92,297 individuals in Alaska who were enrolled in Part B FFS at any time during 2019. About 50 percent of these beneficiaries were female, and 50 percent were male. In contrast, nearly 55 percent and 45 percent of Part B FFS beneficiaries nationally were female and male, respectively.

Chronic conditions: CMS data also show that Part B FFS beneficiaries had a lower prevalence of a variety of chronic conditions, when compared with national Part B FFS beneficiaries. For example, 60 percent of Alaska beneficiaries had high blood pressure in contrast to 71 percent of beneficiaries nationally.

Medicare Part B FFS Utilization and Expenditures

Figure 2: Alaska and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Source: GAO analysis of Medicare claims data. | GAO-21-607R

Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS—code 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

Alaska state officials identified several factors that may affect Medicare beneficiaries' access to health care, including

- Geographic: Medicare beneficiaries may need to travel great distances within the state to obtain care, which could include travel by airplane and overnight lodging, costs not covered by Medicare. This may become expensive for beneficiaries who need ongoing treatment.
- Provider supply: Medicare beneficiaries may have challenges finding providers who accept new Medicare patients. Further, in rural Alaska, the only health care clinic may be a Tribal Health organization.
- Enrollment: Individuals unable to enroll in Medicare online or by phone may face challenges traveling to one of three Social Security Administration offices in Alaska. As a result, some individuals may go without insurance coverage or face late enrollment penalties.

Medicare beneficiaries who receive care at Tribal Health organizations, and are not eligible for IHS, may face challenges reviewing Medicare claims or understanding cost-sharing responsibilities. Such claims do not appear on their Medicare Summary Notice, which includes services billed to Medicare and amounts the beneficiary may owe.

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Enclosure IV

American Samoa

Territory Overview

Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: South Pacific, 2,600 miles southwest of Hawaii. American Samoa's main island of Tutuila has little level land and is mostly rugged.

PHYSICAL SIZE: American Samoa's seven islands cover a land area of 76 square miles, making it slightly larger than Washington, D.C.

POPULATION SIZE IN 2019: 56,900

PEOPLE AGE 65 YEARS AND OVER IN 2020: 3,411 (6.9 percent)

HEALTH CARE DELIVERY: American Samoa has one hospital, the Lyndon B. Johnson (LBJ) Tropical Medical Center, four federally qualified health centers, and one pharmacy.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: American Samoa provides assistance to certain Medicare beneficiaries who are dually eligible for Medicaid by paying for Medicare premiums.

SHIP: American Samoa does not currently have a SHIP to help Medicare-eligible individuals or their caregivers select and sign up for Medicare coverage, including Part B. LBJ Tropical Medical Center officials said they planned to apply for a SHIP grant through the Department of Health and Human Services, Administration for Community Living, which manages the program.

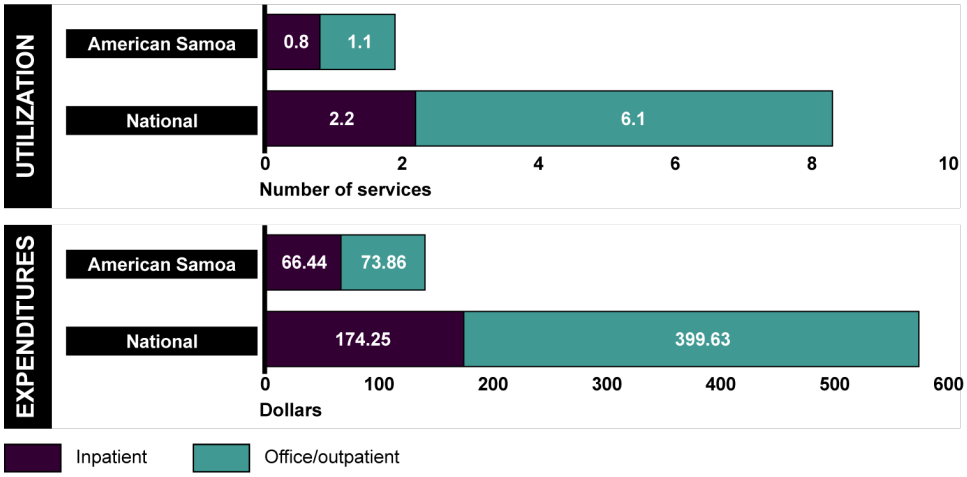
Medicare Part B FFS Beneficiaries

According to CMS data, 2,901 individuals in American Samoa were enrolled in Part B FFS at any time during 2019.

Chronic conditions: CMS data also show that Part B FFS beneficiaries who were enrolled at any point during 2019 had a higher prevalence rate of diabetes (44.0 percent), compared to the national prevalence rate of 33.5 percent. For depression (4.8 percent) and Alzheimer's Disease/dementia (4.1 percent), these beneficiaries had prevalence rates that were significantly lower than the national prevalence rates of 34.3 percent and 12.8 percent, respectively.

Medicare Part B FFS Utilization and Expenditures

Figure 3: American Samoa and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Source: GAO analysis of Medicare claims data. | GAO-21-607R

Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS—code 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

Officials from the LBJ Tropical Medical Center—American Samoa's only hospital—said that several factors may affect delivery of health care:

- Geographic: The closest American soil with access to specialty care is Hawaii, nearly five-hours away by plane. Another challenge is the cost of obtaining medical supplies, which must be shipped from the U.S. mainland, an 11-hour flight from American Samoa.
- Provider supply: According to the hospital's recruitment video, there is 1 physician for every 1,000 residents in American Samoa.[1] LBJ Tropical Medical Center officials said that it is challenging to recruit primary and specialty care providers because of the remote geographic location.
- Medicare payment: Some Medicare beneficiaries seek specialty care in Hawaii, and while there, they may be enrolled in a Medicare Advantage plan that does not pay for services provided in American Samoa, according to LBJ Tropical Medical Center officials.

[1]See *American Samoa LBJ Tropical Medical Center Recruitment*, accessed August 6, 2021, https://www.youtube.com/watch?v=g009O5-Rq0M.

Commonwealth of the Northern Mariana Islands (CNMI)

Territory Overview

Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: Western Pacific, 5,500 miles from the U.S. mainland, and 3,226 miles west of Hawaii.

PHYSICAL SIZE: CNMI's 14 islands cover a land area of 183 square miles.

POPULATION SIZE IN 2019: 49,800

PEOPLE AGE 65 YEARS AND OVER IN 2020: 3,721 (7.2 percent)

NATURAL DISASTERS: Super Typhoon Mangkhut struck CNMI, and Super Typhoon Yutu made landfall across CNMI in 2018.

HEALTH CARE DELIVERY: CNMI's public provider is the Commonwealth Healthcare Corporation, which includes a hospital, laboratory, dialysis clinic, and four community health centers. CNMI's private providers include five clinics, three laboratories—including an imaging center, and a dialysis clinic. CNMI has a locally funded medical referral office to help coordinate and fund care off-island for residents.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: The CNMI Medicaid program provides assistance to certain low-income Medicare beneficiaries who are dually eligible for Medicaid by paying for Medicare Part B premiums.

SHIP: CNMI does not have a SHIP to help Medicare-eligible individuals or their caregivers select and sign up for Medicare coverage, including Part B. CNMI officials said they plan to apply for a SHIP grant through the Department of Health and Human Services, Administration for Community Living, which manages the program.

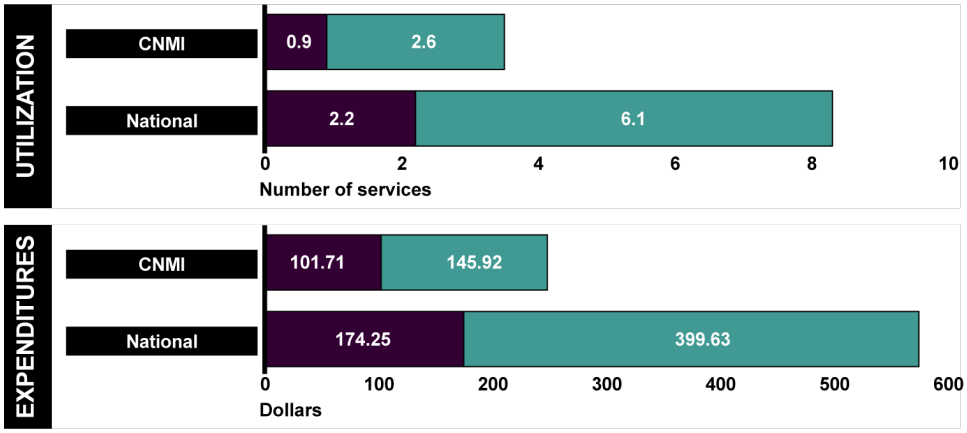
Medicare Part B FFS Beneficiaries

According to CMS data, 2,091 individuals in CNMI were enrolled in Part B FFS at any time during 2019.

Chronic conditions: CMS data also show that CNMI Part B FFS beneficiaries who were enrolled at any point during 2019 had a higher prevalence rate of diabetes (43.2 percent), compared to the national prevalence rate of 33.5 percent. For depression (7.6 percent) and Alzheimer's Disease/dementia (6.2 percent), these beneficiaries had prevalence rates that were significantly lower than the national prevalence rates of 34.3 percent and 12.8 percent, respectively.

Medicare Part B FFS Utilization and Expenditures

Figure 4: Commonwealth of the Northern Mariana Islands and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Legend: CNMI=Commonwealth of the Northern Mariana Islands.

Source: GAO analysis of Medicare claims data. | GAO-21-607R

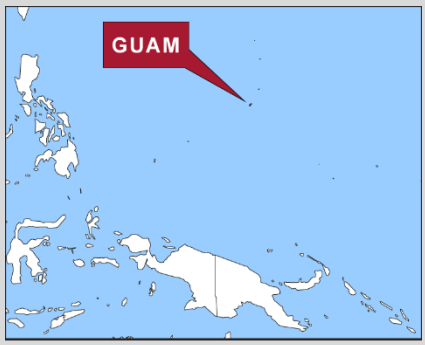
Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS—code 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

CNMI officials identified several factors that may affect access to care for Medicare Part B FFS beneficiaries:

- Geographic: For specialized care, CNMI Medicare beneficiaries may be referred off-island, including to Hawaii, the Philippines, or the U.S. mainland, which results in higher costs due to transportation and other expenses.
- Provider supply: Officials said that while they do have some specialists—including a podiatrist, otolaryngologist, oncologist, nephrologist, and orthopedic surgeon—these specialists largely provide care on the main island of Saipan. However, they may travel to the smaller CNMI islands of Tinian or Rota if needed.

Guam

Territory Overview



Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: Western Pacific about 5,800 miles from the U.S. mainland and 3,800 miles from Hawaii.

PHYSICAL SIZE: 212 square miles; single island with approximately 29 percent occupied by U.S. military bases.

POPULATION IN 2019: 163,200

PEOPLE AGE 65 YEARS AND OVER IN 2020: 16,081 (9.5 percent)

NATURAL DISASTERS: Super Typhoon Mangkhut struck Guam in 2018.

HEALTH CARE DELIVERY: Guam has three hospitals—Guam Memorial Hospital, Guam Regional Medical City, and a U.S. Naval hospital. The U.S. Naval hospital provides services primarily to military personnel and dependents, but it also provides some services to the civilian community.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: Guam's Medicaid program provides assistance to certain low-income Medicare beneficiaries who are dually eligible for Medicaid by paying for Medicare Part B premiums.

SHIP: Guam has a SHIP to help Medicare-eligible individuals or their caregivers select and enroll in Medicare coverage, including Part B.

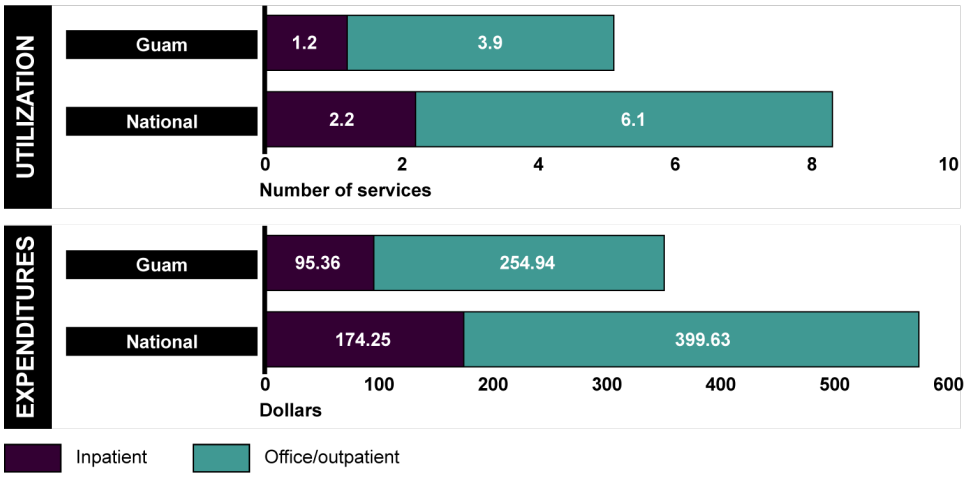
Medicare Part B FFS Beneficiaries

According to CMS data, 12,670 individuals in Guam were enrolled in Part B FFS at any time during 2019.

Chronic conditions: CMS data also show that Guam's Part B FFS beneficiaries who were enrolled at any time during 2019 had a higher prevalence rate of diabetes (48.0 percent), compared to the national prevalence rate of 33.5 percent. Further, beneficiaries had prevalence rates for depression (6.2 percent) and Alzheimer's Disease/dementia (6.1 percent) that were significantly lower than the national prevalence rates of 34.3 percent and 12.8 percent, respectively.

Medicare Part B FFS Utilization and Expenditures

Figure 5: Guam and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Source: GAO analysis of Medicare claims data. | GAO-21-607R

Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS—code 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

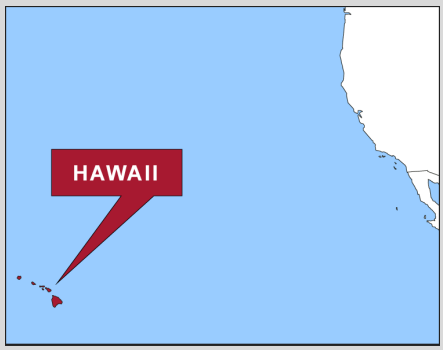
Guam officials identified several factors that can affect access to care for Medicare FFS beneficiaries, including

- Geographic: For specialized care, Guam Medicare beneficiaries may be referred off-island, including to Hawaii, the Philippines, or the U.S. mainland. Additionally, transportation can be problematic for beneficiaries receiving dialysis treatment, and Medicare does not pay to transport beneficiaries for such care.
- Provider supply: According to Guam officials, Guam has medical referral offices to help coordinate transportation and other needs for care off-island for residents.

Guam also has a locally funded Medically Indigent Program to pay for medical expenses of low-income individuals without other health insurance, including payment for off-island medical care and air fare.

Hawaii

State Overview



Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: Eight major islands located in the central Pacific Ocean. The islands lie 2,397 miles from San Francisco, California.

PHYSICAL SIZE: 6,423 square miles; Hawaii is slightly smaller than New Jersey.

POPULATION SIZE IN 2019: 1,415,872

PEOPLE AGE 65 YEARS AND OVER IN 2019: 269,016 (19 percent)

HEALTH CARE DELIVERY: There are 29 hospitals operating in Hawaii, 15 federally qualified health centers, 11 rural health clinics, and seven Native Hawaiian Health System facilities, among other health care providers.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: According to HHS officials, through Medicare Savings Programs, Hawaii is responsible for the Medicare premiums, and often cost-sharing, for certain low-income Medicare beneficiaries.

SHIP: Hawaii has a SHIP to help Medicare-eligible individuals or their caregivers select and enroll in Medicare coverage, including Part B.

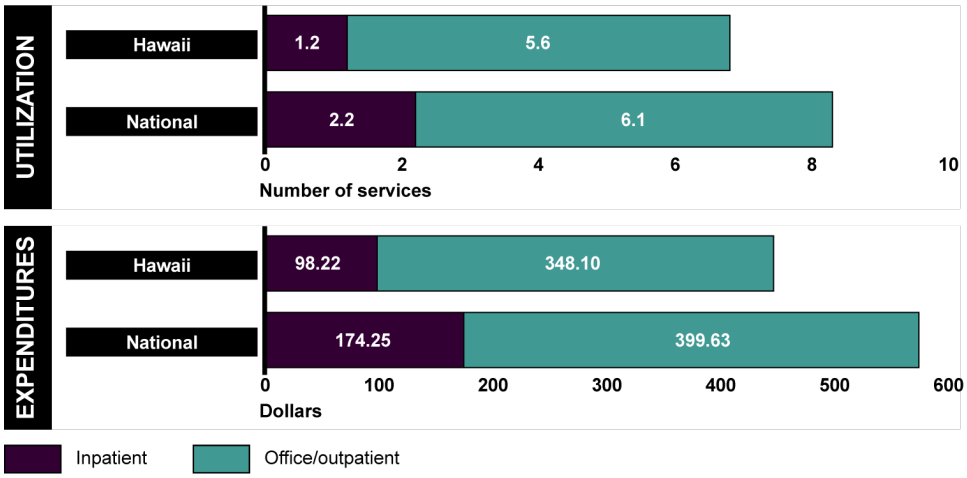
Medicare Part B FFS Beneficiaries

According to CMS data, 122,480 individuals in Hawaii were enrolled in Medicare Part B FFS at any point during 2019.

Chronic conditions: CMS data also show that Part B FFS beneficiaries who were enrolled at any point during 2019 had a slightly higher prevalence rate of high cholesterol, 71.8 percent, compared to the national prevalence rate of 69.4 percent. For arthritis and depression, these beneficiaries had prevalence rates of 37.0 percent and 19.5 percent, respectively—both nearly 15 percent lower than the national prevalence rates.

Medicare Part B FFS Utilization and Expenditures

Figure 6: Hawaii and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Source: GAO analysis of Medicare claims data. | GAO-21-607R

Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS, 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

According to stakeholders, geographic and provider supply factors can affect access to care for Hawaii's Medicare beneficiaries:

- Geographic: Hawaii's geography includes large rural areas, sparsely populated areas, areas separated by ocean, and areas without roads—each of these presents challenges for beneficiaries and providers. Additionally, because of its location, providers in Hawaii have to pay for medical equipment to be shipped to one of the seven populated islands, which can be costly.
- Provider supply: According to the 2021 Report to the Legislature by the Hawaii Physician Workforce Assessment Project, there were statewide shortages of primary care physicians, colorectal surgeons, pathologists, pulmonologists, infectious disease specialists, allergists and immunologists, and hematologists and oncologists.[2] Some Hawaiian islands have acute shortages of physicians. For example, Kauai has no island-based critical care specialists or endocrinologists, among others.

[2]Kelley Withy, University of Hawaii, *Report to the 2021 Legislature: Annual Report on Findings from the Hawai'i Physician Workforce Assessment Project* (December 2020).

Puerto Rico

Territory Overview

Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: Approximately 1,000 miles southeast of Florida in the Caribbean Sea.

PHYSICAL SIZE: 3,425 square miles; one main island and several smaller islands.

POPULATION IN 2019: 3,193,694

PEOPLE AGE 65 YEARS AND OVER IN 2019: 680,257 (21.3 percent)

NATURAL DISASTERS: In September 2017, Puerto Rico experienced Hurricanes Irma and Maria, which caused widespread damage to infrastructure. Puerto Rico also experienced an earthquake in January 2020.

HEALTH CARE DELIVERY: In 2015, Puerto Rico had 64 hospitals—2.68 beds per 1,000 people in contrast to the U.S. mainland, which had 2.90 beds per 1,000 people.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: According to HHS officials, in some circumstances, limits exist on the Medicare cost-sharing liability for individuals in Puerto Rico who are enrolled with full Medicaid benefits. Medicare Savings Programs to assist low-income Medicare beneficiaries with Part B premiums and cost-sharing are not available in Puerto Rico.

SHIP: Puerto Rico has a SHIP to help Medicare-eligible individuals or their caregivers select and enroll in Medicare coverage, including Part B.

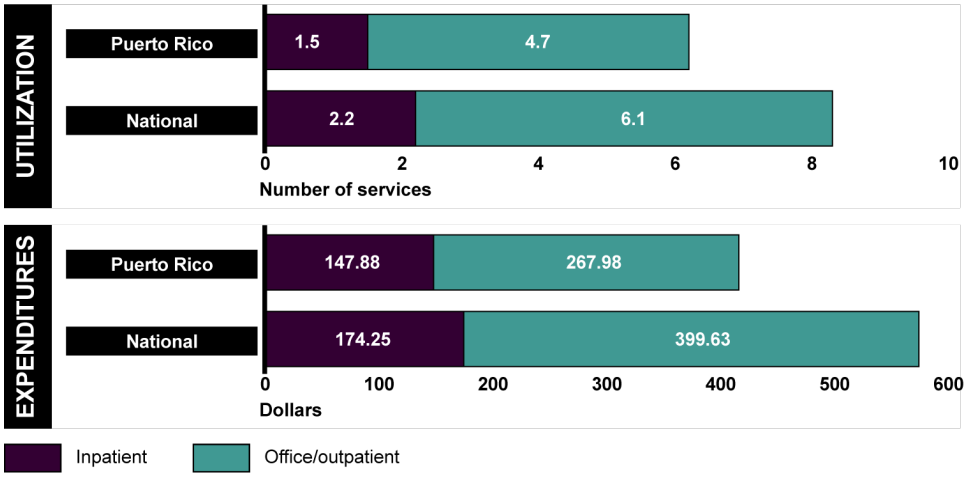
Medicare Part B FFS Beneficiaries

According to CMS data, in 2019, of Part B beneficiaries in Puerto Rico, most were enrolled in Medicare Advantage (613,206) at any time, while 67,535 beneficiaries were enrolled in Part B FFS at any time. A small proportion (5.0 percent) of Part B FFS beneficiaries were dually eligible at any time for Medicaid.

Chronic conditions: CMS data also show that Part B FFS beneficiaries in Puerto Rico had a higher prevalence rate of diabetes (55.6 percent) than the national prevalence rate of 33.5 percent.

Medicare Part B FFS Utilization and Expenditures

Figure 7: Puerto Rico and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Source: GAO analysis of Medicare claims data. | GAO-21-607R

Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS—code 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

Physician associations and government officials identified factors that can affect access to care for Puerto Rico Medicare FFS beneficiaries, including

- Geographic: Providers are concentrated in the San Juan metro area, and residents outside the metro area have limited access to care. Further, certain FFS beneficiaries may travel off-island to receive health care.
- Provider supply: The number of providers, particularly specialists, is declining. For example, one stakeholder noted that considerable demand for endocrinologists exists, and many individuals may need to wait 6 months for an appointment. Further, it is difficult to recruit and retain providers.
- Cost: Some Medicare FFS beneficiaries pay a penalty for Part B late enrollment. In Puerto Rico, individuals who receive Social Security are automatically enrolled in Part A, but not Part B, in contrast to beneficiaries in the states and other territories. Stakeholders said this contributes to a higher proportion of Puerto Rico residents being subject to Part B late enrollment penalties.[3]

[3]The Congressional Research Service noted that 4.2 percent of Puerto Rican Medicare beneficiaries paid the late enrollment penalty in 2010, compared to about 1.4 percent of all Medicare beneficiaries in 2016. See *Congressional Research Service, Puerto Rico and Health Care Finance: Frequently Asked Questions* (Washington, D.C.: 2016).

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U.S. Virgin Islands

Territory Overview

Source: GAO; Map Resources (map). | GAO-21-607R

LOCATION: Caribbean Sea, 1,000 miles from the U.S. mainland.

PHYSICAL SIZE: 3 main islands, 134 square miles, about twice the size of Washington, D.C.

POPULATION IN 2019: 103,900

PEOPLE AGE 65 YEARS AND OVER IN 2021: 20,986 (19.8 percent)

NATURAL DISASTERS: In September 2017, the U.S. Virgin Islands experienced Hurricanes Irma and Maria, which destroyed or damaged nearly all health care infrastructure.

HEALTH CARE DELIVERY: The U.S. Virgin Islands has two hospitals, two federally qualified health centers, 27 clinics, 12 facilities that are National Health Service Corps certified sites, two residential mental health facilities, two dialysis centers, one substance use disorder treatment facility, and many private providers.

ASSISTANCE FOR DUALLY ELIGIBLE BENEFICIARIES: The U.S. Virgin Islands provides assistance to certain Medicare beneficiaries who are dually eligible for Medicaid by paying for Medicare premiums.

SHIP: The U.S. Virgin Islands has a SHIP to help Medicare-eligible individuals or their caregivers select and enroll in Medicare coverage, including Part B.

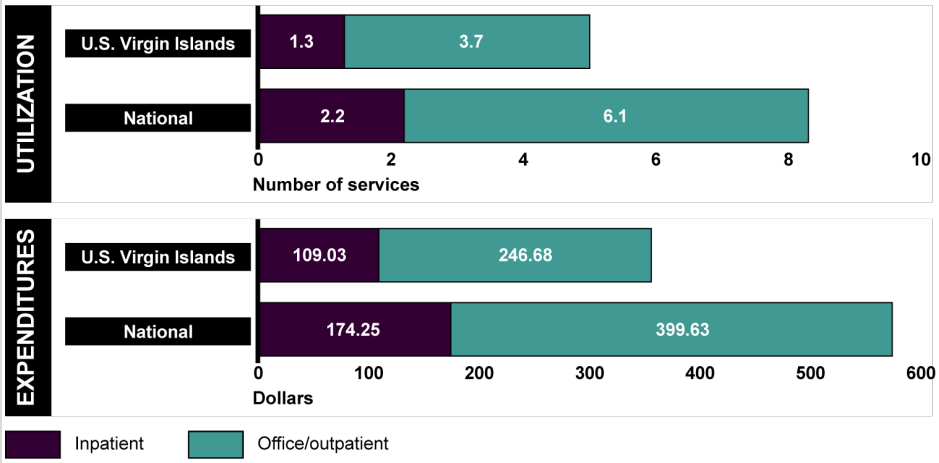
Medicare Part B FFS Beneficiaries

According to CMS data, 18,654 individuals in the U.S. Virgin Islands were enrolled in Part B FFS at any point during 2019.

Chronic conditions: CMS data also show that Part B FFS beneficiaries who were enrolled at any point during 2019 had a higher prevalence of diabetes, 42.8 percent, compared to the national prevalence rate of 33.5 percent. Part B FFS beneficiaries also had a higher prevalence of prostate cancer, nearly 9 percent, compared to the national prevalence rate of nearly 5 percent.

Medicare Part B FFS Utilization and Expenditures

Figure 8: U.S. Virgin Islands and National Per Beneficiary Utilization and Expenditures of Selected Inpatient and Outpatient Evaluation and Management Services, 2019



Source: GAO analysis of Medicare claims data. | GAO-21-607R

Note: This analysis presents seven evaluation and management services which generally include patient consultations, examinations, and coordination of care among providers. Outpatient evaluation and management services include new patient services (Healthcare Common Procedure Coding System—HCPCS, 99204) and three levels of follow-up services (HCPCS 99213, 99214, and 99215). Inpatient evaluation and management services include initial hospital care (HCPCS 99223) and two levels of subsequent care (HCPCS 99232 and 99233).

According to a report by the RAND Corporation, recovery from the 2017 hurricanes was ongoing as of March 2020.[4] The hurricanes significantly damaged health care facilities and increased the loss of providers. For example,

- The Governor Juan F. Luis Hospital and Medical Center was severely damaged, and 80 hospital staff left following the hurricane. A temporary hospital was expected to open in spring 2020, though a more recent news report indicated the opening was delayed.[5]
- Portions of the Schneider Regional Medical Center were destroyed, and the hospital reported losing 175 nurses in the year after the hurricanes. As of March 2020, the hospital was planning a multi-year building restoration.

Additionally, according to RAND, the territory has a severe shortage of behavioral health care providers, and both prior and current governors have declared behavioral health emergencies.

(104458)

[4]Shelly Culbertson et al., *Recovery in the U.S. Virgin Islands: Progress, Challenges, and Options for the Future*, RAND Corporation, (Santa Monica, CA: 2020).

[5]See Ernice Gilbert, *Modular JFL Hospital Will Most Likely Come Online in 2022, Five Years After Hurricanes Irma and Maria* (Virgin Islands Consortium, April 12, 2021).

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