Medicaid and CHIP in the Territories

Medicaid and the State Children's Health Insurance Program (CHIP) operate in the five U.S. territories—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands (USVI). This fact sheet summarizes federal requirements and design features of these programs in the territories, including eligibility and enrollment, benefits, financing and spending, data and reporting, and quality and program integrity. For more details on each territory's individual program, see MACPAC's territory-specific fact sheets.

Individuals born in CNMI, Guam, Puerto Rico, and USVI are U.S. citizens, and those born in American Samoa are U.S. nationals.[1] Their eligibility for federally subsidized programs varies by territory and program. For example, residents of all five territories may participate in Medicaid, CHIP, Medicare, and Social Security, but none except those in CNMI are eligible for Supplemental Security Income (SSI) (Committee on Ways and Means 2014).

Under the Social Security Act (the Act) the territories are considered states for the purposes of Medicaid and CHIP, unless otherwise indicated (§ 1101(a)(1) of the Act). However, their programs differ in many respects from those in the 50 states and the District of Columbia. The most notable difference is that rather than having an open-ended financing structure, Medicaid in the territories operates with an annual ceiling on federal financial participation, referred to as the Section 1108 cap or Section 1108 allotment (§ 1108(g) of the Act). The federal government matches territory dollars up to the specified annual Section 1108 allotment, and beyond that, the territories generally must fund their programs with local funds. Because Medicaid still operates as an entitlement with benefits guaranteed to all eligible individuals who apply, territories historically have exceeded their annual Section 1108 allotments.

Two territories, CNMI and American Samoa, operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them (§ 1902(j) of the Act). This provision allows the Secretary of the U.S. Department of Health and Human Services (the Secretary) to waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the federal medical assistance percentage (FMAP), and the requirement that payment can only be for services otherwise coverable by Medicaid. For example, while neither of these territories provides all of Medicaid's mandatory benefits, they are considered in compliance with federal Medicaid law.

Eligibility and Enrollment

All five territories are permitted to establish income-based eligibility using a measure other than the federal poverty level (FPL). Guam, Puerto Rico, and USVI use local poverty levels to establish eligibility, which are updated by an amendment to the Medicaid state plan. These three territories are also statutorily exempt from providing Medicaid coverage to certain mandatory coverage groups including poverty-related children

and pregnant women and qualified Medicare beneficiaries (§§ 1902(l)(4)(B) and 1905(p)(4)(A) of the Act). American Samoa and CNMI are also exempt from these requirements under their 1902(j) waivers.

American Samoa and CNMI use unique methods to establish income-based eligibility. In American Samoa, Medicaid eligibility is not determined on an individual basis and individuals do not enroll in Medicaid or CHIP as they do in all other territories and states. Instead, federal Medicaid and CHIP funds pay for care provided in the territory in proportion to the population of American Samoans with income that would have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent FPL (CMS 2014). CNMI, the only territory participating in SSI, uses SSI income and asset standards to determine Medicaid eligibility (CMS 2016a).

Guam, Puerto Rico, and USVI have elected to expand their Medicaid programs to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) up to 133 percent of local poverty (CMS 2016a).

All five territories operate Medicaid-expansion CHIP programs (CMS 2015). Puerto Rico is the only territory that uses its CHIP funds to cover additional children whose income levels exceed regular Medicaid eligibility levels. The other four territories use their CHIP funds to pay for services provided to children under age 19 in their Medicaid programs and can access the CHIP enhanced match for these individuals (CMS 2016a).

Territories vary widely in the percentage of their populations covered by Medicaid or CHIP due to differences in eligibility standards and methodologies, as well as differences in the economic conditions for the territories (Table 1).

TABLE 1. Medicaid and CHIP Enrollment as a Share of the Population, June 2019

Territory	Number of enrollees	Approximate percentage of population enrolled in Medicaid or CHIP
American Samoa	37,829	68.4%
CNMI	16,336	28.6
Guam	35,499	21.2
Puerto Rico	1,209,026	37.9
USVI	29,033	27.2

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Enrollment figures for American Samoa are estimates of the portion of the population below 200 percent FPL, the population for which Medicaid pays for health care services. American Samoa does not make individual eligibility determinations and does not have an enrolled population.

Sources: MACPAC analysis of Medicaid enrollment data collected through the Medicaid Budget and Expenditure System, April – June 2019 and 2019 World Populations Prospects data.

Benefits

Medicaid benefits vary across territories. American Samoa and CNMI are not required to offer mandatory Medicaid benefits under their Section 1902(j) waivers. Guam, Puerto Rico, and USVI are required to offer all mandatory benefits, but currently Guam is the only territory to do so. For example, USVI does not cover freestanding birth center or rural health clinic services; and Puerto Rico does not cover non-emergency medical transportation or nursing facility services, citing lack of infrastructure and funding (GAO 2016). In all territories, individuals under age 21 are eligible to receive early and periodic screening, diagnostic, and treatment services (EPSDT) (GAO 2016, CMS 2016e).[2] Additionally, all territories provide some optional benefits. For example, all territories cover prescription drugs, clinic services, dental services, and eyeglasses.[3]

All five territories' Medicaid programs offer some form of cost-sharing assistance for Medicare enrollees who are also eligible for full Medicaid benefits (CMS 2016b). Medicaid programs in American Samoa, Guam, CNMI, and USVI pay Medicare Part B premiums for dually eligible individuals (CMS 2014d). Puerto Rico pays premiums and cost sharing for Medicare Platino plans, a type of Medicare Advantage special needs plan that includes Medicare Part A and B services as well as outpatient prescription drugs. Almost all dually eligible Puerto Ricans are enrolled in Medicare Platino (HHS 2013).

The Medicare Savings Programs, which provide cost sharing assistance to individuals who would qualify as partially dually eligible individuals in the states, are not available in the territories.[4] Similarly, Medicare Part D plans are not available in the territories, but territorial Medicaid programs typically provide prescription drugs to dually eligible beneficiaries. To offset the cost of doing this, each territory receives an additional allotment from the Enhanced Allotment Plan, also referred to as 1935(e) funding. This allotment is separate from the Section 1108 allotment and can only be used to help pay for prescription drugs for low-income beneficiaries (§ 1935(e) of the Act).[5]

Delivery System

Puerto Rico is currently the only territory to use Medicaid managed care, in which the entire Medicaid population is enrolled. Managed care organizations (MCOs) provide commonwealth-wide acute, primary, specialty, and behavioral health services. They are paid risk-based capitated payments. MCOs contract with primary medical groups, which in turn create preferred provider networks (PPNs). Enrollees are auto-assigned to a health plan but may switch once per year, and do not need referrals for specialists in their PPN (MACPAC 2019b).

The Medicaid programs in the other four territories operate on a fee-for-service basis. In American Samoa, Guam, and CNMI, the majority of Medicaid services are provided by one hospital with affiliated clinics that are owned and operated by the territory. In recent years, these territories have expanded the availability of

services at other locations and increased access to off-island services when medically necessary or when services are not available in the territory (CMS 2016a, MACPAC 2021a–c).

The territories do not receive a Medicaid disproportionate share hospital (DSH) allotment and therefore do not make DSH payments to hospitals (§ 1923(f)(9) of the Act).

Financing and Spending

The federal government and territorial governments jointly finance the territories' Medicaid programs. Each territory must contribute its non-federal share of Medicaid spending in order to access federal dollars, which are matched at the designated FMAP, or matching rate. Unlike the states and the District of Columbia, for which federal Medicaid spending is open ended, the territories can only access federal dollars up to the annual Section 1108 allotment.

Federal funding

The territories' Section 1108 allotments are specified in statute, and grow with the medical component of the Consumer Price Index for All Urban Consumers (§ 1108(g)). The territories' CHIP allotments are determined by the Centers for Medicare & Medicaid Services (CMS) based on prior-year spending, the same methodology used for states.

In general, once a territory exhausts its annual federal Medicaid and CHIP allotments, it must fund its program with local funds. However, Congress has provided additional federal Medicaid funds on a temporary basis to the territories for over a decade. Most recently, Congress provided additional funds to the territories through the FY 2020 appropriations package, signed into law on December 20, 2019 (P.L. 116-94), and the Families First Coronavirus Response Act, signed into law on March 18, 2020 (FFCRA, P.L. 116-127). These actions raise each territory's Section 1108 allotment for FYs 2020 and 2021 substantially (Table 2).[6]

TABLE 2. Territory Section 1108 Allotments FYs 2019–2022 (millions)

Territories	2019	2020		2021		2022[1]
		Without P.L. 116-94, FFCRA	Current law	Without P.L. 116-94, FFCRA[1]	Current law	
American Samoa	$12.2	$12.4	$86.3	$12.7	$85.6	$13.0
CNMI	6.7	6.9	63.1	7.1	62.3	7.2
Guam	18.0	18.4	130.9	18.8	129.7	19.2
Puerto Rico	366.7	375.1	2,716.2	383.7	2,809.1	392.5
USVI	18.3	18.8	128.7	19.2	127.9	19.6

Notes: FY is fiscal year. Section 1108 allotments reflect the annual federal allotments (or caps) for federal funds that territories receive under Section 1108(g) of the Social Security Act. P.L. 116-94 is the Further Consolidated Appropriations Act of 2020. FFCRA is the Families First Coronavirus Response Act (P.L. 116-127). CNMI is Commonwealth of the Northern Mariana Islands. USVI is U.S.

Virgin Islands. P.L. 116-94 initially raised each territory's FYs 2020 and 2021 allotments to $84.0 million per fiscal year for American Samoa, $60.0 million per FY for CNMI, $127.0 million per fiscal year for Guam, and $126.0 million per fiscal year for USVI; it also raised Puerto Rico's FY 2020 allotment to $2.6 billion and its FY 2021 allotment to $2.7 billion. FFCRA subsequently raised these allotments to the amounts shown.

P.L. 116-94 included an additional $200 million per FY 2020 and FY 2021 for Puerto Rico if the Secretary certifies that Puerto Rico establishes a payment floor for physician services of at least 70 percent of the payment rates that would apply for such services under Medicare Part B. Puerto Rico implemented this payment increase in 2020 (ASES 2020).

[1] Estimated by trending pre-P.L 116-94 FY 2020 allotments by 2.3 percent (percent change in the medical component of the Consumer Price Index for All Urban Consumers for the 12-month period ending March 2019).

Source: MACPAC analysis of P.L. 116-94, FFCRA, CMS 2019b, and CMS 2019c.

Congress previously provided additional federal Medicaid funds on several occasions. The American Recovery and Reinvestment Act (ARRA, P.L. 111-5) raised each territory's annual allotment by 30 percent for the period between October 1, 2009 and June 30, 2011 (§ 5001(d) of ARRA). The ACA provided the territories with additional federal Medicaid funding on top of their existing Section 1108 allotments: Section 2005 provided a total of $6.3 billion in additional federal funds for the territories available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $1 billion to the territories available to be drawn down between January 2014 and December 2019.[7] Total additional funding for each territory initially ranged from $109.2 million for CNMI to $6.3 billion for Puerto Rico (CMS 2016a).[8]

The territories accessed these funds at different rates, reflecting differences in the structure of their programs and availability of funds to provide the non-federal share. Puerto Rico and CNMI drew their allotments down more quickly than other territories, with Puerto Rico facing imminent funding shortfalls in FYs 2017 and 2018, and CNMI experiencing a gap in federal Medicaid funds in March 2019. Congress subsequently provided additional appropriations to address imminent funding shortfalls in Puerto Rico and CNMI and to respond to natural disasters affecting all five territories in 2017, 2018, and 2019.

- The Consolidated Appropriations Act of 2017 (P.L. 115-31) provided Puerto Rico with an additional $295.9 million.
- The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) provided Puerto Rico with an additional $4.8 billion and USVI with an additional $142.5 million in federal Medicaid funds in response to the impact of Hurricane Maria on those territories' health systems.[9]
- The Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L. 116-20) provided CNMI with an additional $36 million.

Congress has not made additional funding available after FY 2021 (i.e., September 30, 2021), which means that for FY 2022, territory Section 1108 allotments will revert back to their pre-P.L. 116-94 levels (Table 2). Territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds.[10]

Federal medical assistance percentage

The FMAP for the territories is set statutorily at 55 percent, unlike that of the states, which is set using a formula based on state per capita income (§ 1905(b) of the Act). There are several exceptions to the 55

percent FMAP. For FYs 2020 and 2021, the territories each have an increased FMAP. For American Samoa, CNMI, Guam, and USVI, the FMAP is 83 percent, and for Puerto Rico, it is 76 percent. During the national emergency declared in response to the COVID-19 outbreak, the territories will receive the 6.2 percentage point increase provided by FFCRA to all states and territories, effective January 1, 2020. This brings Puerto Rico's FMAP to 82.2 percent and the other territories' FMAPs to 89.2 percent during the emergency period (CMS 2020a). The territories will also receive a higher CHIP enhanced FMAP during the emergency period; 99 percent for Puerto Rico and 100 percent for the other territories (CMS 2020a, b).[11] Like the states, the territories' federal matching rate for almost all program administration is set at 50 percent (§ 1903(a)(7) of the Act).

Territories are also eligible for certain enhanced FMAPs. While the territories cannot claim the higher FMAP for covering the ACA's new adult group, they were eligible for a temporary 2.2 percentage point increase in their regular FMAP for all state plan populations between January 1, 2014 and December 31, 2015 (§§ 1905(y)(1) and 1905(z)(1)(A) of the Act) (CMS 2016b). This raised their FMAPs to 57.2 percent during this period. Additionally, territories are eligible for the expansion-state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the ACA, which is 90 percent in calendar year 2020 (§ 1905(z)(2) of the Act). Currently, only Guam, Puerto Rico, and USVI are accessing this early expansion FMAP.[12]

In general, territories must contribute a non-federal share at the applicable matching rate in order to gain access to federal funds. However, Congress has at times made some of the territories' supplemental appropriations available at a 100 percent matching rate, including

- funds provided for Puerto Rico and USVI under BBA 2018;
- ACA funds expended by American Samoa and Guam between January 1, 2019 and September 30, 2019; and,
- funds provided to CNMI by P.L. 116-20.[13]

Additionally, through the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) and the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116- 69), Congress provided all five territories with a temporary 100 percent matching rate for expenditures occurring from October 1, 2019 to December 20, 2019.[14]

The territories fund the non-federal share of their Medicaid and CHIP programs through general fund revenues and certified public expenditures. Puerto Rico, USVI, and Guam primarily operate using general funds, American Samoa primarily uses certified public expenditures, and CNMI uses a combination (CMS, 2016e).

Spending

As noted above, additional funds provided to the territories by P.L. 116-94 and FFCRA were structured as part of the territories' FYs 2020 and 2021 Section 1108 allotments. As a result, federal spending in FY 2020 did not exceed the allotment in any territory and is unlikely do so in FY 2021 (unlike in years past, when additional federal funds were structured as separate allotments). Spending in Puerto Rico accounts for most of the federal Medicaid and CHIP spending in the territories. In FY 2020, federal Medicaid spending in

all five territories totaled $2.8 billion, with $2.5 billion (90 percent) attributable to Puerto Rico. Federal CHIP funding totaled $174.5 million, with $111.4 million (64 percent) attributable to Puerto Rico (Table 3).

TABLE 3. Medicaid and CHIP Funding and Spending in the Territories, FY 2020 (millions)

Territory	Medicaid			CHIP		
	Section 1108 allotment	Spending		Federal allotment	Spending	
		Federal	Territory		Federal	Territory
American Samoa	$86.3	$46.1	4.9	$5.1	$5.8	$0.0
CNMI	63.1	39.1	3.6	11.8	16.5	0.0
Guam	130.9	122.8	12.0	35.0	29.1	0.0
Puerto Rico	2,716.2	2,516.9	327.9	192.8	111.5	0.8
USVI	128.7	77.8	8.6	11.6	11.8	0.0

Notes: FY is fiscal year. CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Section 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act. Federal CHIP allotments are provided under Section 2104 of the Social Security Act. If states and territories exhaust their own available CHIP allotments, they may receive additional funding from unused state CHIP allotments. American Samoa, CNMI, and USVI received these redistributed funds in FY 2020. For spending and allotments for FYs 2011–2019, see individual territory fact sheets.

0.0 indicates a value less than 0.05.

Sources: MACPAC 2021 analysis of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) and CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2020.

Data and Reporting

Like states, the territories report data on Medicaid and CHIP budget projections using Form CMS-37 and on enrollment and spending (both aggregate and by category) using Form CMS-64. The territories are not required to report expenditures beyond their federal limits, although, in general, they do report all of their spending (CMS 2016e).

Under their Section 1902(j) waivers, American Samoa and CNMI are exempt from all data and reporting requirements. Additionally, none of the territories are considered states for the purpose of required quarterly reporting of statistical and program expenditure data for CHIP (42 CFR 457.740). Due to administrative capacity constraints USVI, Guam, and Puerto Rico are unable to report all of the same data as states even when they are not statutorily exempt. For example, CMS does not collect EPSDT service data via Form CMS-416 from any of the territories, or data on upper payment limit payments for any of the territories except Guam (CMS 2016d).

Use of the Medicaid Management Information System (MMIS), which states typically use for processing claims, has been limited among the territories but this is changing. Puerto Rico and USVI now both have a fully operational MMIS certified to report data to the CMS Transformed Medicaid Statistical Information System (T-MSIS).[15] T-MSIS is the primary administrative data set used for Medicaid program oversight and

accountability, and includes data on eligibility, enrollment, utilization, and spending. USVI implemented its MMIS in partnership with West Virginia (GAO 2015).[16] American Samoa, CNMI, and Guam do not have MMIS nor do they report information to T-MSIS, but they are required to demonstrate reasonable progress towards doing so by October 1, 2021 (P.L. 116-94). For the purposes of developing MMIS, territories can access federal Medicaid funds that do not apply toward their annual Section 1108 allotments at a 90 percent federal match (CMS, 2016c).

Territories are also facing new reporting requirements. Each territory must report to the chair and ranking member of the House Committee on Energy and Commerce and of the Senate Committee on Finance on how they used the extra funds provided by P.L. 116-94 within 30 days of the end of FYs 2020 and 2021. Puerto Rico is subject to additional requirements, including that it must establish and maintain a system for tracking amounts paid by the federal government to the territory and provide information about how these amounts were spent; report on selected measures in the Medicaid and CHIP Scorecard; and, upon CMS request, submit all documentation on contracts awarded by the territory Medicaid program.

Quality Measurement and Program Integrity

Territories are not required to participate in many of the federally required quality and program integrity efforts that apply to states. CNMI and American Samoa are exempt from these requirements through their 1902(j) waivers. USVI, and Guam are statutorily exempt from the Payment Error Rate Measurement (PERM) program, from facing repayments under the Medicaid Eligibility Quality Control program (MEQC), and are not required to implement asset verification systems with financial institutions (42 CFR 431.954; and §§ 1903(u)(4) and 1940(a)(4) of the Act). Puerto Rico is now required to develop and publish plans to satisfy PERM and MEQC program requirements by June 2021.

All five territories are required to designate a program integrity lead other than the Medicaid director within the Medicaid agency.[17] Some territories have implemented provider screening, as well as provisions related to non-payment for health care-acquired conditions and provider-preventable conditions. Puerto Rico, whose entire Medicaid population is enrolled in managed care, requires quality reporting in its managed care contracts (CMS 2016e). It further increased expectations for plans' quality and program integrity responsibilities in its most recent managed care restructuring, implemented in 2018 (MACPAC 2019b).

While territories have not historically had Medicaid fraud control units (MFCUs), Puerto Rico established them in 2018 and USVI in 2019 (CMS 2018c). American Samoa, CNMI, and Guam must now take reasonable steps towards establishing MFCUs by October 2021.[18] Expenditures for establishing an MFCU do not count toward the Section 1108 allotment.[19]

Endnote

[1] Residents of all territories may travel to or establish residency in any state on the mainland without restriction. However, while residing in the territory, they cannot vote in U.S. presidential elections, and do not have a voting representative in Congress. Additionally, they generally do not pay federal income taxes except on income from sources outside of their

territories, including the other territories and states, if that income is over the filing threshold. Residents of the territories do pay most other federal taxes, including Medicare taxes (IRS 2016).

[2] While all territories technically provide the EPSDT benefit under the state plan, there are instances of limitations on the benefit. For example, a report by the 2011 *President's Task Force on Puerto Rico's Status* found that the children in Puerto Rico's Medicaid program only received limited benefits through EPSDT (Muñoz et al. 2011).

[3] Historically, territories were not included in the Medicaid drug rebate program but could receive territorial government-mandated price concessions and other discounts. Effective April 1 2022, territories will be included in the Medicaid drug rebate program but may request a waiver to opt out (CMS 2019a).

[4] Unlike the states, the territories are not required to establish Medicare Savings Programs (§ 1905(p)(4)(A) of the Act).

[5] Individuals in the territories are not eligible for the Medicare Part D Low-Income Subsidy (§1935(e)(1)(A) of the Act).

[6] P.L. 116-94 initially raised each territory's FYs 2020 and 2021 allotments to $84.0 million per FY for American Samoa, $60.0 million per FY for CNMI, $127.0 million per FY for Guam, and $126.0 million per FY for USVI; it also raised Puerto Rico's FY 2020 allotment to $2.6 billion and its FY 2021 allotment to $2.7 billion. FFCRA subsequently raised these allotments further (Table 2).

[7] With the funds from Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. None of the territories chose to establish an exchange.

[8] Section 2005 funds were allocated to each territory by the Secretary. Of the $1 billion provided by Section 1323, $925 million was directed to Puerto Rico by Congress and the remainder was allocated by the Secretary.

[9] Of the BBA funds, $1.2 billion for Puerto Rico and $35.6 million for USVI were conditional on them meeting certain targets related to data reporting and program integrity, which they have met (CMS 2018b).

[10] Federal funds for the Enhanced Allotment Plan, electronic health record incentive program payments, establishment and operation of eligibility systems, Medicaid Management Information Systems (MMIS), and—beginning on July 1, 2017 for Puerto Rico and January 1, 2018 for USVI—Medicaid fraud control units (MFCUs), do not apply toward the annual Section 1108 allotment.

[11] Prior to P.L. 116-94 and FFCRA, the territories' FY 2020 CHIP enhanced FMAP was 80 percent (§ 2101(a) of the ACA; MACPAC 2019a). The higher FMAPs provided during the emergency period (82.2 percent for Puerto Rico and 89.2 percent for the other territories) serve as the base for calculating CHIP enhanced FMAPs during the emergency period (CMS 2020a, b).

[12] Because of these exceptions to the FMAP, the overall federal share of spending can be higher than 55 percent. For example, in FY 2017, federal spending covered 66.4 percent of total spending in Puerto Rico (MACPAC 2019b).

[13] P.L. 116-20 allowed American Samoa and Guam to access their remaining ACA Section 2005 funds at a 100 percent matching rate because prior to this legislation, both territories were projected to leave a significant amount of ACA funds unspent at the time of expiration, due to difficulty generating the non-federal share needed to draw down these funds.

[14] P.L. 116-59 provided a 100 percent matching rate from October 1, 2019 to November 21, 2019; P.L. 116-69 extended the 100 percent matching rate through December 20, 2019.

[15] The Bipartisan Budget Act of 2018 conditioned a portion of the additional funds it provided to Puerto Rico and USVI on making improvements to their data reporting and program integrity capacity. The territories were required to make reasonable and appropriate steps, as certified by and on a timeline specified by the Secretary, toward establishing methods of collecting and reporting reliable data to the Transformed Medicaid Statistical Information System (T-MSIS) and establishing an MFCU. Both Puerto Rico and USVI met their targets on schedule and received the full amount of BBA funds (CMS 2018b).

[16] West Virginia began allowing USVI to use its MMIS in 2013 in a first-of-its-kind partnership. While West Virginia does not charge for the use of the system, USVI does contribute toward maintenance and operating costs, which it pays directly to the fiscal agent. This arrangement allows USVI to avoid having to construct a system from scratch and allows West Virginia to reduce its own contribution towards maintenance and operations (GAO 2015, CMS 2016b).

[17] Territories that do not satisfy this requirement will be subject to an FMAP reduction in each quarter of FY 2021. The amount of the potential reduction is 0.25 percentage points multiplied by the number of quarters the requirement is not satisfied (not to exceed 5 percentage points).

[18] American Samoa and CNMI are not required to establish MFCUs under their Section 1902(j) waivers, but P.L. 116-94 required the Secretary to periodically reevaluate whether the waivers should continue to apply to MFCU requirements.

[19] Federal financial participation for such expenditures has been excluded from Puerto Rico's annual Section 1108 allotment since July 1, 2017 and from the USVI's annual allotment since January 1, 2018 (§ 1108(g)(4) of the Act).

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