EDITORIAL

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Healthcare Disparities Affecting Americans in the US Territories: A Century-Old Dilemma

In 1917, the Jones Act granted US citizenship to natives of Puerto Rico, the first among the 5 territories acquired by the United States since 1898.[1] A dilemma in that early period—"Does the Constitution follow the flag?"—was addressed in several cases considered by the Supreme Court between 1901 and 1932, known as the "Insular Cases."[2] These decisions ultimately set the legal basis to limit the constitutional rights of US citizens who reside in the territories. Law scholars have recently argued the need to "Reconsider the Insular Cases" and their sociopolitical consequences in light of their inconsistencies with contemporary constitutional and international law, and human rights principles.[3]

DISPARITIES IN FEDERAL HEALTHCARE FUNDING

The doctrine of the Insular Cases may have influenced the Social Security Act in 1935 and Medicare and Medicaid in 1965, because these programs are applied differently to the approximately 4 million US citizens who reside in the territories compared with those residing in the 50 states and the District of Columbia. These differences were examined in a 2005 Government Accountability Office (GAO) report to Congress.[4] The GAO found uniform and profound differences in the implementation of the Medicaid program across all 5 territories, with a Medicaid per capita funding of only one tenth of that in the states. For the Medicare program, spending per beneficiary in the territories was consistently less than half of that in the average state. Since then, these disparities remain and new ones have emerged (**Table**).

DISPARITIES IN QUALITY OF CARE AND OUTCOMES

Healthcare funding disparities may have contributed to observed gaps in key hospital performance measures and outcomes for Medicare beneficiaries in the territories. In one study, Puerto Rico ranked last among all states and the District of Columbia on average performance across 22 Medicare quality indicators.[5] Another study found that Fee-for-Service Medicare beneficiaries in the US territories admitted with acute myocardial infarction, pneumonia, or heart failure had higher 30-day mortality and lower performance on core process measures.[6] Likewise, Medicare Advantage enrollees in Puerto Rico fared worse in 15 of 17 performance measures recently evaluated.[7] In the treatment of acute myocardial infarction, US territories also lagged during a period of rapid improvement of the door-to-balloon time metric in the states.[8] However, several Puerto Rico hospitals now match the states' performance, thus supporting the potential to reduce quality gaps.[9] The root causes of quality gaps between the US territories and the states are likely complex and need continued exploration and scrutiny.

DISPARITIES IN HEALTHCARE INFRASTRUCTURE

The results of a national survey that included Puerto Rico and the US Virgin Islands showed fewer registered nurses, emergency medicine specialists, and intensive care unit beds, as well as longer emergency department wait times.[10] Moreover, the GAO reported significantly fewer skilled nursing facilities in all US territories compared with the states, which may increase hospital length of stay and costs.[4] Compared with the states, where most hospitals had electronic health record technologies by 2014, their adoption in Puerto Rico hospitals lagged as a result of being excluded from the incentives provided by the Health Information Technology for Economic and Clinical Health Act of 2009.[11] Compounding this, the exodus of physicians and

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Table Comparison of Medicare and Medicaid Programs in the US Territories and States

Differences in Medicare*	Territories	States and District of Columbia	Potential Impact on Territories
Part A Hospital Payments under the IPPS	Cost-based (not IPPS) system except in PR where lower base rate of IPPS payments until 2016	Higher base rate of IPPS payments	Financial strain in hospital operations and infrastructure
Part A Medicare Disproportionate Share Hospital Payments (PR)	Formula yielded lower supplemental payments	Higher supplemental payments	Financial strain in hospital operations and infrastructure
Part B Enrollment (PR)	Must "opt in" (77% enrollment)	Automatic (95% enrollment)	Less access to physicians
Part B Physician Fee Schedule (PR)	Geographic Practice Cost Index formula yields lowest fees of all 50 states and District of Columbia	Variably higher fees according to the Geographic Practice Cost Index formula	Physician scarcity and exodus impairs patient access to care
Part D Prescription Benefit	No direct individual subsidy	Direct subsidy to low income beneficiaries	Less access to prescribed medications
Part C Medicare Advantage (PR)	Benchmark driven down by a lower territory fee-for-service component	Benchmark based on higher state fee-for-service component	Cost-minimization strategies such as provider network reductions by the Medicare Advantage industry impairs patient access to care
HITECH Act/Hospital Electronic Health Record Incentive (PR)	Ineligible for incentives until 2016	Eligible for incentives since 2011	Slow adoption of electronic health record and disadvantage in data-driven value-based market
Differences in Medicaid	**Territories**	**States and District of Columbia**	**Impact on Territories**
Federal Medical Assistance Percentage	Set at the 50% minimum available to the states until 2011 when increased to a fixed 55%	Variable (50%-83%) according to need as defined by the poverty level	Increased share paid by the local government
State Children's Health Insurance Program	Lower fund allocation not proportional to children in need	Fund allocation proportional to need	Increased share paid by the local government
Maximum Annual Medicaid Funding	Subject to a low statutory cap	Open-ended and not subject to a cap	Increased share paid by the local government
Medicaid Disproportionate Share Hospital Payments	Excluded from participation	Included	Lower hospital resources to treat the poor and uninsured
Minimum Mandatory Services	Not strictly enforced because of lower funding	Strictly enforced and met	Scarcity of nursing facility and home-health services

HITECH = Health Information Technology for Economic and Clinical Health; IPPS = Inpatient Prospective Payment System; PPS = Prospective Payment System; PR = Puerto Rico.
*Several of the differences in the Medicare program apply specifically to Puerto Rico.

allied healthcare professionals from Puerto Rico as a result of the combined healthcare and financial crisis further threatens access to care.[12]

DISPARITIES IN ACCESS TO DATA ON QUALITY AND OUTCOMES

The US territories and their underrepresented minorities have been excluded from national databases, such as the Dartmouth Atlas of Health Care and the National Healthcare Quality and Disparities Reports of the Agency for Healthcare Research and Quality.[13,14] Likewise, although clinical data registries have become increasingly relevant to improve quality through data, their implementation is costly.[15,16] In Puerto Rico, cost is a contributor to the limited penetration of cardiovascular registries despite the high number of invasive cardiac procedures performed.[17] For example, no cardiac surgery programs participate in the Society for Thoracic Surgeons registry, and only a handful of hospitals have limited participation in the American College of Cardiology National Cardiovascular Data Registries.[18,19] Without robust data sources, hospitals in Puerto Rico and the other US territories will be less able to compete for healthcare dollars in America's data-driven, value-based reimbursement system, leading to widening of healthcare disparities.[20]

MOMENTUM IN CONGRESS AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

Last year alone, 3 bills (H.R. 2635, S. 1961, and S. 2381) addressing healthcare disparities were introduced in Congress, and the Omnibus Appropriations Act of 2016 included provisions to confer equitable base payments and participation in the Health Information Technology for Economic and Clinical Health Act for Puerto Rico hospitals. A Centers for Medicare & Medicaid Services-proposed rule published in April 2016 aimed to achieve parity in Medicare Disproportionate Share payments and payments for capital-related costs for Puerto Rico hospitals. Another Centers for Medicare & Medicaid Services-proposed rule published in July 2016 included a revision of the Geographic Practice Cost Indices that lowered payments to Puerto Rico physicians. Finally, the "Puerto Rico Oversight, Management, and Economic Stability Act," which was enacted to create a financial oversight board to help manage the Puerto Rico fiscal crisis, will also create a Congressional Task Force on Economic Growth to report on "impediments in current Federal law and programs to economic growth in Puerto Rico including equitable access to Federal health care programs."[21]

CONCLUSIONS

Geographic healthcare disparities affecting the US territories need attention. In a country that states a commitment to the pursuit of health equity, decisive and meaningful action is required to achieve the healthcare parity all, not just stateside Americans, deserve. In the words of President Barack Obama, "We don't turn our backs on our fellow Americans. We don't treat folks differently because of where they live. Instead, we treat each other as Americans."[22] As American citizenship in the US territories turns 100, it is time to address healthcare disparities in funding, infrastructure, outcomes, and data that affect the "insular" US citizens.

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