Medicaid and CHIP in American Samoa

American Samoa is a U.S. territory made up of seven islands in the South Pacific Ocean. It became a U.S. territory in 1900 and began participating in Medicaid in 1983 (CMS 2016a).

For the purposes of Medicaid and the State Children's Health Insurance Program (CHIP), American Samoa is considered a state unless otherwise indicated (§ 1101(a)(1) of the Social Security Act (the Act)). However American Samoa has a Section 1902(j) waiver, which allows its Medicaid and CHIP programs to operate differently than programs in the 50 states and the District of Columbia (§ 1902(j) of the Act).[1] Under this waiver, the Secretary of the U.S. Department of Health and Human Services may waive or modify any Medicaid requirement except 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 (§ 1902(j) of the Act).

This fact sheet summarizes the main requirements and design features of American Samoa's Medicaid and CHIP programs, including eligibility and enrollment, benefits, financing and spending, data and reporting, and quality and program integrity.

Eligibility and Enrollment

In American Samoa, Medicaid eligibility is not determined on an individual basis and individuals do not enroll in Medicaid or CHIP as in other territories and states. Instead, federal Medicaid and CHIP funds pay for care provided at the Lyndon B. Johnson Tropical Medical Center (LBJ) in proportion to the population of American Samoans with incomes below the Medicaid and CHIP income eligibility thresholds. The medical center is owned by the territory and is the only Medicaid provider in American Samoa. It provides almost all of the health care services in the territory at little or no out-of-pocket cost (CMS 2016a).

To determine the level of federal financial participation for Medicaid, American Samoa uses census data to calculate the proportion of American Samoans with income under 200 percent of the federal poverty level (FPL), referred to as the claiming percentage, and applies it to the total allowable expenditures for services provided at LBJ. The Medicaid claiming percentage excludes adults over age 65, children under age 19 with income between 100 and 200 percent FPL, and non-citizens of American Samoa. Individuals over age 65 are excluded from the Medicaid claiming percentage because they are dually eligible and covered by Medicare for most services. To determine the portion of care matchable at the CHIP enhanced matching rate, American Samoa calculates the claiming percentage for children under age 19 with income between 100 and 200 percent FPL. If CHIP expenditures as determined by this formula exceed the annual CHIP allotment and any redistribution CHIP funding, they can be added to Medicaid expenditures. The estimates of American Samoans below the Medicaid and CHIP income thresholds and the Medicaid and CHIP

claiming percentages must be approved by the Centers for Medicare & Medicaid Services (CMS) (CMS 2016b, 2014, 2012).

As of June 2019, 37,829 American Samoans were estimated to be below 200 percent FPL, approximately two-thirds of the population (MACPAC 2021).

Benefits

Services at the medical center are available to every American Samoan generally without charge. American Samoa is exempt from covering mandatory benefits under its Section 1902(j) waiver; it does not provide all 17 mandatory benefits. For example, it does not provide nursing facility, nurse midwife, or freestanding birth center services, citing insufficient funding and lack of infrastructure (GAO 2016). It provides many optional benefits, including dental and psychologist services and outpatient prescription drugs (CMS 2016b). All Medicaid enrollees under 21 are eligible to receive early and periodic screening, diagnostic, and treatment (EPSDT) services (CMS 2016c).

In 2017, American Samoa added federally qualified health center (FQHC) services to the state plan and, under certain circumstances, off-island and out-of-country services (allowing American Samoans to access services in Hawaii or New Zealand) (CMS 2017b, c).[2]

Benefits for dually eligible beneficiaries

The territory pays the cost of Medicare Part A and B deductibles and coinsurance for all American Samoans enrolled in Medicare. It claims the federal Medicaid match for the estimated proportion of these costs attributable to dually eligible beneficiaries. This calculation assumes that the percentage of Medicare beneficiaries who are dually eligible for Medicaid is the same as the percentage of American Samoans over age 65 who fall below 200 percent FPL. Therefore, the same percentage determined for all Medicare Part A and Part B deductible and coinsurance are allowable costs for Medicaid reimbursement (CMS 2012).

No Medicare Part D plans are currently available in American Samoa to provide prescription drug coverage. Dually eligible beneficiaries may obtain prescription drugs directly from LBJ generally without cost sharing (CMS 2016a). To help finance these costs, American Samoa receives a federal allotment from the Enhanced Allotment Plan (also known as 1935(e) funding), which was $322,609 in FY 2018 (CMS 2018c).[3] The allotment is separate from the Section 1108 allotment described below and can only be used for this purpose (§ 1935(e) of the Act).

Financing and Spending

The federal government and the government of American Samoa jointly finance American Samoa's Medicaid program. American Samoa must contribute its non-federal share of Medicaid spending in order to access federal dollars, which are matched at the designated FMAP, otherwise known as the matching

rate. Unlike the states, for which federal Medicaid spending is open ended, American Samoa can access federal dollars only up to an annual ceiling, referred to as the Section 1108 cap or Section 1108 allotment.

Federal funding

American Samoa's annual Section 1108 allotment was set in statute when its Medicaid program was established, in 1983, and grows with the medical component of the Consumer Price Index for All Urban Consumers (§ 1108(g) of the Act). American Samoa's CHIP allotment is determined by CMS based on prior year spending, the same methodology used for states.

In general, once American Samoa exhausts its annual federal Medicaid and CHIP allotments, it must fund its program with local funds. [4] However, Congress has provided time-limited supplemental federal Medicaid funds to American Samoa and other territories on several occasions but most recently 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 raised American Samoa's FY 2020 allotment from $12.4 million to $86.3 million, and its FY 2021 allotment from approximately $12.7 million to $85.6 million (CMS 2019a).[5,6]

Additionally, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided the territories with a total of $7.3 billion in additional federal funds for their Medicaid program (i.e., on top of their annual Section 1108 allotments). ACA Section 2005 provided $181.3 million to American Samoa, which was available to be drawn down between July 2011 and September 2019. ACA Section 1323 provided an additional $16.5 million, which was available to be drawn down between January 2014 and December 2019.[7]

Congress has not made additional funding available after FY 2021 (i.e., September 30, 2021), which means that for FY 2022 and future years, American Samoa's Section 1108 allotment will revert to pre-P.L. 116-94 levels (approximately $13.0 million in FY 2022).

Federal medical assistance percentage

The FMAP for American Samoa and the other territories is set statutorily at 55 percent, unlike that of the states, where the FMAP is set using a formula based on state per capita income (§ 1905(b) of the Act). For FYs 2020 and 2021, American Samoa has a temporary FMAP of 83 percent. During the national emergency declared in response to the COVID-19 outbreak, effective January 1, 2020, American Samoa will receive the 6.2 percentage point increase provided by FFCRA to all states and territories. This brings American Samoa's FMAP to 89.2 percent during the emergency period. American Samoa will also receive a 100 percent CHIP enhanced FMAP during the emergency period (CMS 2020a, b). [8] Like the states, the American Samoa's federal matching rate for almost all program administration is set at 50 percent (§ 1903(a)(7) of the Act, CMS 2016b).

American Samoa is eligible for the enhanced matching rate for certain expenditures. The territories cannot claim the newly eligible FMAP of 100 percent available to states expanding to the new adult group. Though 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 (90 percent in CY 2020), American Samoa had not claimed any expenditures under this FMAP (CMS 2018c, 2016b).[9] In addition, American Samoa received a temporary 2.2 percentage point increase in its regular FMAP between January 1, 2014 and December 31, 2015 (§ 1905(z) of the Act, CMS 2016a).

In general, territories must contribute a non-federal share at the applicable matching rate in order to gain access to federal funds. As previously noted, American Samoa owns, operates, and funds the territory's only hospital where almost all care in the territory is provided. The federal government provides the annual allotments for Medicaid and CHIP subject to their respective claiming percentages and matching rates. American Samoa finances these operations primarily through certified public expenditures (CMS 2016c). Due in part to limited capacity at the hospital to provide services, the territory has often experienced difficulty generating non-federal share it needs to draw down federal funds. (CMS 2018a).

In response to these difficulties and natural disasters affecting American Samoa in 2018 and 2019, Congress passed the Additional Supplemental Appropriations for Disaster Relief Act of 2019, P.L. 116-20 in June 2019; this made the territory's remaining ACA funds available at a 100 percent federal matching rate for the period between January 1 and September 30, 2019. Additionally, Congress provided American Samoa a temporary 100 percent matching rate for expenditures occurring from October 1, 2019 to December 20, 2019 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).

Total spending

In FY 2020, federal Medicaid spending in American Samoa was $46.1 million, or 2 percent of all federal Medicaid spending in the territories. Federal CHIP spending totaled $5.8 million, or 3 percent of total federal CHIP spending in the territories (Table 1)

As noted above, additional funds provided to American Samoa by P.L. 116-94 and FFCRA were structured as part of American Samoa's FYs 2020 and 2021 Section 1108 allotments. As a result, federal spending in FY 2020 did not exceed the allotment and is unlikely do so in FY 2021. In FYs 2011–2019, federal spending for Medicaid in American Samoa exceeded the annual Section 1108 allotment every year (Table 1). This spending reflects use of the additional funds available under Sections 2005 and 1323 of the ACA, which were available through September 2019, and structured separately from the annual allotment).[10] Federal spending grew in FY 2019 due to the 100 percent matching rate available between January 1 and September 30, 2019. Spending declinedslightly in FY 2020 (Table 1).

TABLE 1. Medicaid and CHIP Spending in American Samoa, FYs 2011–2020, by Source of Funds (millions)

Year	Medicaid				CHIP			
	Section 1108 allotment	Federal spending	American Samoa spending	Total spending	Federal allotment	Federal spending	American Samoa spending	Total spending
FY 2020	$86.3	$46.1	$4.9	**$51.0**	$5.1	$5.8	$0.0	**$5.8**
FY 2019	12.2	48.1	7.0	**55.1**	4.8	2.5	0.0	**2.5**
FY 2018	11.9	20.1	15.3	**35.4**	3.1	4.6	0.2	**4.8**
FY 2017	11.5	19.4	15.1	**34.5**	2.9	3.6	0.1	**3.7**
FY 2016	11.1	21.8	14.8	**36.5**	2.1	2.6	0.0	**2.7**
FY 2015	10.9	15.2	11.5	**26.7**	1.7	1.7	0.7	**2.4**
FY 2014	10.6	14.6	12.0	**26.6**	1.4	1.4	0.6	**2.0**
FY 2013	10.2	13.3	10.9	**24.2**	1.3	1.3	0.6	**1.9**
FY 2012	9.9	17.0	14.0	**31.0**	1.2	1.2	0.6	**1.8**
FY 2011	9.6	15.7	15.1	**30.8**	1.2	1.2	0.6	**1.8**

Notes: FY is fiscal year. Section 1108 allotments reflect the annual federal allotments (also referred to as caps) that territories receive under Section 1108(g) of the Social Security Act. Federal spending in excess of the Section 1108 allotment for FYs 2011 – 2019 reflects use of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), as well as spending not subject to the cap. 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 received these redistributed funds in FYs 2016–2018 and again in FY 2020..

0.0 indicates a value less than 0.05.

Sources: MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2020; CMS 2019b; MACPAC 2019 analysis of CMS regional office narrative reports for FYs 2011–2018.

Data and Reporting

American Samoa is exempt from all Medicaid data and reporting requirements under its Section 1902(j) waiver. However, it does report data on budgets and expenditures using Form CMS-37, and on enrollment and aggregate and category-specific spending using Form CMS-64 (CMS 2016c).

Like the other territories, American Samoa does not submit quarterly statistical and program expenditure data for CHIP. It also does not submit data on the use of EPSDT services via Form CMS-416 or data on upper payment limit payments. It does not have a Medicaid Management Information System or report

information to the Transformed Medicaid Statistical Information System (T-MSIS) but is required to demonstrate reasonable progress towards doing so by October 1, 2021 (P.L. 116-94). American Samoa 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 it used the extra funds provided by P.L. 116-94 within 30 days of the end of FYs 2020 and 2021.

Quality and Program Integrity

American Samoa is exempt from federal quality and program integrity requirements under its Section 1902(j) waiver. It is unclear what provider screening or quality measures are in place internally at its government-owned hospital, the primary source of care on the island.

P.L. 116-94 included new program integrity requirements for American Samoa. Before the end of FY 2020, American Samoa is required to designate a program integrity lead within the Medicaid agency other than the Medicaid director.[11] Additionally, while the territory has not historically had a Medicaid Fraud Control Unit (MFCU), it is now required to take reasonable steps towards establishing a MFCU by October 2021.[12]

Endnotes

[1] The Section 1902(j) waiver is only available to American Samoa and the Commonwealth of the Northern Mariana Islands.

[2] Out-of-country providers are required to have Joint Commission International accreditation or meet credentialing standards, have a signed agreement with the American Samoa Medicaid agency, and satisfy Medicaid conditions of participation. Services can be furnished when emergency or medically necessary services are not available in American Samoa, when the out-of-country provider is the nearest source of care, or when the aggregate cost of needed care is less than the same care is provided in the United States, including transportation costs.

[3] Like the other territories, American Samoa is not eligible for the Medicare Part D low-income subsidy (§ 1935(e)(1)(A) of the Act).

[4] Federal funds for the Enhanced Allotment Plan (EAP), electronic health record incentive program payments, and the establishment and operation of eligibility systems and Medicaid Management Information Systems do not apply toward the cap.

[5] P.L. 116-94 raised American Samoa's FYs 2020 and 2021 allotments to $84 million. Subsequently, FFCRA further raised the FY 2020 allotment to $86.3 million and the FY 2021 allotment to $85.5 million.

[6]We estimate what the FY 2021 allotment would have been without these additional funds by trending the pre-P.L. 116-94 FY 2020 allotment by 2.3 percent (the percent change in the medical component of the Consumer Price Index for All Urban Consumers for the 12-month period ending March 2019).

[7] With the funds from Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. Neither American Samoa nor the other territories chose to establish an exchange.

[8] Prior to P.L. 116-94 and FFCRA, American Samoa's FY 2020 CHIP enhanced FMAP was 80 percent (§ 2101(a) of the ACA; MACPAC 2019). The 89.2 percent FMAP provided during the emergency period serves as the base for calculating the CHIP enhanced FMAP during the emergency period (CMS 2020a, b).

[9] Though American Samoa is eligible for this matching rate, it had not claimed expenditures in this category as of July 30, 2018 (CMS 2018c).

[10] Spending over the cap also includes a small amount of expenditures not subject to the cap, including EAP spending. In FY 2017, EAP spending was approximately $300,000 (CMS 2017a).

[11] American Samoa 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).

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

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