Andy Pulotta's
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RECOMMENDED ASG STRATEGY
FOR
OBTAINING FEDERAL MEDICAID FUNDING

DRAFT

December 4, 1981

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December 4, 1981

Charles R. McCuddin
Director, ASHPDA
LBJ Tropical Medical Center
Pago Pago, American Samoa 96799

Dear Mr. McCuddin:

The attached report contains our recommendations for ASG's strategy for obtaining Federal Medicaid funding. This work was authorized under Task Order Number 2, Contract Number CM-525-82, and was performed by Jerry Siegel and Mike Murray. It reflects the suggestions and advice of a number of individuals knowledgable in Medicaid and Territorial affairs.

I will be pleased to present and review this draft report with you, Mr. Ace Tago and other ASG officials during the week of December 7, and finalize the report based on the comments and suggestions received.

Soifua,

Gerald N. Siegel

Michael W. Murray

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CHAPTER I

MANAGEMENT SUMMARY

I. MANAGEMENT SUMMARY

ASG participates in a wide range of specific Federal grant programs that provide financial assistance to numerous local programs --education, law enforcement, housing, public works, the arts, public health, etc. The importance of this funding is evidenced by the fact that approximately 22 percent of the total FY82 ASG budget is made up of specific Federal grants.

ASG does not, however, participate in the single largest Federal grant program -- Medicaid -- even though each of the 50 States and all of the Territories are involved in this program. The reasons for this are not known for sure, but some of them may be that:

- When the Medicaid program was first enacted by Congress in 1965, ASG health care costs were not a major problem, as they are now, and the appointed governor and administration may not have considered the potential funding to be significant.
- The American Samoan people may have been culturally opposed to a program that carried a "welfare" connotation.
- ASG officials may have wisely concluded that the administrative burdens of a Medicaid program would outweigh the gains, particularly one that would require a number of skilled management and administrative personnel which are needed in other public and private sector positions.

Whatever the past reasons were, the time has come to re-examine this potential source of funding in terms of what it could do for ASG and how ASG could obtain such funds without the burdensome requirements or the welfare overtones.

A. POTENTIAL FUNDING

The potential funding from a Federal Medicaid grant, based on the FY82 ASG budget for DOH, is estimated to be between $550,000 and $1,275,000. The reason for the range of the estimate is due to the uncertainties about the number of residents who would be eligible to enroll in an ASG Medicaid program. This, in turn, is dependent on what would be an acceptable poverty line for American Samoa and the number of residents falling below that poverty line.

The higher reimbursement estimate is based on a recent calculation of ASG's current poverty line made by the Development Planning Office. The lower estimate is the result of a lower poverty line and, consequently, a fewer number of residents enrolled and this is based on the experience of the Commonwealth of the Northern Mariana Islands (CNMI). When the detailed 1980 Census data become available, these estimates should be further refined and the Census Bureau's poverty line for ASG be evaluated. Nevertheless, the ultimate determination would be made in negotiations with the Health Care Financing Administration (HCFA) where the details for establishing the poverty line will be decided with ASG.

B FINANCIAL ADVANTAGES

Regardless of the uncertainties about the amount which could be obtained from Medicaid, there are a number of obvious advantages:

- These funds could account for 7.5 percent to 17.5 percent of the FY82 budget for DOH and thus help to alleviate current budget pressures and help finance needed health care improvements.

- These funds could form an essential foundation in any ASG plan to restructure health care financing because they provide a viable means of financing care for the poor that do not fall entirely on those able to pay.

C ALTERNATIVES AND RECOMMENDATIONS FOR OBTAINING THE FUNDS

Given the obvious advantages to ASG of using the Medicaid funds, the next question is how can the monies be obtained. Since the present Medicaid statutes, Title XIX of the Social Security Act and related titles, do not authorize ASG to participate in the Medicaid program, we have developed and evaluated several alternatives as follows.

A direct approach would be for ASG to request Congress to amend the Social Security Act to permit ASG to participate in the Medicaid program. However, this would mean that ASG would also have to be involved with other directly related "welfare" oriented programs to get access to Medicaid funds. In addition, there would be administrative requirements which many are convinced would be excessively burdensome to ASG.

In order to avoid these problems, we examined another alternative that would have ASG request Congress to authorize a demonstration program to allow ASG to have Federal funds to design and operate an alternative program to Medicaid that meets the unique needs of the Territories. While this alternative has the promise of avoiding the burdensome requirements of the Medicaid program and the related welfare connotations, there are certain risks to legislating a demonstration grant and to the continuation of Federal funding after the demonstration period ends.

For these reasons, we believe a combination of the two offers the greatest advantage with the least disadvantages and risk. The recommended alternative would have ASG request Congress to amend the statutes, as in the first alternative, but have Committee Report language state ASG's intent to develop a demonstration project to show the advantages of a Medicaid program that has been specifically designed for a Territory such as American Samoa.

D. SUGGEST IMPLEMENTATION APPROACH

Because there are obvious financial advantages to acquiring the funds and there is one, if not two, viable alternatives for obtaining the funds, the next step is to decide how to go about it. The following summarizes our suggestions for this:

- Review this draft strategy and approach with key ASG executives and obtain agreement to proceed.
- Obtain written endorsements from the ASG executive and legislative branches to demonstrate support to the Federal level.

- Prepare a concept paper and presentation materials.
- Present and discuss the ASG concept paper with key representatives and staff of Congress, HCFA and DOI.
- Continue efforts through lesislative and grant award processes.

* * * *

The following chapters discuss the alternatives, key demonstration grant terms and conditions, and the suggested implementation approach.

CHAPTER II.

ALTERNATIVES TO OBTAINING FUNDS

II. ALTERNATIVES TO OBTAINING FUNDS

This chapter contains a discussion of the three basic alternatives for obtaining a Medicaid grant. The pros and cons of each alternative are summarized along with the recommended approach.

A. ALTERNATIVE 1

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States to provide medical assistance to low income persons who are:

- Age 65 or over, Title I.
- Blind, Title X.
- Disabled, Title XIV.
- Aged Blind and Disabled, Title XVI.
- Members of Families with Dependent Children, Title IV, Part A.

The program is jointly funded by the Federal and State governments and administered by the States within the broad Federal rules for deciding those who are eligible, the types and ranges of services, the payment levels for services, and the administrative and operating procedures. Payments for services are made directly by the State to those funishing the services.

Title XI of the Social Security Act contains the general provisions of the entire act and, in Section 1101(2) (1), the term "state" is defined. The term "state" includes Puerto Rico, Virgin Islands and Guam for Titles, I, IV, X, XIV, XVI and XIX. (CNMI) has been extended the same eligibility for the Federal services and financial assistance as they apply to Guam by the terms of the Covenant to Establish the CNMI (PL94-241).

American Samoa is included in the definition of "state" only for Title V, Maternal and Child Health and Crippled Children's Services, and for Part B of Title XI, Professional Standards Review. As a result, ASG is not eligible for Federal dollars for Medicaid or for funding under the provisions of the other titles of the Social Security Act.

Given this situation, Alternative 1 would be for ASG to request

Congress to change the Social Security Act to allow it to become eligible for a Title XIX, Medicaid grant. However, the statutes should also be changed to allow ASG to participate in Titles I, IV, XIV and XVI. This is because a state's operation of the Medicaid program is tied directly to the general income and resource eligibility criteria that are contained in the state plan approved for those titles.

The obvious advantage of this alternative is that it permits ASG to obtain the desired monies. However, there are a number of disadvantages.

- There are particularly burdensome Medicaid rules; such as, developing approved state plans that contain the general income and resource eligibility requirements for each of the titles, and developing the administrative unit required to maintain and operate the Medicaid portion of the program.

- The practical and political advisability of this alternative would very likely be questioned because of the problems other Territories and States have experienced with the Medicaid program and related titles, (CNMI, for example), and the current Administration's desire to simplify Federal administrative requirements in general, and the Medicaid program in particular. Moreover, any implementation of the other "welfare" oriented titles could cause concerns among the Samoans and claims from other quarters that the U.S. was continuing to destroy local cultures and moving her Territories toward mainland welfare states.

Since the disadvantages of this alternative seem to heavily outweigh the advantages, the following alternative was considered.

B. ALTERNATIVE 2

This alternative would have ASG request Congressional action to permit or require a demonstration project which would utilize Fedeal monies for funding the delivery of health care to the poor in ASG. The project would be designated to demonstrate that the present Medicaid program is inappropirate to the unique problems and requirements of the Territories, and that there is a more cost effective approach which could have applicability to other Territories as well

as to the small "insular-like" States and local jurisdictions.

The advantages of this alternative are that:

- It goes to the heart of ASG's needs — financing health care for the poor - with a system specifically designed for ASG without tagging on the other welfare oriented titles.
- It attempts to avoid the burdensome regulatory requirements.
- It has the potential for applicability to other similar jurisdictions.

The disadvantages are that:

- If written by Congress specifically for ASG, there could be a legal challenge by other Territories or States wishing the same option. To overcome this, there could be some pressure to write it broadly to include several or many other Territories and States.
- At the expiration of the demonstration grant period, in 3 to 5 years, a new source of funding would need to be found to finance care for the poor.

C. ALTERNATIVE 3

This alternative is a combination of the best parts of 1 and 2, which seeks to avoid their disadvantages. Its key elements are:

- To obtain Congressional action to include ASG in the definition of "State" for the purposes of Medicaid and all of the related titles.
- To obtain Committee Report language to clarify that ASG's intent is not to implement the entire Medicaid program, as it presently exists, and that for cultural and other reasons unique to American Samoa, it intends to demonstrate a superior alternative to the Medicaid program for the Territories.
- To obtain from HCFA, under the provisions of Section 1115, Title IX of the Social Security Act, a waiver of the requirements for titles other than Medicaid and to develop a mutually acceptable demonstration grant.

The advantages of this alternative are that:

- It is a demonstration grant but with the promise of continued Medicaid funding if successful and permanent involvement in the Medicaid Program in any event.

- It gets health care financing for the poor without the welfare programs.

- Facilitates the political and practical acceptance of ASG's proposal.

- Permits ASG the opportunity to develop its own reasonable program and to avoid the burdensome regulatory requirments.

- Results in a program that is potentially transferrable to other Territories and States.

- Avoids the potential problems of writing a statute solely for an ASG demonstration program or one so broad that ASG might not get a grant.

The disadvantages of this alternative are also applicable to the other two:

- The time required for Congressional action.

- The time required to obtain a demonstration grant.

- The overall budget concerns at the Federal level.

On balance, it appears clear that Alternative 3 is the most desirable course of action for ASG to pursue. Should some unforeseen problem arise with it, then Alternative 2 would be the viable choice. In any event, Alternative 1 should be avoided.

CHAPTER III.

KEY GRANT TERMS AND CONDITIONS

III. KEY GRANT TERMS AND CONDITIONS

There are several terms and conditions in the demonstration grant that will be important to ASG in terms of reimbursement and ease of administration. By the same token, Congress and HCFA are certain to have key requirements that, at least in concept, are part of the present Medicaid program or that they would want included in the grant conditions. In general, ASG will probably seek to maximize reimbursement and minimize administration while HCFA will seek to assure program and financial integrity. Both parties should agree at the outset to "keep it simple". The following are those reqirements considered key along with the position and approach suggested for ASG.

A. METHODOLOGY FOR DETERMINING THE POVERTY LINE

The methodology used by the Development Planning Office to estimate the current poverty line (see Appendix A) should be used as the baseline. Since it results in a large percentage of the population who fall below the poverty line, it will probably be questioned by HCFA. The detailed 1980 Census data should be used to verify that methodology and compare its results with the poverty level for ASG established by the Census Bureau and then apply that to the number of ASG residents falling below the level. The methodology and data used by Guam and CNMI should also be obtained for comparison purposes, as well as existing poverty line data for other jurisdictions.

B ELIGIBILITY DETERMINATION AND ENROLLMENT

The method by which eligibility will be determined for each case and the method by which residents will be enrolled and disenrolled is likely to become a key requirement. An eligibility determination and enrollment process at the point of patient encounter at LBJ is one approach while another might be an outreach approach using information in the tax files if permitted. Maintenance of the enrollment files could be performed through: (1) the tax files; (2) a separate information system — manual or computerized; or (3) an addition to

the information system plans of DOH/ASHPDA. In any of these cases, any overall plans for a prepaid enrollment program for the entire population should be considered.

ASG and HCFA may wish to consider another approach that avoids the above efforts and system requirements. This would involve a block grant based upon the expected number of residents falling below the poverty line. Here the burden would fall on the need to periodically update the data required to calculate the ASG poverty line and assurances that those eligible but not discretely enrolled had access to care at the same quality level. In effect, HCFA would be reimbursing for a group of eligibles rather than for specific individuals on the basis of "presumptive eligibility" for which there is some precedent. This may be culturally more acceptable because there would not be the stigma of being a "card carrying" Medicaid recipient.

C. REIMBURSEMENT PAYMENT APPROACH

If the enrollment is on an individual basis, reimbursement could be on a service basis or on a prepaid, capitated amount. A service basis should be avoided because of the accounting efforts that would be needed to record hundreds of thousands of individual services charges and to assemble them for each Medicaid enrollee receiving those services. Clearly, an all-inclusive rate or a monthly or periodic prepaid amount based on the average costs incurred for an enrollee or the population as a whole would be more desirable. For FY82, for example, the annual per capita for ASG medical care cost is estimated to be approximately $190 (see Appendix A). LBJ management effort will be required to develop an acceptable and defensible annual or periodic capitation rate.

If the grant terms were based on the total number of expected residents falling below the current poverty line, then reimbursement would be in a lump sum from HCFA to ASG and DOH. This, of course, would greatly simplify the administrative requirements for

reimbursement and payment as well as eligibility determination and enrollment.

D. UTILIZATION REVIEW (UR)

If DOH meets Medicare's UR requirements, this should satisfy Medicaid. If not, UR will have to be developed or strengthened in either case. The work of the Off-Island Patient Referral Committee with the Honolulu based physician review coordinator should give credibility to ASG's capabilities and intentions, and guidance to the development of review criteria at LBJ.

E. EVALUATION APPROACH

Since this will be a demonstration grant, HCFA will probably require an evaluation component to the project. This also should be kept simple but sound. For example:

- One evaluation component could involve comparison of the cost of ASG's Medicaid alternative to those of a comparable or control Territory or State. The cost comparisons could be made on the basis of the total program or on the basis of individual enrollees. The costs to be compared could be those for administration and medical services and of various subsets or categories.

- Another evaluation component could involve changes in the health status and utilization of the enrollees.

F. OTHER REQUIREMENTS

The following are other factors that are likely to be required or addressed by HCFA in the demonstration grant that ASG should be aware of but which are not likely to be burdensome or difficult to resolve:

- Scope of services to be provided to enrollees.

- Source of the ASG Medicaid match.

- Appeals process.

- Record keeping and auditing assurances and controls.
- Provider agreements.
- Staffing and administrative costs.

CHAPTER IV

SUGGESTED IMPLEMENTATION APPROACH

IV. SUGGESTED IMPLEMENTATIONS APPROACH

The approach suggested for carrying out the recommended alternative is composed of a number of steps which are summarized below:

Task 1: **Review and Obtain Agreement on the Basic Strategy Concepts, and Grant Approach with the:**

- Executive Branch.
- Legislative Branch including the ASG Congressional Representative.

Task 2: **Obtain Written ASG Endorsement from the:**

- Governor.
- DOH Director.
- Fono in resolution form or, if not in session, written support from the President of the Senate and the Speaker of the House.

Task 3 **Prepare Concept Paper and Presentation Material**

(This report as well as the reports on the "Off-Island Patient Referral Study" and the "Recommendations for a new ASG Health Care Financing Plan" can readily be used to extract most all of the following proposal material). The content of the material should include:

- Overall summary of purpose and intent of ASG's request.
- Description of the ASG Health Care system and its uniqueness.
- ASG's overall funding pressures and the impact of increasing health care costs on and off-island.
- ASG's recent efforts and plans to increase health care revenues and reduce costs.
- The need to finance health care for the poor in ASG.
- ASG's legal Medicaid status relative to all of the other Territories and States.

- The importance of Medicaid funding to finance health care for the poor in ASG and the expected Medicaid grant amount.

- The problems ASG would have in operating the present Medicaid program.

- Summary of the Proposed Demonstration Grant:

  - Authority (Section 1115).

  - Scope (Title 19 only but adapted to ASG.

  - Methodology for Determining the Poverty Line.

  - Elegibility Determination and the Enrollment.

  - Reimbursement/Payment Approach.

  - Utilization Review.

  - Evaluation Approach.

  - Other Factors.

Task 4: **Present and Discuss Concept Paper with ASG Delegate and Key Staff and Members of the Insular Affairs and Medicaid Subcommittees to Seek Advice and Revise as Necessary**

Task 5: **Present and Discuss Concept Paper with Key HCFA Staff, beginning with the Pacific Area Representative in Honolulu, to Seek Advice and Revise as Necessary.**

Task 6: **Discuss Concept with DOI Officials to Explain Project and to Avoid an Off-Setting Reduction in the DOI Grant-at-Large.**

Task 7: **Select Sponsor and Co-Sponsors to Introduce Legislation and Track Progress.**

Task 8: **Prepare Justification Document and Testimony for Hearings.**

Task 9: **Prepare HCFA Demonstration Grant Proposal When Legislation has been Passed and Signed.**

Task 10: **Negotiate Grant with HCFA and Implement Project.**

The above tasks should begin as soon as possible with the objective of having the proposal considered by the Second Session of this Congress beginning in January for the purpose of obtaining a grant award and funding in FY82.

AMERICAN SAMOA GOVERNMENT
PAGO PAGO, AMERICAN SAMOA 96799
DEVELOPMENT PLANNING OFFICE

In reply refer to:
Serial: 922

30 October 1980

TO: Joseph M. Pereira, Director
Development Planning Office

FROM: Deputy Director
Development Planning Office

SUBJECT: Calculation of American Samoa's Poverty Line

Based on Janet's information that the current U.S. poverty income level for households with an average household size is $7,125, I have computed American Samoas household poverty level based on 1977 data (see attached Table) to be $5,580. This poverty income level is probably low for the current, because it is based on 1977 situations. Based on the household income distribution data provided in the attached table, 57.4% of all households fall under the $5,550 poverty line. Based on our projected 1980 population of 33,500 and assuming an average household size of 7.1, there are currently 2,710 (57.4% of 4,720 households) American Samoa households currently under the $5,500 poverty line. (Note: If average household size has decreased since 1977 the estimated number below poverty line is understated.)

Methodology

	U.S.	American Samoa
Poverty Line	$ 7,125	X
Median Income	15,000	6,580
Avg. Household Size	4	7.1

$\frac{\$7,125}{\$15,000} = .475$

.475 x $6,580 = $3,126 (Unadjusted for American Samoa's large avg. household size)

$\$3,126 \times \frac{7.1}{4} = \$3,126 \times 1.775 = \$5,550$

APPENDIX A

Preliminary Medicaid Reimbursement Estimates

Preliminary Medicaid Reimbursement Estimates

These estimates are based on the following key assumptions which govern the variables affecting reimbursement:

- ASG will establish an annual premium for each enrollee.
- The premium is based on an average per capita cost for the entire population.
- The utilization of services by Medicaid enrollees would be the same as for the population as a whole.
- The cost is for medical care on-island and off-island.
- Included in the costs are the FY82 budgeted expenditures for LBJ and Off-Island care plus their proportionate share of Departmental General and Administrative expense, plus the ASG indirect rate plus the estimated depreciation expense based on historical costs. It is assumed that all of these costs would be considered reasonable and allowable for Medicaid reimbursement purposes.
- The FY 1982 population in AS is 33,500, (see attached letter), and that 70 percent are residents and the remaining 30 percent are non-residents who would not be eligible for Medicaid.
- The Method A estimate is based on the above assumptions and the calculation contained in the attachment prepared by the Development Planning Office.
- The Method B estimate is based on the above assumptions and the further assumption that approximately 25 percent of the residents would be eligible for Medicaid as experienced by CNMI and the poverty line established for its Medicaid program.

The decision makers should be cautioned that these are preliminary estimates that indicate the relative magnitude of the potential for Medicaid funding and that they are not absolute. The final amount will be resolved by HCFA and ASG based on the reimburse approach, the ASG poverty line, detailed and current census data, and the acceptance or resolution of the above assumptions.

1. **Annual Per Capita Estimate**
DOH FY82 Budget (Millions)

DOH FY82 Budget (Millions)

	$	%	Overhead Application *	Total Medical Care
o LBJ	$4.5			
o Off Island	.7			
Total Medical Care	5.2	79		
o Other (Public Health, etc.)	1.4	21		
Total Direct	6.6	100	$1.2	$6.4
o Overhead:				
- DOH G & A	.7			
- ASG Indirect	.6			
- Depreciation	.2			
Total Overhead	1.5			
Total	$8.1			

o Per Capital Cost of ASG Medical Care : $6.4 ÷ 33,500 — $190
* (79%) X $1.5 total overhead = $1.2)

2. **Method A (Using Development Planning Office Approach**

o Number in population below poverty line: 7.1 average family size x 2,710 families below line =	19,200
o Percent Residents	x 70%
o Number of Residents Medicaid Eligible	13,400
o Annual Premium	x $190
o Total Cost	$2,550,000*
o Federal Share	$1,275,000*
o ASG Share	$1,275,000*

* Plus Program Administrative Costs

3. **Method B (Based on CNMI Experience)**

o	Population	33,500
o	Percent Residents	x 70%
o	Number of Residents	23,500
o	Percent Medicaid Elgible	x 25%
o	Number of Residents Medicaid Eligible	5,900
o	Annual Preminimum	x $190
o	Total Cost	$1,120,000 *
o	Federal Share	$ 560,000 *
o	ASG Share	$ 560,000 *

* Plus Program Administrative Costs