

***AS MEDICAID
STATE PLAN
(MSP)***

American Samoa Medicaid State Agency

***Updated as of 01/2024*

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1902 (J) WAIVER

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1902(J)
WAIVER

American Samoa Medicaid State Agency

GENERAL WAIVER FOR MEDICAID PROGRAM

IN

AMERICAN SAMOA

TRANSMITTAL #	83-1	DATE	
REC'D RO		BY	
APPROVED	3/7/83	EFFECTIVE	10-1-82

MEDICAID STATE PLAN
AND
GENERAL WAIVER

AMERICAN SAMOA
October, 1985

GENERAL WAIVER FOR MEDICAID PROGRAM
IN AMERICAN SAMOA

A. INTRODUCTION:

Section 136 of Public Law 97-248 (HR 4961) authorized American Samoa to participate in Title XIX of the Social Security Act beginning October 1, 1982. This section gives extreme latitude to the Secretary of Health and Human Services and authorizes him to waive or modify any of the requirements of Title XIX except: 1) The Federal medical assistance percentage; 2) The limitation of \$750,000 in Federal funds; and, 3) The use of these funds for the medical services described in paragraphs (1) through (18) of section 1905(a). Congress has given this flexibility in recognition of American Samoa's unique circumstances and health care delivery system.

In requesting waiver or modification of various provisions of Title XIX, the Government of American Samoa wishes to assure the Secretary that it does not request, directly or indirectly, any waiver or modification of the three exceptions or non-waiverable provisions listed in the enabling legislation. Should any of the elements contained in the attached State Plan or outlined below appear to require a waiver or modification of these three exceptions, American Samoa is prepared to make any necessary changes in the State Plan to be consistent with Congressional intent.

B. WAIVER REQUEST:

Except for the three provisions listed in section 136, a waiver or modification is requested for any and all provisions of Title XIX of the Social Security Act, of the Code of Federal Regulations related to Title XIX and of Action Transmittals and other program or policy guidelines for the operation of Title XIX issued by the Health Care Financing Administration which are not in conformity with the operation of the Medicaid program in American Samoa as proposed in its State Plan.

C. JUSTIFICATION FOR WAIVER

Several main factors form the basis for the proposed State Plan which has been submitted to HCFA: 1) The nature of the health care delivery system in American Samoa; 2) The cultural sensitivity and objection to welfare-type programs; 3) A cash based economy and the nature of family resources in American Samoa; and, 4) The extent of resources required to develop and operate a traditional Medicaid program.

1. Nature of the Health Care Delivery System in American Samoa

Compared to the multiple health care delivery system in the U.S., there is only one delivery system in American Samoa. It is owned, operated and financed almost entirely by the Government, and all personnel, including the physicians and medical officers, are salaried. The population of 33,500 has virtually unlimited access to a comprehensive range of health and medical care services on-island and in Honolulu where a small number of patients are referred for specialized diagnostic and treatment services not available at the LBJ Tropical Medical Center in Samoa. This single system simplifies greatly the administration of a Medicaid program. As a result of this system, the services provided to American Samoans have been divided into on-island and off-island services, which are described in Section 3 of the attached State Plan.

2. The Cultural Sensitivity and Objection to a Welfare-type Program

Culturally, the Samoan way is for the extended family to provide for the financial needs of members including food, shelter, clothing and other needs. Government is not viewed as the provider of such needs. For this reason, American Samoa has not sought to become eligible under the cash assistance programs of the Social Security Act (e.g. AFDC, SSI) or the Food Stamp Program. Health care, however, has historically been provided by government and is not viewed negatively as welfare, as the cash programs are. The concern of American Samoa in the past has been that medical

assistance under Medicaid was directly linked to the "welfare" programs and would require the identification of individuals as welfare recipients - a cultural stigma that might prevent those in need of care from seeking such care.

3. Cash Based Economy and The Nature of Family Resources

Since World War II, forty years ago, American Samoa has moved from an economy that was predominately subsistence based to one which is now cash based.

Virtually all resources of an extended family are communal and for the use of all the family members. As a result of this practice, it is often impossible to distinguish individual resources from immediate family resources from extended family resources. The program of imposing a traditional needs test for Medicaid eligibility becomes impractical in this context.

3. ~~X~~ The Extent of Resources Required to Develop and Operate a Traditional Medicaid Program

The operation of the traditional Medicaid program requires the establishment of a number of systems such as eligibility determination, fee schedule, reimbursement and billing procedures, quality control, fraud investigation etc. The personnel, equipment and other resources to set up these systems for the number of persons out of the total population of 33 500 would be considerable and far from cost-effective. In addition, the nature of the health care delivery and cultural realities would make the establishment of such unnecessary or ineffective.

D. DESCRIPTION OF PROPOSED AMERICAN SAMOAN PROGRAM

Within the context of the four factors discussed above, the proposed State Plan describes a Medicaid Program that is consistent with the Samoan way and culture and has practical and economically frugal administrative requirements. As a result, this program varies considerably from the traditional state plan and Medicaid program in several areas. In particular, section 2 (Coverage and Eligibility), 4 (General Program Administration) and 6 (Financial Administration) have been reworked considerably. The proposed plan reflects a simplified approach to financial and program administration. In the area of financial management, the entries required on the HCFA-64's and 25's have been

reduced, and a per capita methodology for determining reimbursement has been developed, as reflected in Section 6 of the State plan.

Also in the area of program administration, items such as the size of the Medical Assistance Unit, the safeguarding of information, the provider agreement requirements, etc., have been tailored to reflect the American Samoan system. These are outlined in Section 1, 4, and 7 of the State plan.

The most innovative feature of the proposed program is the Presumptive Eligibility Concept, which eliminates the need for individual eligibility determinations. Although this system is described in Section 2 of the State Plan, it is important to reiterate it here.

Because American Samoa is not authorized and does not wish to participate in the cash assistance programs for low income aged, blind or disabled persons, or for members of families with dependent children, different standards of eligibility than those used in a traditional Medicaid program must be used. The ownership of resources in American Samoan culture makes the consideration of resources as part of eligibility standards impossible. Consistent with the fact that American Samoa is a cash based economy, a more reliable method of eligibility determination is to use only an income standard. Moreover, income in American Samoa is a primary determinant of one's resources.

Without the cash assistance programs and their accompanying payment and needs standards, the income standard for eligibility would logically be pegged to the poverty level. As described in the State Plan, poverty levels exist only for the 50 states and the District of Columbia. Use of American Samoa's median income and the United States' median income as a ratio for determining a poverty level for American Samoa would appear to be a defensible method of determining an income standard for Medicaid eligibility. Use of the poorest state's median income would result in a considerably higher ratio and poverty level. The ratio of the minimum wages in American Samoa and the United States which are established in law could be another method of determining a poverty level in American Samoa. The fact that Samoa has several

minimum wages for different types of employment and that each creates a higher ratio and higher poverty level and therefore a higher number of eligibles complicates this method. The process described in the State Plan would establish the lowest level of the considered options.

In the fifty states, Medicaid eligibility is not directly tied to the poverty level but rather to the cash assistance standards under AFDC, SSI etc., which are below the actual poverty level in most cases. To adjust for this fact, the poverty level determined for American Samoa would be deflated by the ratio of the public assistance needs standards to the U.S. poverty level. (It should be noted, however, that those who receive cash assistance also receive an amount of food stamps which depends on family size and income. The combination of cash assistance and food stamp bonus amount brings people much closer to the poverty level). The SSI program provides a national needs standard only for one and two person households which can be used to determine the deflator ratio. Because each state is free to establish needs standards and payment levels under the AFDC program, no national standards for families of 3, 4 etc., exist for determining a deflator. The California AFDC standards are lower than SSI levels for 1 and 2 person households but are relatively close and would seem to be used with some validity for 3, 4 etc., person households. By applying the deflator factor to the lowest poverty level, a needs standard that would restrict the number of eligibles for Medicaid to the lowest of the options would be determined. It is important to recognize that this results in a very conservative number of eligibles.

If Mississippi were used for comparison with American Samoa instead of the U.S. for median income, the poverty level would increase by 36% for each family size. The deflator factor would decrease by about 18-32 percent. As a result, the potential numbers of eligibles calculated as an example in the State Plan would not change significantly.

The negative cultural sensitivity to being identified as a "welfare recipient" indicates the need for finding an eligibility system other than the traditional method. The presumptive eligibility concept proposed in the State Plan would be responsive to the cultural sensitivity and at the same time greatly simplify the operation of the Medicaid program. Moreover, the need for individual eligibility determination is further negated by the nature of the health care system in Samoa which consists of a single, government-operated system.

The concept of presumptive eligibility is not without precedent in a needs test program. For example, the elderly as a group are presumed to meet the income test for social services under Title XX of the Social Security Act. Also, the Refugee Act allows for refugees to be determined presumptively eligible for health care services for up to 12 months after arrival in this country.

The 1980 census data should contain sufficient information to determine income by household size, which could then be used in conjunction with the income level for Medicaid eligibility established in the proposed State Plan. Presently, the census data are not yet available in sufficient detail to be used. As a result, the process and data described in the proposed State Plan appear to be the best method and information available. The estimated number of persons who would be presumed eligible may seem high, but other demographic data provide some support, although indirectly, of the estimates.

The average household size in the U.S. is 2.5 persons; in Samoa the figure is 7.1. Over 55% of the population of American Samoa is under age 19 compared to 32% of the U.S. These two facts when placed together with the amount of income by household seem to indicate a high dependent population in financial need. In addition, 1980 census data indicate that 24.4% of the persons in Mississippi are below the poverty level.

Practically, the needs level and the number presumed to be eligible in American Samoa must be compared to the grant ceiling of \$750,000. Using FY 81 costs and the number presumed to be eligible that year, the total cost of providing service to the eligible population would have been over \$1.9 million and well in excess of the federal limit of \$750,000 ($\$1.9 \times 50\% = \$850,000$). Even if the number eligible in FY 83 drops significantly to 17 percent, which is well below Mississippi but somewhat higher than the U.S. at 14 to 15 percent eligible, American Samoa would exceed the federal limit based on estimates of FY 83 Medicaid costs.

Finally, it should be noted that American Samoa has established minimal co-payments for all persons who receive services at the hospital or clinics. Payment of these co-payments is waived in certain circumstances, primarily based upon one's ability to pay. Linkage of the standards for co-payment relief to individual Medicaid eligibility would not be feasible, however, since the procedure for co-payment relief is very informal with flexible guidelines and does not involve the traditional US means test for eligibility. To use the co-payment system as a means of determining Medicaid eligibility would be impractical, culturally unacceptable and negate all of the administrative savings of a presumptive eligibility process.

E. ASSURANCES THAT NON-WAIVERABLE REQUIREMENTS OF SECTION 136 WILL BE MET

Section 6, D of the attached State Plan describes the methodology to be used for determining Medicaid costs. The methodology will assure that the costs of only those services provided for under Section 1905(a) (1) - (18) will be used for determining the federal financial participation to be claimed at a 50 percent rate up to the maximum of \$750,000. Specifically, patient records and invoices will be carefully reviewed and all non-covered services (for example, cosmetic surgery and less-than-effective drugs) will be subtracted from the medical services costs to be claimed under Medicaid.

The services used to determine the federal financial participation are currently being provided on and off-island as enumerated below and detailed in Section 3, A of the State Plan:

<u>Service</u>	<u>On-Island</u>	<u>Off-Island</u>
1. Inpatient Hospital	X	X
2. Outpatient Hospital	X	X
3. Other Laboratory and X-Ray		X
4. Skilled Nursing Services		X
5. Physician Services	X	X
6. Medical or other Remedial Care		X
7. Home Health Services		X
8. Private Duty Nursing		X
9. Clinic Services		X
10. Dental	X	X
11. Physical Therapy	X	X
12. OT, Speech, Language, Hearing		X
13. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses	X	X

Mandatory services not provided on-island, even though provided off-island, are excluded because they are culturally unacceptable on-island.

The off-island services are provided by Medicare certified facilities with the exception of Tripler Army Medical Center in Honolulu and its affiliated mainland military providers to which Tripler patients may be referred for highly specialized services.

SECTION 1

American Samoa Medicaid State Agency



TOGIOLA T.A. TULAFONO
Governor

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EXECUTIVE ORDER No.: 006 -2011

AN ORDER LOCATING THE STATE MEDICAID OFFICE FROM THE AMERICAN SAMOA MEDICAL CENTER AUTHORITY TO THE OFFICE OF THE GOVERNOR AND PROVIDING FOR THE OVERALL FUNCTIONS, DUTIES AND RESPONSIBILITIES OF THE OFFICE

Section 1: Authority

This Executive Order is issued under the authority granted to the Governor in Article IV, Sections 6 and Section 7, Revised Constitution of American Samoa and the American Samoa Code Annotated, §4.0111.

Section 2: Purpose

The purpose of this Order is to provide for the orderly establishment of the State Medicaid Office and to provide for the duties and responsibilities of said office for the orderly planning, implementation, maintenance and revision of American Samoa's State Medicaid Plan to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.

Section 3. Establishment of State Medicaid Office

The State Medicaid Office is herewith established in the Office of the Governor.

Section 4. State Medicaid Office Duties and Responsibilities

The State Medicaid Office shall discharge and assume the following duties and responsibilities:

- A. To recommend appointments to the Medicaid Coordinating Council; and
- B. To prepare, review, approve, and monitor implementation of the State Plan and amendments for long term administration of the Medicaid program in the Territory; and
- C. To review, approve, execute and monitor proposed actions and recommendations of the Medicaid Coordinating Council; and

- D. To ensure that the Medicaid program in the Territory is administered consistently with the U.S. law and regulations administration, U.S. Department of Health and Human Services (reference: 1998, P.L. 25-22); and
- E. To act to improve overall health system performance in the Territory.

Section 5. Medicaid Director

The current Medicaid Director shall continue to serve in such capacity until such time as the Director of Health shall appoint a new director or until the Legislature provides procedures for the appointment of a new director.

Within the first six months of this Order, the Medicaid Director shall amend the Medicaid State Plan, titled *General Waiver for Medicaid Program in American Samoa* (1981), to:

- a. Establish the American Samoa Office of the Governor as the Single State Agency;
- b. Outline the organizational structure of the Medicaid Office within the Office of the Governor. The Medicaid Director shall report to the Governor through the Secretary of American Samoa who shall have immediate direct supervision of the Stated Medicaid Office and the Director;
- c. Establish the duties and responsibilities of the Medicaid Office;
- d. Identify a full list of proposed services to be eligible under the Medicaid waiver, including the addition of approved Home and Community-Based Services.

Section 6. Appointment of Medicaid Coordinating Council

Established herewith within the State Medicaid Office is the Medicaid Coordinating Council. The following positions, along with the Director of Health, are permanent members of the Medicaid Coordinating Council:

Secretary of American Samoa
Director, Department of Human and Social Services
Chairman, American Samoa Medical Center Authority Board of Directors
Chief Executive Officer, American Samoa Medical Center Authority
Chief Financial Officer, American Samoa Medical Center Authority
Medical Services Director, Department of Health

Each department represented on the Council shall provide one staff member to assist the work of the Council. The Governor may appoint additional non-permanent members to the Council as he deems necessary from time to time. Non-permanent members shall serve for two years and may be reappointed and removed by the Governor without cause.

Section 7. Council Duties and Responsibilities

The Council shall discharge and assume the following duties and responsibilities:

- A. To create, review and recommend for final adoption proposals to amend as necessary the Medicaid state plan, the annual presumed eligible report, and to assist in determining whether the Medicaid program in the Territory is carried out consistent with U.S. law and regulations administration, Department of Health and Human Services; and
- B. To review and propose actions in order to bring the Territory into compliance with federal laws, regulations and policies regarding the administration of Medicaid in the Territory; and
- C. To review and monitor any and all new, current and ongoing Medicaid compliance initiatives in the Territory, including but not limited to compliance with provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Act of 2010; and
- D. Any other Medicaid related issues that may arise from time to time.

Section 8: Finality of Administrative Decisions, Policies, Rules and Regulations

In accordance with 42 CFR 43.10(e)(3), if other local agencies or offices perform services for the State Medicaid Office, they must not have the authority to change or disapprove any administrative decision of the State Medicaid Office, or otherwise substitute their judgment for that of the State Medicaid Office with respect to the application of policies, rules and regulations issued by the State Medicaid Office.


Section 9: Repealer

This Executive Order supersedes and effectively repeals all previous Executive Orders and General Memoranda regarding this specific subject matter.

Section 10: Effective Date

This order shall take effect immediately.

Dated: August 23, 2011.



TOGIOLA T.A. TULAFONO
Governor of American Samoa

cc: Per Standard List
Medicaid Coordinating Council Members

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM

State/Territory: American Samoa

Citation As a condition for receipt of Federal funds under Title XIX
45 CFR of the Social Security Act, the
part 201
Office of the Governor (Single State Agency)

Submits the following State Plan amendment for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State Plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

HCFA ID: 7982E

Revision State: American Samoa

TN N. 11-002

**Supersedes
TN No. 83-001**

Approval Date NOV 02 2011 **Effective Date: October 1, 2011**

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193



U.S. Territory of American Samoa
Medicaid State Agency

State Plan Amendment
Section I

September, 2011

TN N. 11-002
Supersedes
TN No. 83-001

Approval Date NOV 02 2011 *Effective Date: October 1, 2011*

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

LIST OF AMENDMENTS

No:	Title of Attachments
1.1 -A	Attorney General's Certification (Executive Order)
1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2- A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Eligibility determinations (Not Applicable)

TN N. 11-002
Supersedes
TN No. 83-001

Approval Date NOV 02 2011 Effective Date: October 1, 2011

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

Citation SECTION I: SINGLE STATE AGENCY ORGANIZATION
12 CFR
431.10 1.1 Designation and Authority
AT-79-29

- (a) **The Office of the Governor is the Single State Agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the Social Security Act. (All references in this plan to “the Medicaid Agency” mean the agency named in this paragraph)**

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State Agency and citing the legal authority under which it administers or supervises administration of the program.

TN N. 11-002
Supersedes
TN No. 83-001

Approval Date NOV 02 2011 *Effective Date: October 1, 2011*

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: American Samoa

Citation
Sec. 1902 (a)
of the Act

1.1(b) The State Agency that administered or supervised the administration of the Sec. 1902(a) of the Act plan approved under title X of the Act as of January 1, 1965, has been separately designated to ~~administer~~ or supervise the administration of that part of this plan which relates to blind individuals.

/ / Yes. The State agency so designated is

This agency has a separate plan covering that portion of the State Plan under title XIX for which it is responsible.

/ X/ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

TN N. 11-002
Supersedes
TN No. 83-001

Approval Date NOV 02 2011 Effective Date: October 1, 2011

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State: American Samoa

Citation
Intergovernmental
Cooperation Act
Of 1968

1.1 Waivers of the single State agency
requirement which are currently
operative have been granted under
authority of the Intergovernmental
Cooperation Act of 1968.

Yes. ATTACHMENT 1.1-B describes these
waivers and the approved alternative
organizational arrangements.

Not applicable. Waivers are no longer
in effect.

Not applicable. No waivers have
Ever been granted.

TN N. 11-002
Supersedes
TN No. 83-001

Approval Date NOV 02 2011 Effective Date: October 1, 2011

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: American Samoa

Citation 1.2 Organization for Administration
42 CFR The organizational charts on pages 4 & 5 of Section I are updated to
431.11 reflect the change in Medicaid's Single State Agency.

- (a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.
- (b) Within the State agency, the Medicaid Office has been designated as the Medical Assistance Unit. ATTACHMENT 1.2-B contains the functions and an organizational chart of the unit.
- (c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.
- (d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to functions they will perform.

/X/ Not applicable. Only staff of the agency named in paragraph 1.1(a) makes such determinations.

TN N. 11-002
Supersedes
TN No. 88-001

Approval Date NOV 02 2011 Effective Date: October 1, 2011

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State American Samoa

Citation

42 CFR 1.3
431.50(b)
AT-79-29

Statewide Operation

The plan is in operation on a Statewide Basis in accordance with all requirements of 42 CFR 431.50.

~~X~~ The plan is State administered.

— The plan is administered by the political subdivisions of the State and is mandatory on them,

TN N. 11-002
Supersedes
TN No. 88-001

Approval Date NOV 02 2011 Effective Date: October 1, 2011

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

**Revision: HCFA-AT-80-38(BPP)
May 22, 1980**

State: American Samoa

1.4 State Medical Care Advisory Committee

**Citation
42 CFR
431.12(b)
AT-78-90**

There is an advisory committee to the Medicaid Agency Director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

**TN N. 11-002
Supersedes
TN No. 88-001**

Approval Date NOV 02 2011 **Effective Date: October 1, 2011**

ATTACHMENT

1.1-A

American Samoa Medicaid State Agency

ATTACHMENT 1.1-A

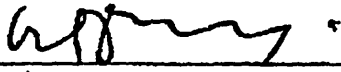
ATTORNEY GENERAL CERTIFICATION:

I certify that:

The Office of the Governor, American Samoa Government, is the single State Agency designated to administer and supervise the administration of the State Plan under Title XIX of the Social Security Act.

The legal authority under which the agency administers and supervises the administration of, the plan on a Territory-wide basis is:

The Executive Order No: 006-2011; Approved and Effective August 23, 2011 (Attached)



Signature

Sept 12, 2011
Date

FEPULEA'I ARTHUR RIPLEY
ATTORNEY GENERAL OF AMERICAN SAMOA

Title

TN No 11-002
Supersedes
TN No: 83-001

Approval Date NOV 02 2011 Effective Date October 1, 2011

ATTACHMENT

1.2-B

American Samoa Medicaid State Agency

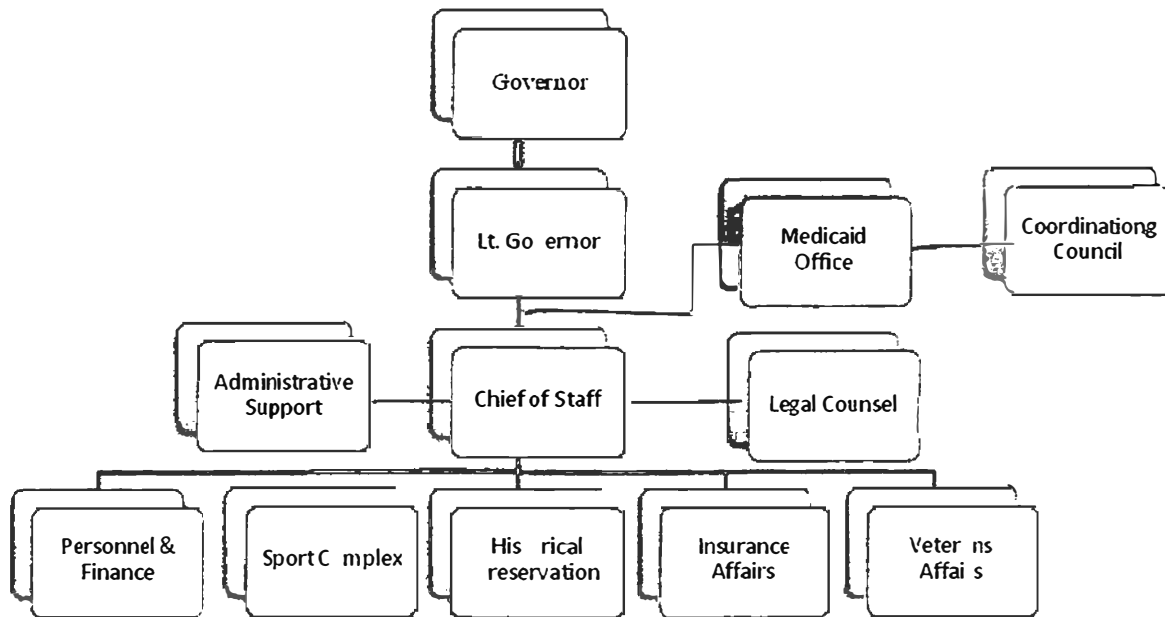
Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

State: American Samoa

Description of Functions of the State Medicaid Agency and Updated Organizational Chart

(Organizational Chart)



TN N. 11-002
Supersedes
TN No. 87-004

Approval Date Nov 8 2011 Effective Date: October 1, 2011

Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

State: American Samoa

Description of Functions of the State Medicaid Agency and Organization Chart

The key functions are:

- Administers Medicaid Program and determines what services are offered.
- Establishes Organization of the Medicaid Agency and Medical Assistance Unit Medicaid Office)
- Assures availability of patient services mandated by the State Plan through arrangement with service providers.
- Performs utilization review and assesses quality of care and identifies program abusers
- Makes policy decisions and provides program oversight.
- Medicaid agency maintains an agreement with each on-island and off-island provider furnishing services under the plan, in which the provider agrees to:
 - (a) To keep any record necessary to disclose the extent of service of the provider
 - (b) On request, furnish to the Medicaid Agency or the Secretary, any information regarding payments claimed by the provider for furnishing services under this plan.
 - (c) Maintain the confidentiality of patient information for other than medical or program administrative purposes.
- (d) Not discriminate against any individual seeking services under this plan, on the basis of race, sex, religion, color, national origin or handicap.
- Medicaid Agency assures that it has procedure for identifying providers of service by Social Security number and that it reports information required by Section 6041 of the Internal Revenue Code (26 U.S.C. 6041) regarding the filing of annual information returns showing amounts paid to providers.
- Medicaid Agency assures that it employs methods of administration, acceptable to the Secretary of U.S DHHS, and described in this plan, that are necessary for the proper and efficient operation of the program.
- Medicaid Agency assures that appropriate and accurate collection of patient payments and expenditures of program funds is achieved through a program of budgetary/expenditures and audit controls in place in the agency and its affiliates. In addition, independent financial audits will be conducted on a periodic basis.

TN N. 11-002
Supersedes
TN No. 88-001

Approval Date NOV 02 2011 Effective Date: October 1, 2011

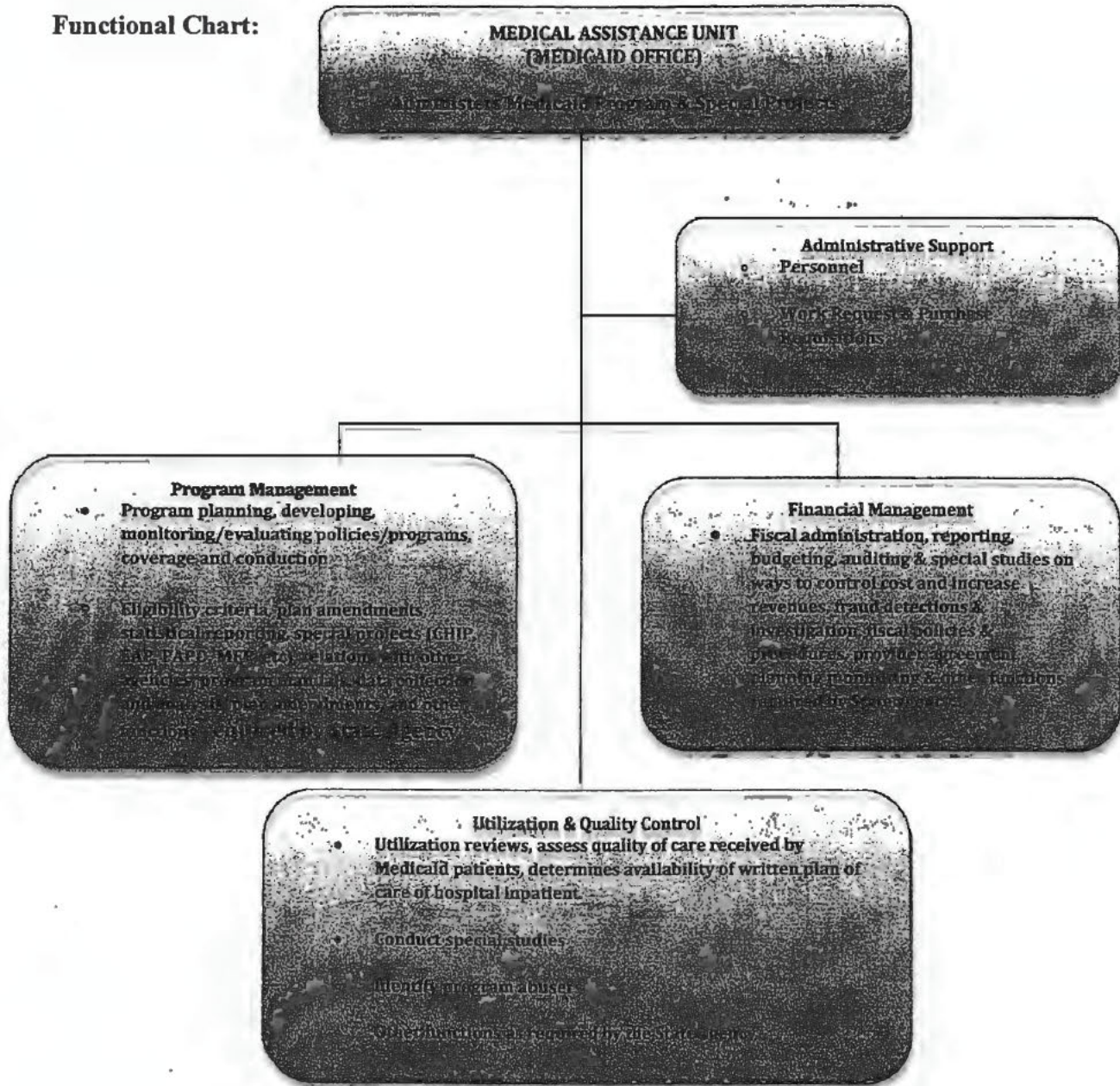
Revision: HCFA-PM-87-4 (BERC)

OMB No: 0938-0193

ATTACHMENT 1.2-B (1)

Functions and Organizational Chart of Medical Assistance Unit (Medicaid Office)

Functional Chart:

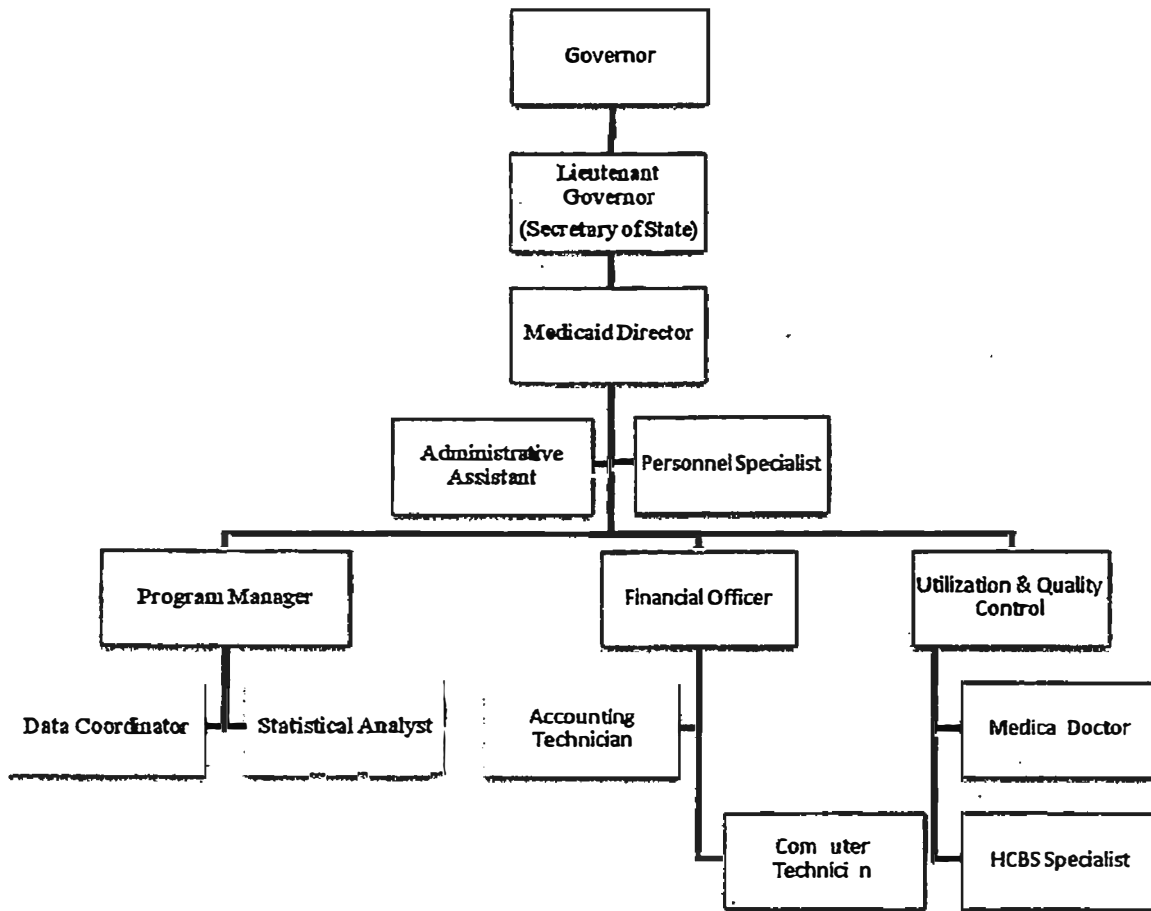


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ATTACHMENT 1.2-B (3)

Description of Functions of each position of Medical Assistance Unit (Medicaid Office)

Medicaid Director

1. Is responsible for the administration of programs and services provided under this plan.
2. Is responsible for policy development, planning, monitoring and evaluation of the programs.
3. Ensures that the Medicaid program in the Territory is administered consistently with the applicable federal and local laws and regulations.
4. Establishes the American Samoa Office of the Governor as the Single State Agency.
5. Outlines the organizational structure of the Medicaid Office within the Office of the Governor with the Medicaid Director reporting to the Governor through the Secretary of American Samoa establishes the duties and responsibilities of the Medicaid Office.
6. Establishes the duties and responsibilities of the Medicaid Office
7. Identifies a full list of proposed services to be eligible under the Medicaid waiver, including the ad of approved Home and Community-Based Services.
8. Determines the annual eligibility population of Medicaid program for expenditure reimbursement.
9. Prepares and submits to CMS for approval any state plan amendments.
10. Reviews and approves program budget.
11. Coordinates Medicaid activities with other agencies including Title V, State Vocational Rehabilitation Agency, Federally Qualified Health Center, Behavior health, the Territorial Administration on Aging, and the Territory's Health Information Technology program.
12. Reviews and makes recommendations to the State Agency regarding addition or deletion of provider types.
13. Provides oversight of federal and state compliance for all Medicaid programs (CHIP & EAP).
14. Performs other functions as required by State Agency Administration.

Medical Doctor

1. Is responsible for medical direction and medical oversight of all programs under this plan.
2. Works with Medicaid Director in developing and maintaining agreement with each on-island and off-island provider furnishing services under the plan (Reference to #8 of Section 4 of this plan).
3. Ensures that Medicaid State Agency establish and maintain a formal utilization review and quality assurance program to ensure the attainment and maintenance of high standards of professional and ethical practices. This program shall be consistent with

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Medicare/Medicaid quality assurance certification standards for hospitals (Reference to Part B of the Section 4 of this plan).E

4. Exercises medical interpretation; and assesses new technology.
5. Provides oversight of federal and state compliance related to quality management and review of annual quality management plans.
6. Monitors health service programs under this plan including Maternal Child Health, Family Planning, EPSDT, dental, immunization, behavior health, public health clinics, and dental service.
7. Provides problem resolution, including individual quality of care issues for members, access to care, level of coverage, and quality of coverage provided.
8. Is responsible for quality management development and analysis (e.g., utilization reports and performance indicators).
9. Coordinates and conducts focused medical audits.
10. Performs other functions as required by the State Agency administration.

Financial Officer

1. Is responsible for fiscal administration including financial reports (CMS-37 budget and CMS 64-Expenditures).
2. Works with the Medicaid Director in program budget development and control.
3. Oversees third party liability program
4. Is responsible for financial audit.
5. Implements fraud detection/investigation program.
6. Performs other functions as required by State Agency administration.

Program Manager

1. Assists in the administration and implementation of the program activities.
2. Supervises the implementation of the special programs such as CHIP and EAP.
3. Coordinates review of proposed legislation, determines impact upon organizational operations, estimates effects, and monitors progress.
4. Performs studies, analysis, and evaluations of programs.
5. Identifies policy issues of areas where additional guidance from CMS is required.
6. Prepares the annual eligibility determination report.
7. Performs other functions as required by the State Agency administration.

Computer Technician

1. Handles computerized system development and maintenance.
2. Provides technical assistance in computer hardware and software, etc.
3. Performs other functions as required by State Agency Administration.

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Data Coordinator

1. Assists in the implementation of the Medicaid programs.
2. Is responsible for Data system development, planning, management, maintenance.
3. Coordinates data collection, analysis, interpretation with other relevant agencies such as Department of Commerce (demographic data), Office of Immigration (illegal aliens data), LBJ (service utilization data and provider data), Department of Health (service utilization data and provider data), FQHC (service & provider data), behavior health (service and provider data), dental (CHIP data), etc.
4. Coordinates data activities with the Territory's Health Information Technology program (HIT).
5. Coordinates data handling and analysis for program reporting, performance measures, and related projects.
6. Performs other functions as required by State Agency Administration.

Statistical Analyst

1. Assists in the performance of Data system Management activities.
2. Prepares and distributes statistical reports as required.
3. Maintain program manuals.
4. Analyzes relevant data and prepares interpretations as required.
5. Performs other functions as required by State Agency Administration.

Administrative Assistant

1. Develops and implements procedures for expediting the flow of clerical work for the office.
2. Coordinates the processing of personnel action for recruitment, promotions, step increments and other personnel requests.
3. Prepares work requests and purchase requisitions for the programs.
4. Maintains office records and important documents.
5. Types reports and correspondence.
6. Receives and records requests for information and publications.
7. Receives visitors and explains Medicaid policies and procedures to the public.
8. Performs other functions as required by State Agency Administration.

Accounting Technician

1. Coordinates with accounting and data processing on fiscal matters.
2. Assists in executing of the functions and duties of the financial section.
3. Other functions as required by state agency administration.

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Description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the Plan

<u>POSITION TITLE</u>	<u>NO. OF STAFF</u>
Secretary of State (Lt. Governor)	1
Medicaid Director	1
*Medical Doctor	2
*Financial Officer	1
Program Manager	1
Data Coordinator	1
Statistical Analyst	1
*Administrative Assistant	1
*Accounting technician	2
Quality Assurance Program Coordinator (LBJ)	1
*HCBS Specialist	1
Total	13

*new positions to be hired.

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SECTION 2

American Samoa Medicaid State Agency

SECTION 2—ELIGIBILITY

I. PRESUMPTIVE ELIGIBILITY CONCEPT

A. General Description of the Presumptive Eligibility Concept, Requirements for the Annual Presumptive Eligibility Populations Report and Claiming Percentages

Using the authority provided under the 1902(j) waiver, American Samoa does not process individual determinations based on income and non-financial eligibility criteria. Instead, American Samoa uses a concept of presumptive eligibility, utilizing various census and immigration data to annually estimate the number of individuals and the percentage of the population that fall below the respective income thresholds for Medicaid, CHIP and American Samoa's Enhanced Allotment Plan (EAP) for Medicare prescription drug coverage. These percentages will be further utilized to calculate respective claiming percentages to apply to Medicaid, CHIP and EAP eligible costs incurred by LBJ Tropical Medical Center (LBJ). The process for determining the presumed eligible and effective claiming percentages is described in this section. Additional details on the reimbursement methodologies and federal financial claiming for American Samoa's Medicaid, CHIP, and EAP programs can be found in Attachments 4.19-A and 4.19-B, and the Enhanced Allotment Plan (included in this Medicaid State Plan), as well as American Samoa's CHIP State Plan.

1) Medicaid

American Samoa will annually estimate the number of individuals with income below 400 percent of the federal poverty level (FPL). After removing all non-citizens and non-US nationals, this number of individuals will be determined to be presumed eligible for Medicaid-funded healthcare services, and their claims eligible for Federal Financial Participation (FFP). After making an adjustment to account for Medicare beneficiaries (described below) and lawfully present pregnant woman and individuals under 21 that qualify under the territory's election to cover such lawfully present individuals, this estimated number of Medicaid eligible individuals will be divided by the total American

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Samoan population to arrive at an effective claiming percentage which may be applied to all Medicaid-eligible services delivered by LBJ.

American Samoa elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan. An individual shall be considered lawfully present if he or she is a non-citizen or non-national who is lawfully present in American Samoa under the immigration laws of American Samoa.

LBJ currently does not have the capability to report patient charges by cost center and by payer classes; as a result, LBJ cannot isolate and remove Medicare costs from its total costs. Therefore, to ensure that Medicaid is always serving as the payer of last resort, this section also calculates and removes the presumed dual-eligible Medicaid/Medicare beneficiaries from the presumed eligible Medicaid population to create a presumed eligible Medicaid primary population, and a Medicaid primary claiming percentage. This guarantees that the hospital is not federally reimbursed for services provided to dual eligible beneficiaries through both Title XIX and Title XVIII of Medicare. Until such time as LBJ is able to report patient charges by cost center and payer class, the presumed eligible Medicaid primary population will serve as the transitional basis for American Samoa Medicaid to claim Title XIX FFP.

2) CHIP

American Samoa operates its CHIP program as an expansion of the State's Medicaid plan. American Samoa also elects to cover lawfully present children under 21 in its Title XXI-funded Medicaid expansion, in accordance with section 2107(e)(1)(j) of the Social Security Act. As a result, additional calculations are done in order to estimate the portion of Medicaid-eligible claims incurred at LBJ that may be claimed at the enhanced CHIP Federal Medical Assistance Percentage (EFMAP).

As a Medicaid expansion, and pursuant to the CHIP Special Rule in Section 2110(b)(3) of the Social Security Act, American Samoa's CHIP program may

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only claim Title XXI FFP at the CHIP EFMAP after its 1108(g) Medicaid cap has been exceeded.

However, Section 1905(u)(2)(B) does authorize immediate access to the CHIP EFMAP for claims incurred by individuals fitting the definition of an “optional targeted low-income child.” This term is explained in 1905(u)(2)(B) as a Medicaid eligible child who would not have qualified for medical assistance under the State Plan under Title XIX as in effect on March 31, 1997. In 2006, American Samoa expanded its income threshold for Medicaid eligibility from 100% FPL to 200% FPL. As a result, the claims incurred by children under 19 years of age, who fall between 100% and 200% FPL, plus the claims incurred by lawfully present individuals under 19 years of age who fall under 200% FPL (due to American Samoa’s election as discussed above to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States), become immediately eligible for the CHIP EFMAP. Historically, the claims incurred by this population have been enough to draw the entirety of American Samoa’s annual CHIP grant prior to the end of each fiscal year. As a result, this section will focus on the process through which available age band and income data will be utilized to estimate the number of individuals and the percentage of the American Samoan population that fits the criteria to be considered optional targeted low-income children. These numbers will be used to create a presumed eligible claiming percentage that will be used to claim Title XXI FFP at the CHIP EFMAP.

The optional targeted low-income children represent only a sub-set of CHIP eligible beneficiaries in American Samoa. However, because it is their claims that exhaust the annual CHIP grant, references in this section to the presumed eligible CHIP population, and the CHIP claiming percentage will refer to this specific group of children. All other children (those with income between 0%-100% FPL) will be included in the presumed eligible Medicaid population and Medicaid claiming percentage. American Samoa will be able to access FFP for this group of children at the standard Medicaid FMAP at the start of the fiscal year, as is the current practice.

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3) EAP

Federal Regulation 42 CFR 423.907(b)(2) specifies that EAP reimbursement is only available for dual-eligible beneficiaries, or other low-income Medicare beneficiaries with income less than 150% FPL. Therefore, American Samoa annually will estimate the percentage of individuals with income below 150% of FPL. The resulting percentage will serve as the effective claiming percentage for EAP FFP for eligible Medicare prescription drug claims at LBJ. (Medicare Part D is not available in American Samoa and in lieu of Part D, Enhanced Allotment Payment is made available to American Samoa dual-eligible Medicare/Medicaid beneficiaries.)

4) Future Process

As noted above, LBJ does not have the capability to report patient charges by cost-center and by payer classes. LBJ is currently in the process of implementing an accounting system that will enable these capabilities and allow LBJ to file a complete Medicare 2552 cost-report. Once LBJ is able to file this cost-report they will be able to accurately apportion their costs among Medicaid, Medicare and other payers. They will also be able to isolate costs incurred by ineligible non-citizen and non-nationals. At this point, the adjustments made for ineligible non-citizens or non-nationals, as well as for Medicare beneficiaries will no longer be necessary, and the effective claiming percentages for American Samoa's Medicaid, CHIP, and EAP programs will be based solely on poverty level data. This future process for determining the effective claiming percentages is described in Item D below.

The remainder of this section is comprised of data requirements and calculations necessary to determine the number and percentage of presumptively eligible beneficiaries, as well as the claiming percentages for Medicaid, CHIP, and EAP for the upcoming Federal Fiscal Year (FFY). It also describes the reporting required by CMS in order to approve the determined presumed eligible populations and claiming percentages.

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B. Population and Demographic Data Determinations

1) *Determination of Total Population and Necessary Population Subsets*

- a) **Total population for computation year:** The existing data of mid-year population count by ASG Department of Commerce for the computation year will be utilized to determine the total American Samoan population.
- b) **Estimate of non-citizens, who are also non-US nationals¹:** The most recent data providing the number of non-citizens and non-nationals and their immigration status (i.e., AS permanent resident, temporary resident, undocumented) by population, if available, residing in the Territory during the computation year will be obtained from the ASG Immigration Office in the Attorney General's Office.
- c) **Estimate of Medicare beneficiaries:** Data on the number of Medicare beneficiaries residing in the Territory during the computation year will be obtained from Centers for Medicare and Medicaid Services (CMS). If the Territory has its own data from a survey conducted by ASG agency or other recognized authority as approved by CMS, such data can be utilized.
- d) **Estimate of lawfully present Pregnant Women and a separate estimate of lawfully present Individuals under 21:** Data that the Territory has from a survey conducted by an ASG agency or other recognized authority as approved by CMS can be utilized.

2) *Determination of Income and Age Levels:*

- a) **The percentage of American Samoans that live below 400% of FPL** will be determined using the most recent U.S. Census data².

¹ This estimate will include all individuals who are neither U.S. citizens or U.S. nationals: eligible non-citizens and non-nationals who are lawfully present in American Samoa under the immigration laws of American Samoa, and ineligible non-citizens and non-nationals (including those who are undocumented). For clarification, persons born in American Samoa are considered U.S. nationals.

² It is presumed that the income distribution of Medicare beneficiaries mirrors that of the general population. Therefore, it is presumed that the percentage of Medicare beneficiaries that are dual-eligible for Medicaid is equivalent to the percentage of American Samoans who fall at or below 400% FPL. As a result this same percentage of eligible Medicare secondary costs will be eligible for FFP as described in Supplement 1 to Attachment 4.19-B.

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- b) **The percentage of American Samoans that live below 150% of FPL** will be determined using the most recent U.S. Census data.
 - c) **The percentage of American Samoans that live between 100%-200% FPL** will be determined using the most recent U.S. Census data.
 - d) **The percentage of American Samoans that are below 19 years of age** will be determined using the most recent projections from the U.S. Census Bureau.
 - e) **The percentage of American Samoans that are below 21 years of age** will be determined using the most recent projection from the U.S. Census Bureau.
 - f) **The percentage of American Samoans that live below 200% of FPL** will be determined using the most recent U.S. Census data.

**C. Annual Determination of Presumed Eligibility Populations Report –
Transitional Methodology**

This document will report the number of presumed eligible Medicaid, CHIP and EAP beneficiaries, and the subsequent claiming percentages for Medicaid, CHIP and EAP reimbursement. These annual determinations will be used prospectively for the claiming of FFP in the upcoming Federal Fiscal Year. This report will be prepared annually and submitted to CMS Region IX by August 15 of each year.

The report will consist of the following steps:

1) Calculation of Presumed Eligible Medicaid/CHIP Population

- a) To determine the potentially eligible Medicaid/CHIP population, the estimated number of individuals who are non-citizens and non-nationals are removed from the total population. Using data described in Item 1(B)(1) above, the calculation is as follows:

(Total Population)
Minus (-)
(all non-citizens and non-nationals)
Plus (+)
(lawfully present individuals under age 21 years of age)
Plus (+)
(lawfully present pregnant women)

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Equal (=)
(Potentially Eligible Medicaid/CHIP Population)

- b) The percentage determined in Item 1(B)(2)(a) will then be applied to this number to equal the presumed eligible Medicaid/CHIP population. The calculation will be:

(Potentially Eligible Medicaid/CHIP Population)
Multiply by (x)
(Estimated percentage of individuals falling below 400% FPL)
Equal (=)
(Presumed Eligible Medicaid/CHIP population)

2) Stratification of Presumed Eligible CHIP Populations

- a) The percentages determined in Item 1(B)(2)(c), Item 1(B)(2)(d), Item 1(B)(2)(e), and Item 1(B)(2)(f) are applied to the potentially eligible Medicaid/CHIP population to stratify the group into distinct Medicaid and CHIP populations.

The necessary calculations will be:

(i) (Potentially eligible Medicaid/CHIP population)
Minus (-)
(lawfully present individuals under 21 years of age)
Minus (-)
(lawfully present pregnant women)
Multiply by (x)
(Percentage of American Samoans under 19 years of age)
Multiply by (x)
(Percentage of American Samoans with income between 100-200% FPL)
Equal (=)
(Presumed eligible CHIP population subgroup A)

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(ii) (Lawfully present individuals under 21 years of age)

Multiply by (x)

(Percentage of American Samoans under 19 years of age divided by percentage of
American Samoans under 21 years of age)

Multiply by (x)

(Percentage of American Samoans with income below 200% FPL)

Equal (=)

(Presumed eligible CHIP population subgroup B)

(iii) (Presumed eligible CHIP population subgroup A)

Plus (+)

(Presumed eligible CHIP population subgroup B)

Equal (=)

(Presumed eligible CHIP population)

3) Calculation of Presumed Eligible Medicaid Population

To isolate the presumed eligible Medicaid population, the calculation will be:

(Presumed Medicaid/CHIP eligible population)

Minus (-)

(Presumed CHIP eligible)

Equal (=)

(Presumed eligible Medicaid population)

4) Calculation of Presumed Dual-Eligible Medicare/Medicaid Populations

As noted in the General Description of this section, the presumed dual-eligible beneficiaries must be removed from the presumed Medicaid eligible population to ensure that FFP is not drawn for services already reimbursed by Medicare.

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Furthermore, as noted in the footnote to Item 1(B)(2)(a) it is presumed that the income distribution of Medicare beneficiaries mirrors that of the general population. Therefore, to determine the presumed eligible Medicaid primary population, the estimated dual-eligible Medicaid/Medicare beneficiaries are calculated and removed from the presumed eligible Medicaid population. Using additional data from Item 1(B) above, the calculations are as follows:

$$\begin{array}{r} \text{(Estimate of Medicare Beneficiaries)} \\ \text{Multiplied by (x)} \\ \text{(Estimated percentage of individuals falling below 400\% FPL)} \\ \text{Equal (=)} \\ \text{\textit{(Presumed dual-eligible Medicaid/Medicare population)}} \end{array}$$

5) Calculation of Presumed Eligible Medicaid Primary Population

This presumed dual-eligible population will then be removed from the presumed eligible Medicaid population. The calculation will be:

$$\begin{array}{r} \text{(Presumed eligible Medicaid population)} \\ \text{Less (-)} \\ \text{(Presumed dual-eligible Medicaid/Medicare population)} \\ \text{Equal (=)} \\ \text{\textit{(Presumed Eligible Medicaid Primary population)}} \end{array}$$

6) Calculation of EAP Presumed Eligible Population

In order to calculate the presumed eligible EAP population, the estimated number of Medicare beneficiaries, as determined in Item 1(B)(1)(c), is multiplied by the percentage of individuals with income below 150% FPL, as determined in Item 1(B)(2)(b). The calculation will be:

$$\begin{array}{r} \text{(Estimate of Medicare Beneficiaries)} \\ \text{Multiplied by (x)} \\ \text{(Estimated percentage of individuals falling below 150\% FPL)} \end{array}$$

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Equal (=)

(Presumed Eligible EAP population)

D. Determination of Claiming Percentages

1) Calculation of Medicaid Claiming Percentage

The numbers of presumed eligible CHIP and Medicaid primary beneficiaries will be divided by the entire American Samoan population (as determined in Item 1(B)(1)(a)) to determine the respective claiming percentages for the purpose of American Samoa claiming FFP from available Title XIX and Title XXI funds. The calculation for the presumed eligible Medicaid claiming percentage will be as follows:

(Presumed Eligible Medicaid Primary Population)
Divided by (÷)
(Total Population)
Equal (=)
(Medicaid Claiming Percentage)

2) Calculation of CHIP Claiming Percentage

The calculation for the CHIP claiming percentage will be as follows:

(Presumed eligible CHIP Population)
Divided by (÷)
(Total Population)
Equal (=)
(CHIP Claiming Percentage)

If the Territory's available CHIP allotment funding has been exhausted for the fiscal year, the CHIP claiming percentage will be added to the presumed Eligible Medicaid claiming percentage for the remainder of the Federal Fiscal Year. Once the claiming percentages have been combined, all eligible claims will be reimbursed at the Title XIX FMAP

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3) Calculation of EAP Claiming Percentage

The percentage of individuals with income below 150% FPL, as determined in Item 1(B)(2)(b), also serves as the effective claiming percentage for eligible EAP prescription drug claims at LBJ (Medicare Part D).

E) Annual Determination of Presumed Eligibility Report Once Medicare 2552 Cost Report can be Completed

As noted in Item 1(A)(4), LBJ is in the process of implementing an accounting system to record patient charges by cost centers and by payer classes. This will enable the hospital to complete the Medicare 2552 cost report. Upon completion, LBJ will be able to isolate costs from Medicaid (as well as costs for lawfully present pregnant women and individuals under 21), Medicare and other payers. They will also be able to isolate costs for non-citizens and non-nationals. At such time, the transitional calculations described above to determine the claiming percentages will no longer be necessary. Rather, the claiming percentages for Medicaid, CHIP, and EAP will be derived purely from the census data in Item 1(B). These claiming percentages will be determined by performing the following calculations:

1) Calculation of CHIP Claiming Percentage (to be applied to costs for Medicaid, excluding costs for lawfully present pregnant women and costs for lawfully present individuals under 21)

$$\begin{aligned} & \text{(Percentage of American Samoans under 19 years of age)} \\ & \quad \text{Multiplied by (x)} \\ & \text{(Percentage of American Samoans with income between 100\%-200\% FPL)} \\ & \quad \text{Equal (=)} \\ & \quad \text{(CHIP Claiming Percentage)} \end{aligned}$$

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2) Calculation of Medicaid Claiming Percentage (to be applied to costs for Medicaid, excluding costs for lawfully present pregnant women and costs for lawfully present individuals under 21)

The baseline for the Medicaid claiming percentage will be the percentage of American Samoans with income below 400% FPL, as determined in Item 1(B)(2)(a). However, at the start of the year, when CHIP funds are still available and being accessed, the CHIP claiming percentage will be subtracted from the baseline Medicaid claiming percentage to determine the effective Medicaid claiming percentage. The calculation will be determined as follows:

$$\begin{aligned} & \text{(Percentage of American Samoans below 400\% FPL)} \\ & \quad \text{Minus (-)} \\ & \quad \text{(CHIP Claiming Percentage)} \\ & \quad \text{Equal (=)} \\ & \text{(Medicaid Claiming Percentage)} \end{aligned}$$

If available CHIP allotment funding for the fiscal year has been exhausted, and assuming Medicaid funds remain, the effective Medicaid claiming percentage will then become the percentage of American Samoans below 400% FPL.

3) Calculation of CHIP Claiming Percentage (to be applied to costs for lawfully present individuals under 21 years of age)

$$\begin{aligned} & \text{(Percentage of American Samoans below 19 years of age divided} \\ & \quad \text{by percentage of American Samoans under 21 years of age)} \\ & \quad \text{Multiply by (x)} \\ & \text{(Percentage of American Samoans with income below 200\% FPL)} \\ & \quad \text{Equal (=)} \\ & \text{(CHIP Claiming Percentage for Lawfully Present Individuals} \\ & \quad \text{Under 19 years of age)} \end{aligned}$$

4) Calculation of Medicaid Claiming Percentage (to be applied to costs for lawfully present individuals under 21)

$$\begin{aligned} & \text{(Percentage of American Samoans below 400\% FPL)} \\ & \quad \text{Minus (-)} \\ & \text{(CHIP Claiming Percentage for Lawfully Present Individuals Under 19)} \end{aligned}$$

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Equal (=)

***(Medicaid Claiming Percentage for Lawfully Present Individuals
Under 21 years of age)***

If available CHIP allotment funding for the fiscal year has been exhausted, and assuming Medicaid funds remain, the effective Medicaid claiming percentage will then become the percentage of American Samoans below 400% FPL.

5) Calculation of Medicaid Claiming Percentage (to be applied to costs for lawfully present pregnant women)

(Percentage of American Samoans below 400% FPL)

Equal (=)

(Medicaid Claiming Percentage for Lawfully Present Pregnant Women)

The effective Medicaid claiming percentage is the percentage of American Samoans below 400% FPL.

6) Calculation of EAP Claiming Percentage

As noted in Item 1(D)(3), the EAP claiming percentage is not affected by the adjustments for non-citizens, non-nationals or Medicare beneficiaries. Therefore, the EAP claiming percentage will remain the percentage of individuals with income below 150% FPL, as determined in Item 1(B)(2)(b).

F. Submittal of Eligible Computations to the Regional Office

These computations will be sent to the CMS Region IX Office in the following report:

1. In the Annual Determination of Presumed Eligibility Populations Report that is described in Section C above.

II. CMS APPROVAL ROLE

The CMS Region IX Office must approve the Annual Determination of Presumed Eligibility Populations Report, which will include the claiming percentages for Medicaid, CHIP, and EAP.

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ATTACHMENT
2.7-A

American Samoa Medicaid State Agency

MEDICAID SERVICES OUTSIDE OF THE UNITED STATES

A. Subject to the availability of local and federal matching funds, Medicaid services outside of American Samoa may be furnished to eligible individuals under the following conditions:

1. Emergency or medically necessary services are not available in American Samoa; “Emergency” is defined as an immediate, catastrophic injury caused by an accident putting a patient at immediate risk of loss of life or limb.
2. Comprehensive diagnostic, screening, other lab and x-ray services not available on-island for purposes of early disease detection, intervention and to control costs associated with delayed treatment.
3. The out-of-country provider is the nearest source of care;
4. The aggregate cost of the needed care is less than the aggregate cost of the same care when provided in the United States. Transportation and accommodation costs shall be taken into consideration to calculate the aggregate cost of care.

B. In order for American Samoa Medicaid to reimburse an out-of-country provider for the services referenced in subsection (A) above, the out-of-country providers must meet the following requirements:

1. Out-of-country institutional providers must have The Joint Commission International (JCI) accreditation or the highest level accreditation available in that country meeting international standards;
2. Out-of-country non-institutional providers must have JCI hospital privileges and must have passed the credentialing standards of the JCI accredited hospitals. Non-institutional providers having JCI hospital privileges and credentials will be considered to have fulfilled functionally equivalent licensing and credentialing requirements as those in effect in American Samoa;
3. Out-of-country providers must have a signed provider agreement with the American Samoa Medicaid Agency and a Procurement Contract with the American Samoa Government Office of Procurement;
4. Out-of-country providers must satisfy all Medicaid conditions of participation, with the exception of the requirement that providers must be licensed to practice medicine and surgery by the American Samoa Health Regulatory Services Board;

TN # 19-002 Approval Date March 23, 2020
Supersedes TN # 17-001 Effective Date October 1, 2019

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5. Out-of-country providers must be subject to the same utilization standards as in-state providers;
 6. Out-of-country providers must bill at the U.S. exchange rate in effect at the time the service was provided;
 7. Payments must be made and received through a U.S. bank account (pursuant to the Affordable Care Act's Medicaid Prohibition on Payments to Institution or Entities Located Outside of the United States).

C. Statement on Benefit Limitations and Authorizations

1. Out-of-country medical care described in subsection (A) above, must be not be available on island and must be essential to save life, significantly alter an adverse prognosis or promote disease prevention through early disease detection through diagnostic services not available on island. Health benefits are subject to the limitation under 3.1-A. Palliation, experimental and cosmetic procedures will not qualify for coverage.
2. Medicaid coverage for medical care, transportation and accommodation services furnished for out-of-country referral must receive prior authorization for reimbursement from the American Samoa Medicaid Agency in accordance with Medicaid's standard operating procedures.
3. The attending physician is required to submit a written request for emergency and medically necessary care not available on island to Medicaid. The referral shall include a detailed description of the patient's health problems, consultant recommendations and/or the reasons for the referral. The out-of- country medical referral request shall be reviewed and approved by the American Samoa Medicaid program. All medical care not detected on island but related to the patient's original referral must be pre-approved by Medicaid to be eligible for coverage once the patient is in the accepting county. Any medical care not related to the original referral require prior authorization from Medicaid.
4. To help control and manage American Samoa's Medicaid program from costly acute and emergency care, referrals for comprehensive disease prevention medical care shall be initiated from and approved by Medicaid pursuant to a rigorous screening plan.

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SECTION 3

American Samoa Medicaid State Agency

AMERICAN SAMOA MEDICAID STATE AGENCY

Revision: HCFA-PM-91-4 (BPD)

OMB No.0938

SECTION 3: SERVICES, GENERAL PROVISIONS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation

Part 440

Subpart B

1902(e) 1905(p),

1905(a), 1905(p)

1915, 1920, and

1925 of the Act

State/Territory: American Samoa

3.1 Amount, Duration, and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1902(a), 1905(p), 1915, 1920, and 1925 of the Act.

ATTACHMENT 3.1-A lists, identifies and describes the Medicaid-eligible services currently being performed on the Territory and specifies all limitations on the amount, duration and scope of those services.

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ATTACHMENT

3.1-A

ATTACHMENT 3.1-A

Attachment 3.1-A identifies and describes the medical and remedial services provided to the Medicaid population and specifies all limitations on the amount, duration and scope of those services.

1. **Inpatient hospital services**

Inpatient hospital services means acute inpatient services, other than services in an institution for tuberculosis or mental disease, furnished on island under the direction of a physician or dentist and that include the following room and board and professional services on a continuous 24-hour-a-day basis:

- a) Acute medical
- b) Acute surgical
- c) Acute pediatric
- d) Acute obstetrics/gynecology
- e) Intensive care

These services will be provided in a facility that is licensed or formally approved as a hospital by American Samoa Health Service Regulatory Board and that has a utilization review plan in effect for Medicaid patients and meets the requirements for participation in Medicare. Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing-bed approval.

A. Provider Eligibility Requirements

An approved hospital is one which meets all of the following conditions:

1. Licensed as a general hospital by the Territory/State of American Samoa; and
2. Qualified to participate under Title XVIII of the Social Security Act, and has in effect a hospital utilization review plan applicable to all patients who received medical assistance under Title XIX of the Social Security Act (Medicare), and
3. Signed agreement to participate with and abide by the rules and regulations of the American Samoa Medicaid Program.

B. Benefit Limitations/without limitations

Services are provided without limitations.

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2. a. **Outpatient hospital services**

Outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to an outpatient by or under the direction of physician or dentist in an approved general hospital outpatient department.

A. **Provider Eligibility Requirements**

An approved hospital is one which meets all of the following conditions:

1. Licensed as a general hospital by the Territory/State of American Samoa; and
2. Qualified to participate under Title XVIII and has in effect a hospital utilization review plan applicable to all patients who medical assistance under Title XIX of the Social Security Act (Medicare); and
3. Signed agreement to participate with and abide by the rules and regulations of the American Samoa Medicaid Program.

B. **Benefit Limitations**

1. **Covered Services**

- a) General medical clinic
- b) General surgical clinic
- c) Pediatric clinic
- d) Obstetrics/Gynecology clinic
- e) Ear, Nose and throat clinic
- f) Eye clinic
- g) Dental clinic
- h) Emergency Room Service - Emergency hospital services means services necessary to prevent the death or serious impairment of the health of an individual; and services provided by the most accessible hospital available that is equipped to furnish the services because of the threat to the life of health of the individual even if the hospital does not currently meet the conditions for participation under Medicare; or the definition of inpatient or outpatient hospital services under the American Samoa Medicaid State Plan). Emergency services are provided regardless of immigration status.

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- i) Laboratory and diagnostic test
- j) Diagnostic radiology
- k) Medical and surgical supplies
- l) Drugs which are prescribed by physicians and cannot be purchased without a prescription.
- m) Dialysis treatment and related services
- n) Hospital-based physician services
- o) Physical, occupational and inhalation therapy
- p) Computed Tomography including head scan and body scan (Patient/client who needs a head or body scan at LBJ Tropical Medical Center must carry a referral from attending physician.
- q) Diabetes, and related services and supplies.
- r) Care for tuberculosis or Lytico (amyotrophic lateral sclerosis) and Bodig (Parkinson disease) and related services.
- s) Routine or annual physical examination.
- t) Behavior Health Services - Behavior health services include screening, brief intervention, treatment and prevention related to mental health and substance abuse. Behavior health conditions are treated in a range of settings including primary care at community health clinic, social service program, hospital primary care clinic and men health clinic where individuals are treated for depression, anxiety and other issues.

These services are provided with no limitations.

2. Not Covered Services

Non-emergency use of Emergency Room.

2.c. Federally Qualified Health Center (FOHC) Services

Federally Qualified Health Center (FQHC) Services as defined in section 1905(a)(2)(C) of the Social Security Act (the Act). FQHC services include services provided by physicians (MD/MBBS), dentists, advanced practice registered nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, clinical psychologists, licensed clinical social workers, dental hygienists, visiting nurses, and other ambulatory services included in the state plan.

3. Other Laboratory and X-ray Services

The LBJ hospital laboratory provides technical laboratory services on island. Tafuna Federally Qualified Health Center operates a mini lab that serves only patients seen at that facility. Tafuna FQHC refers tests that cannot be handled at its mini lab to LBJ Hospital lab. Off-island professional and technical laboratory and radiological services are ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by Territorial/State law. Such services will be provided in an office or similar facility other than in a hospital outpatient department or clinic. They are provided by a laboratory that meets the requirements for participation in Medicare.

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1. Provider Eligibility Requirements

To qualify for participation as a laboratory under American Samoa Medicaid Program, the following requirements must be met:

- a. Approved and licensed as a laboratory by appropriate authority and the Territory of American Samoa; and
- b. Certified as a laboratory under the Title XVIII Medicare Program.

2. Benefit Limitation

a. Covered Services

Laboratory procedures ordered by a physician.

b. Not Covered Services

Services that are not medically necessary as determined by the patient's physician.

4. a Skilled Nursing Facility - Not provided

4. b Early Periodic Screening, Diagnosis and Treatment Services (EPSDT)

Early Periodic Screening, Diagnosis and Treatment services are screening and diagnostic services to determine physical or mental defects in patients under age 21 and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. All medically necessary services are provided to individuals under 21 years of age.

A. Provider Eligibility Requirements

To provide early periodic screening, diagnosis and treatment services, the following providers are qualified:

- (a) All practitioners, physicians, dentists, audiologists, and optometrists licensed by the American Samoa Health Service Regulatory Board.
- (b) Independent clinics and hospitals that have executed a signed agreement with the Medicaid Program.

B. Benefits Limitations

1. Covered Services

a. Screening examination

TN No: 11-002

Supersedes

TN No: 87-004

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- b. Immunizations at the screening
- c. Refractive eye examination and eyeglass prescription by an ophthalmologist or optometrist once every two years or when referred by screening.
- d. Hearing test and hearing aid.
- e. Necessary dental care is furnished to children under 21 years of age by the Public Health Dental Clinic and by the school dental program under LBJ Tropical Medical Center.

2. Not Covered Services

Screening of persons twenty-one (21) years old and over.

4. c Family Planning Services - Not provided

5. Physician Services

Physician services are services furnished by a physician within the scope of practice of medicine or osteopathy as defined by State law and by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy. These services may be provided in the patient's home, physician's office, a hospital, or elsewhere.

A. Provider Eligibility Requirements

To participate as a provider in the Medicaid program, a physician must be licensed to practice medicine and surgery in the Territory by American Samoa Health Service Regulatory Board.

B. Benefit Limitation

1. Covered Services

- a) Medical and surgical services
- b) Injections and drugs dispensed by the physician
- c) Services & supplies incidental to physician's services
- d) Kidney dialysis and related services
- e) Medically indicated circumcision.
- f) Diabetes, and related services and supplies
- g) Routine physical examination
- h) Care for tuberculosis

2. Not Covered Services

- a) Cosmetic surgery

TN No: 11-002

Supersedes

TN No: 87-004

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- a) Immunization and vaccine readily available free of charge at community health clinics
- b) Acupuncture

6) **Medical or Other Remedial Care provided by licensed practitioners**

- a. Podiatrist Services
 - Not Covered except for individuals under the age of 21 pursuant to EPSDT. Services must be determined medically necessary and authorized by the territory.
- b. Optometrist Services
Services are limited to the following:
 - One complete visual analysis including refraction once every two years per eligible beneficiary.
 - One interim diagnostic eye exam once every two years per eligible beneficiary.

A participating practitioner, public or private, must meet the following requirements:

- Licensed (could be from any of the 50 states, 5 U.S. Territories or an internationally recognized licensing body).
- Certified by the American Samoa Health Regulatory Services Board.
- Approved for participation as a provider by the American Samoa Medicaid State Agency.

Coverage service and limitations may not apply when medically necessary and requires prior authorization.

Not Covered

- Medication dispensed at an office.
- Vision Training.
- Pathology Services, as specified in optometry license.

- c. Chiropractor Services
 - Not Covered except for individuals under the age of 21 pursuant to EPSDT. Services must be determined medically necessary and authorized by the territory.
- d. Other Licensed Practitioner Services
 - Services of a licensed clinical psychologist within their scope of practice according to state/territory law.
 - Services of licensed nurse practitioner within their scope of practice according to state/territory law.
 - Services of licensed physicians' assistant within their scope of practice according to state/territory law.
 - Services of a licensed marriage and family counselor within their scope of practice according to state/territory law.

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7) **Home Health Services**

Home health services are services that will be provided to patients referred off-island from a physician as part of a written plan of care that the physician reviews every 60 days. The services will be provided in the patient's temporary place of residence. Home health services will include the following services and items:

- a. Nursing services, as defined in the state nursing practice act, that are provided on a part-time or intermittent basis by a home health agency that is either a public or private organization that meets the requirements for participation in Medicare.
- b. Home health aide services provided by a home health agency.
- c. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.
- d. Physical therapy services provided by a home health agency or by a facility licensed by the state to provide medical rehabilitation services.

A. Provider Eligibility Requirements

A participating Home Health Agency is a public or private agency or organization which meets the following requirements.

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1. Certification as a Home Health Agency under Title XVIII Medicare Program.
2. Approval for participation as Home Health services provider by the American Samoa Medicaid Program.

B. Benefit Limitations

1. Covered Services

- a. Nursing care when ordered by and included in the attending physician's plan of treatment and provided by or under the direct supervision of a licensed nurse (Registered nurse, licensed practical nurse) on an intermittent or part-time basis.
- b. Personal care services provided by a home health aide under the supervision of a registered nurse when determined medically necessary by the physician as part of the patient's treatment plan.
- c. Medical supplies necessary to the adequate support of an attending physician's plan of treatment outside of inpatient setting.

2. Not Covered Services

- a. Medical social services
- b. Speech and occupation therapy
- c. Home maker services
- d. Chore services

Currently, these services are only provided to patients referred off-island when medically necessary.

7.a. Medical Supplies, Equipment and Appliances

Pursuant to 42 CFR § 440.70 and other applicable state and federal law or regulation, medical supplies, equipment and appliances shall be provided to a patient if certified by a physician written plan of care. A physician shall review biannually the necessity and suitability of medical supplies, equipment and appliances for use by the patient.

A. Provider Eligibility Requirements

- a. Certified by the American Samoa Health Regulatory Board
- b. Approval for participation as a Provider by the American Samoa Medicaid Program.

B. Benefit Limitations

1. Covered Services

- a. Equipment and appliances are defined as items which are primarily customarily used to serve a medical purpose, generally is not useful to a person in the absence of disability, illness or injury, can withstand repeated use and can be reusable and removable.
- b. Medical supplies are those health care related items which are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

2. Not Covered Services

- a. DME and supplies for any hospital resident or in settings where medical equipment is a part of facility costs (e.g., hospital, nursing facility). Such services are covered under inpatient cost.
- b. All medically necessary supplies and equipment shall be covered; unusual types shall be preauthorized based on medical necessity determination.

8. *Private Nursing Duty*

Off-island nursing services will be provided for patients who are authorized off-island care, and require more individual and continuous care, after hospital inpatient services, than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. Such services will be provided by a registered nurse or a licensed practical nurse under the direction of the physician to a patient in his temporary off-island residence before the patient is authorized to return to his principal on-island residence by the attending off-island physician and as less costly alternative to extend inpatient hospital, skilled or intermediate care services.

Currently, this service is not provided on-island.

A. Provider Eligibility Requirements

To participate as a provider in the Medicaid program, a private duty nurse must be licensed by American Samoa Health Services Regulatory Board

B. Benefits Limitations

No limitations

9. **Clinic Services**

Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by the facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. These services are provided under the direction of a physician or dentist. Clinic services include the following services provided to outpatients.

- a. Services furnished at a clinic by or under the direction of a physician or dentist.
- b. Services furnished outside the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address

A. Provider Eligibility Requirements

Each clinic must be individually approved by the American Samoa Health Regulatory Board and the Medicaid Program.

B. Benefits Limitations

Approved clinics may, to the extent of their specialty, provide only medically necessary services which are covered under this Medicaid plan.

9.a. **Dialysis Clinics**

The following dialysis services are covered.

1. Hemodialysis and peritoneal dialysis support services are covered on-island when they are provided by a Medicaid enrolled certified free-standing ESRD facility.
2. Dialysis is covered for patients referred and approved by the Medicaid State Agency through the off-island medical referral program.

A. Provider Eligibility

- a. Approval for participation as a provider by the American Samoa Medicaid State Agency.
- b. Certified to operate as a dialysis center or free-standing facility under Title XVIII of the Medicare Program.

10. Dental Services

Diagnostic, preventative and corrective procedures will be provided by or under the supervision of a dentist in the practice of his profession who is licensed to practice dentistry or dental surgery.

A. Provider Eligibility Requirements

Any dentist who is licensed to practice in American Samoa, agrees to abide by the policies, regulations, and procedures as promulgated by the American Samoa Program, and signs a provider agreement, is eligible to participate in the dental care aspects of the American Samoa Medicaid Program.

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B. Benefit Limitations

1. Covered Services

- a) Dental services necessary for relief of pain and infection.
- b) Restoration of teeth and maintenance of dental health
- c) Medically Necessary situation as determined by the patient's dentist.

11.a Physical Therapy

Physical Therapy services are provided in accordance with 42 CFR 440.110. The services are provided under the direction of a qualified physical therapist who is a graduate of a program of physical therapy approved by both the Council of Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and is licensed by the Territory of American Samoa.

A. Provider Eligibility Requirements

Any Physical therapist licensed by American Samoa Health Service Regulatory Board to practice in American Samoa, who accepts Medicaid policies, regulations, and procedures and signs a provider agreement, is qualified to participate in the program.

B. Benefit Limitations

These services are provided only for inpatient and outpatient hospital at LBJ Tropical Medical Center..

11. b. Occupational therapy

Occupational therapy services prescribed by a physician will be provided by or under the direction of a qualified occupational therapist, including the necessary supplies and equipment, who is a graduate of a program of occupational therapy approved by both the Council on Medical Education of the American Medical Association, engaged in the supplemental Occupational Therapists Association and is registered by the latter. The services will be provided in accordance with 42 CFR 440.110.

A. Provider Eligibility Requirements

Any occupational therapist licensed by American Samoa Health Service Regulatory Board to practice in American Samoa, who accepts Medicaid policies, regulations, and procedures and signs a provider agreement, is qualified to participate in the program.

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TN No: 87-004

B. Benefit Limitations

These services will be provided only for inpatient and outpatient hospital at LBJ Tropical Medical Center.

11c. **Speech Therapy & Audiology Services**

Services for patients with speech, hearing and language disorders will be provided by or under the direction of a speech pathologist or audiologist for patients referred by a physician and will include the necessary supplies and equipment. The speech pathologist or audiologist will have a certificate of clinical competence from the American Speech and Hearing Association, will have completed the equivalent educational requirements and work experience for the certificate or will have completed the academic program and is acquiring supervised work experience to qualify for the certificate. The services will be provided in accordance with 42 CFR 440.110.

A. Provider Eligibility Requirements

Any speech pathologist or audiologist licensed to practice speech therapy and/or audiology on American Samoa, who accepts Medicaid policies, regulations, and procedures and signs a provider agreement, is eligible to participate in the program.

B. Benefit Limitations

These services will be provided only for inpatient and outpatient hospital at LBJ Tropical Medical Center.

Covered Services

- a. Diagnostic speech evaluation
- b. Diagnostic audiological evaluation
- c. Hearing evaluation and hearing aid.

12. **Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses**

12a. Prescribed Drugs

Consistent with the authority described at section 1902(j) of the Social Security Act, the requirement for American Samoa to comply with the requirements of section 1902(a)(54) of the Social Security Act is waived. As a result, American Samoa is not required to comply with the applicable requirements of section 1927 of the Social Security Act, or the implementing regulations at 42 CFR Part 447, Subpart I.

Prescribed drugs means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are-

- 1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice in accordance with the State Medical Practice Act; and

- 1) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
- 2) Dispensed by the licensed pharmacist or practitioner on a written or electronic prescription that is recorded and maintained in the pharmacist's or practitioner's records.

A. Provider Eligibility Requirements

Pharmacies licensed to operate on American Samoa may be eligible to participate in the Territory's Medicaid Program provided they abide by all policies and procedures, have a licensed pharmacist on board, and have signed an agreement with the Medicaid Program.

B. Benefit Limitations

1. Covered Services

- a. The prescription must be dispensed by a licensed pharmacist.
- b. Prenatal vitamin/mineral supplements.
- c. Select over the counter (OTC) drugs.

2. Not Covered Services

- a. Investigational drugs

12. b. Dentures

Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

These services are provided without limitations.

12. c. Prosthetic Devices

Prosthetic Devices means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to—

- 1) Artificially replace a missing portion of the body;
- 2) Prevent or correct physical deformity or malfunction; or
- 3) Support a weak or deformed portion of the body.

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- 4) Surgically implanted cardiac artificial valves, pace makers, and intra ocular lens for cataract patients;

12.d. Eyeglasses means lenses, including frames and other aids to vision prescribed by a physician skilled in diseases of the eye (ophthalmologist) or by an optometrist; whichever patient may select, to improve vision.

A. Benefit Limitations

1. Covered Services

- a. Prescription eyeglasses limited to one pair each every two (2) years except when determined medically necessary.
- b. Prescriptions sunglasses limited to one pair each every two (2) years except when determined medically necessary.
- c. Rigid gas permeable (RGP) prescription contact lens are limited to one (1) pair every two (2) year except when determined medically necessary.
- d. Prescription soft contact lens are limited to twenty four (24) pairs every two (2) years except when determined medically necessary.
- e. Repair or replacement of broken eyeglasses and sunglasses limited to once every two (2) years.
- f. Eyeglasses will be provided to EPSDT recipients beyond and above limitations based on the determinations of medical necessity and prior authorization.
- g. Prior authorization is required to receive the combined benefit of eyeglasses, prescription contact lens and/or sunglasses based on the determinations of medical necessity.

2. Not Covered Services

- a. Eyeglasses with correction of below plus or minus(+or-) .50 diopters or 10-cylinder axis.
- b. Cosmetic glasses, sunglasses and contact lenses

13. Diagnostic, Screening, Preventive and Rehabilitative Services

13. a. Diagnostic Services

Diagnostic Services, except as otherwise provided under this plan includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a patient. These services are performed only when deemed medically necessary by the patient's physician.

13. b. Screening Services

Screening Services means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain disease.

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13. c. Preventive Services

Preventive Services means services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to-

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AMERICAN SAMOA MEDICAID STATE AGENCY

- (1) Prevent diseases, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency.

A. Benefit Limitations

1. Covered Services

a. Pelvic Examination

Pelvic examination means a preventive/screening examination performed by a physician and associated laboratory test, furnished to a woman of childbearing age without signs or symptoms for the purpose of early detection of cervical cancer or other abnormalities and includes the physician's interpretation of the results of the procedure.

The following limitations apply to coverage:

- 1) For female 16 years of age and above, one pelvic exam every 36 month;
- 2) For female 16 and over with a history and/or family history of cervical cancer, transmitted diseases and/or other high risk factors, pelvic examination may be provided more frequent than 36 months subject to justification from a physician.

b. Screening Mammography

Screening mammography means a radiological procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

The following limitations apply to coverage:

- (1) The service must be, at a minimum, a two-view exposure (that is, a crania-caudal and a medial lateral oblique view) of each breast.

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(2) For women 35-39 years of age, one baseline mammogram;

(3) For women 40-49 years of age, one mammogram every two years;

(4) For women 50 years of age or older, one mammogram every twelve months;

(5) For women age 40 and over with a history and/or family history of breast cancer, one mammogram every twelve months.

c. Pap Smear

Once every 12 months or every 3 years after 3 consecutive satisfactory normal or negative pap smear for female age 16 and over.

d. Tobacco-Use Cessation

Provider Eligible Requirements: Public Health licensed providers practicing within their scope of practice to provide tobacco counseling services to eligible individuals.

Benefit Limitation: Provide counseling and medication coverage for at least two cessation attempts per year.

i. Face-to-face counseling. Each cessation attempt is at least four sessions of at least 30 minutes each.

14. Intermediate care facility (ICF/MR) services---not provided.

15. Inpatient psychiatric facility services for individuals under 21 years of age---not provided.

16. Nurse-midwife Services---not provided.

17. Hospice---not provided.

TN # 17-001

Approval Date JUN 21 2017

Supersedes TN # 12-001

Effective Date April 1, 2017

18. Off-Island Care and Procedures Not Available on American Samoa

Medicaid may refer patients off-island for medical care under certain conditions. Patients may be referred off-island for emergency services, acute medical services, or comprehensive diagnostic screening, other lab, and x-ray services not available on-island for purposes of early disease detection, intervention and to control costs associated with delayed treatment. All referrals are handled in accordance with the policies and procedures of the American Samoa Medicaid Agency. Patients referred under the Medicaid Program shall be covered for medical, transportation and accommodations services only. Services may be on an inpatient or outpatient basis depending upon the medical necessity as determined by the Medicaid agency's referral policies. Transportation must be necessary to provide patient with access to medical care with providers and includes emergency and non-emergency air travel, land and sea. (Refer to Attach. 3.1-D).

Statement on Benefit Limitations and Authorizations

1. Off-island medical care described above, must be essential to save life, significantly alter an adverse prognosis, or provide early diagnostic disease prevention not available on island for purposes of intervention, early disease detection and cost controls of the Medicaid program.
2. Off-island medical services are subject to the benefits limitations under Attachment 3.1-A requiring certain services shall be done on-island. Palliation, experimental or cosmetic procedures shall not qualify for off-island referral.
3. Medicaid coverage for medical care, transportation and accommodations services furnished for off-island referral must receive prior authorization for reimbursement from the American Samoa Medicaid Agency in accordance with Medicaid's standard operating procedures for off-island referral.
4. Emergency and acute medical care not available on island require the referring physician to submit to Medicaid a written request including a detailed description of the patient's health problems, treatment recommendations and the reasons for referral. Patients must provide their medical records as needed for complete medical evaluation for acceptance by the accepting provider. The off-island medical treatment request shall be reviewed and approved by the American Samoa Medicaid Agency pursuant to its policies and procedure for off-island referral.
5. Diagnostic disease prevention referral services are done directly by the Medicaid State Agency pursuant to Medicaid's standard operating procedures for such referrals, and are limited to persons determined at-risk for serious medical conditions based upon medical necessity and health survey results.
6. All referrals must be accepted by the receiving providers to be eligible for approval by Medicaid.

26. **Personal Care Services**

1. Personal Care Services are services provided to individuals who require assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL).
2. Using the flexibility authorized by Section 1902(j) of the Social Security Act, Personal Care Services will be limited to eligible beneficiaries residing at qualified Medicaid Authorized Long-Term Care and Support Services (LTCSS) facilities. Services will be furnished by the LTCSS facility.
3. Under Section 1905(a)(24) of the Social Security Act, Personal Care Services shall not be provided to individuals who are inpatients or residents of a hospital, nursing facility, intermediate care facility for developmentally disabled, or institution for mental disease. Additionally, personal care services must not be provided in other living arrangement which includes personal care as a reimbursed service under the Medicaid program.
4. Personal care services are authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the state) otherwise authorized for the individual in accordance with a services plan approved by the state.

A. **Provider Qualifications**

A qualified Personal Care Services provider is a Medicaid authorized Long-Term Care and Support Services facility which meets the following requirements:

1. In accordance with CFR 440.167(a), personal care services are provided by an individual who is qualified to provide such services and who is not a member of the individual's family.
2. Personal Care Aides must have 120 hours of practical training under the supervision of a registered nurse or under an approved Certified Nursing Aide Program.
3. All Personal Care Aides must have criminal background checks
4. Personal Care Aide (PCA) staff are at least 18 years of age.
5. Healthcare professional staff are licensed by the Department of Health Regulatory Service Board.
6. LTCSS facilities shall comply with Medicaid program policies and procedures.
7. Approved for participation as a Personal Care Services Provider by the American Samoa Medicaid Program

B. **Benefits Limitations**

1. **Covered Services**

TN#: <u>20-001</u>	Approval Date: <u>03/23/2021</u>
Supersedes TN#: <u>NEW</u>	Effective Date: <u>10/01/2020</u>

- a. In order to be eligible for Medicaid reimbursement, PCA ADL services shall include, but not limited to, the following:
 - i. Cueing or hands-on assistance with performance of routine activities of daily living (such as, bathing, transferring, toileting, dressing and feeding)
 - ii. Assisting in incontinence, including bed pan use, changing urinary drainage bags, changing protective underwear, and monitoring urine input and output;
 - iii. Assisting with persons with transfer, ambulance and range of motion exercises.
 - b. PCA services include assistance with instrumental activities of daily living (IADL).
 - c. In order to be eligible for Medicaid reimbursement, PCA IADL services shall include, but not limited to, the following:
 - i. Personal hygiene, light housework, laundry, meal preparation, grocery shopping, using the telephone, medication management, and money management.
2. Not Covered Services
- a. Medical Social Services
 - b. Speech, audiological and occupation therapy
 - c. Chore services
 - d. Room and Board at LTCSS facility

ATTACHMENT

3.1-D

TRANSPORTATION AND ACCOMMODATIONS

Attachment 3.1-D lists and describes the manner in which transportation services are provided to individuals presumed to be eligible for Medicaid benefits.

Transportation

Transportation is provided by the American Samoa Medicaid State Agency when a Medicaid patient has no other means of getting to and from covered medical services, whether emergency or medically necessary non-emergency.

The following are the methods utilized to assure necessary transportation of patients to and from providers:

1. Air transportation to and from off-island will be provided through scheduled or chartered commercial, government or private aircraft. Such transportation will be provided to Medicaid patients and attendants who are authorized by Medicaid for off-island medical referral in accordance with its policies and procedures.
2. Transportation to and from outer islands of American Samoa will be provided through scheduled or chartered commercial, government or private carrier by land, air or sea. Such transportation shall be provided to Medicaid patients and attendants who are authorized by Medicaid.
3. Ground transportation in the U.S. or out-of-country will be covered by Medicaid when necessary to transport patients to and from emergency medical treatment and including non-emergency.
4. For on-island emergency or non-emergency transportation, Medicaid will cover transportation when necessary for emergency purposes or to transport patients to and from medical appointments.

The Medicaid agency assures that the transportation provided for off-island and on-island medical services are appropriate and sufficient to reasonably achieve the patient's needs. Transportation carriers must be approved Medicaid providers. In addition, all providers utilized by the Medicaid Agency shall be licensed and certified by recognized, national or international licensing authorities.

3.2 COORDINATION OF MEDICAID WITH MEDICARE & OTHER INSURANCE

Revision: HCFA-PM-93-5 (MB)

MAY 1993

State: American Samoa

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance

(b) Deductible/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n),
1905(a) and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B

describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902

(i) Qualified Medicare

(a)(10)(E)(i) and
1905(p)(3) of the Act

Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30),
and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

√ For the entire range of services available under Medicare Part B.

— Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30),
1905(a), and 1905(p)
of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

TN No. 12-006

Supersedes

TN No. N/A

Approval Date SEP 12 2012 Effective Date April 1, 2012

Revision: HCFA-PM-91-4

(BPD)

Supplement 1 to ATTACHMENT 4.19-B

AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: American Samoa

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 of this attachment (see 3. above).

Revision: HCFA-PM-91-4

(BPD)
4.19-B

Supplement 1 to ATTACHMENT

AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: American Samoa

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance
	Part B	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance
Other Medicaid Recipients	Part A	<u>NR</u>	Deductibles	<u>NR</u>	coinsurance
	Part B	<u>NR</u>	Deductibles	<u>NR</u>	coinsurance
Dual Eligible (QMB Plus)	Part A	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance
	Part B	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Supplement 1 to ATTACHMENT 4.19-B

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: American Samoa

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

Payment of Medicare Part A and Part B Deductible/Coinsurance

Presumptive Eligibility is a special method American Samoa utilizes that does not involve individual eligibility determination based on personal income and citizenship status. Rather, aggregate population data regarding income levels and citizenship is utilized to perform calculations to determine the number of presumed eligible Medicaid beneficiaries, and the percentage of allowable costs incurred at LBJ Tropical Medical Center (LBJ) that are eligible for Federal Financial Participation.

It is assumed that the income distribution of Medicare beneficiaries mirrors that of the general population. Therefore, it is assumed that the percentage of Medicare beneficiaries who are dually eligible for Medicaid is the same as the percentage of American Samoans who fall at or below 200% FPL (as determined in Item 1(B)(2)(a) of Section 2). As a result, it is presumed that this same determined percentage of all Medicare Part-A and Part-B deductible/coinsurance are allowable costs for Medicaid reimbursement. American Samoa Medicaid Office will apply the same percentage determined in Item 1(B)(2)(a) of the Annual Determination of presumed eligibility as the claiming percentage for all Medicare Part-A and Part-B deductibles/coinsurance in order to determine the allowable reimbursement. For detailed information on determining both the number of presumed eligible Medicaid beneficiaries and those beneficiaries who are presumed to be dually eligible for Medicaid and Medicare, please refer the eligibility of the State Plan under Section 2.

Page 3

TN No. 12-006

Supersedes

TN No. N/A

Approval Date _____

SEP 12 2012

Effective Date April 1, 2012

HCFA ID: 7982E

SECTION 4

American Samoa Medicaid State Agency

SECTION 4: GENERAL PROGRAM ADMINISTRATION

A. METHODS OF ADMINISTRATION

The Medicaid agency assures that it employs methods of administration, acceptable to the Secretary, and described in this plan, that are necessary for the proper and efficient operation of the program.

In consideration of the approval of this plan and to ensure the proper and efficient operation of the Medicaid program, ASG agrees to utilize Federal funds received under this plan as follows:

1. To implement the hospital Plan of Correction to remove Medicare standards deficiencies. This will be first priority in order to assure continued certification for participation in Medicare and Medicaid. This in turn will assure continued funding. Once Medicare deficiencies have been removed, high priority will be given efforts to maintain hospital standards at, or above, Medicare standards.
2. To improve and upgrade health care delivery in American Samoa. This is one of the purposes for which ASG was granted a waiver of most Federal requirements and is a high priority objective of the ASG. Some examples are:
 - a) achieve and maintain physician, dentist, and RN staffing levels consistent with needs established in approved health plans.
 - b) assure the development and maintenance of an effective quality assurance program including: implementation of a viable on-going education program for physician, dentist, and other professional health workers.
3. To implement additional procedures and controls in order to qualify for additional Federal funds. In the event that ASG will not otherwise receive all funds allowable within the Federal ceiling, additional staff and/or procedures will be used to qualify for additional funding. Some examples are: inservice training to implement Family Planning Services, procedures to claim administration & Management costs, etc.

1. Safeguarding Information of Patients

The Medicaid agency assures on-island confidentiality of patient medical information through a system that limits access to patients' medical records by authorized medical and business office personnel. Such access is limited to purposes directly related to medical care administration. Off-island, confidentiality of patient information is assured by agreements signed by providers. Patient financial information is maintained in confidence by the Director and Financial Manager of DOH and used exclusively for purposes directly related to the administration of American Samoa's health care delivery program.

2. Quality Control to Reduce Erroneous Expenditures

Administration auditing to assure appropriate and accurate collection of patient payments and expenditures of program funds is achieved through a program of budgetary/expenditure and audit controls in place in the Department of Health. In addition, independent financial audits will be conducted on a periodic basis.

TRANSMITTAL # <u>85-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D BY _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>10-7-85</u>	EFFECTIVE _____

16 (Amended effective 10/1/85)

3. Fraud Detection and Investigation Program

Provider fraud is controlled on-island through a program of budgetary/expenditure and audit controls in place at the Department of Health.

Off-island services are monitored by the American Samoa Off-Island Referral Committee and the DOH Financial Manager to ensure that only DOH authorized patients and escorts receive off-island services.

4. Maintenance of Records

Records used to determine the number of presumptive Medicaid eligibles, costs of Medicaid services, service utilization, amount of Federal Financial Participation claimed and patient payment liability are maintained by DOH for a 5 year period to allow auditing and efficiency of program administration.

5. Availability of Agency Program Manuals

The Medicaid agency assures access to program manuals, rules and policies, including this plan, by individuals outside the Medicaid agency. Access is available at the agency's office and through other entities as determined appropriate by the agency.

6. Reporting Provider Payments to Internal Revenue Service

The Medicaid Agency assures that it has procedures for identifying providers of service by Social Security number and that it reports information required by section 6041 of the Internal Revenue Code (26 U.S.C. 6041) regarding the filing of annual information returns showing amounts paid to providers.

7. Relations with Standard Setting and Survey Agencies

The Medicaid agency assures the utilization of Medicare standards in regard to relations with standard setting and survey agencies.

8. Required Provider Agreement

The Medicaid agency maintains an agreement with each on-island and off-island provider furnishing services under the plan, in which the provider agrees to:

- a) Keep any record necessary to disclose the extent of service the provider furnishes to patients;
- b) On request, furnish to the Medicaid agency or the Secretary, any information maintained under paragraph 9(a) of this section and any information regarding payments claimed by the provider for furnishing services under this plan;

17 (Amended effective 10/1/85)

TRANSMITTAL # <u>85-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D NO _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>10-9-85</u>	EFFECTIVE _____

- c. Maintain the confidentiality of patient information for other than medical or program administrative purposes;
- d. Not discriminate against any individual seeking services under this plan, on the basis of race, sex, religion, color, national origin or handicap; and

9. Relations with other Agencies

The Medicaid State agency coordinates its Medicaid program activities with other agencies including Title V, State Vocational Rehabilitation Agency, and the Territorial Administration on Aging.

18 (Amended effective 2/2/88)

TRANS. NO.: 88-1 APPROVE: MAY 25 1988 EFFECTIVE: JAN 1 1988

B. QUALITY ASSURANCE AND UTILIZATION CONTROL OF HOSPITAL
INPATIENT SERVICES

The Medicaid State Agency shall establish and maintain a formal utilization review and quality assurance program to ensure the attainment and maintenance of high standards of professional and ethical practices. This program shall be consistent with Medicare/Medicaid quality assurance certification standards for hospitals.

The Medicaid Agency uses the following policies and methods to assure control of the utilization of Hospital Inpatient Services:

1. Plan of Care and Medical Necessity of Treatment

At the time of admission to the hospital, a physician or medical officer involved in the care of the individual will establish a written plan of care which will include:

a. Diagnoses, symptoms, complaints and complications, and outpatient workup, indicating the need for admission;

b. Any orders for:

Procedures, including Surgical procedures
Medications
Treatments
Restorative and rehabillitive services
Activities
Social Services
Diets
Diagnostic Work-ups

c. Plans for continuing care.

d. Documentation of reaction/response to treatments, and plans for continuing care.

e. Plans for discharge, to include treatment & medication regime and plans for follow-up, as appropriate.

Each plan of care will be reviewed, at least every 60-days, for appropriateness of levels of care and plans of care.

TRANSMITTAL # <u>35-1</u>	EFFECTIVE <u>10-1-85</u>
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APPROVED <u>10-7-85</u>	EFFECTIVE _____

2. Hospital Review Plan: General

The LBJ Tropical Medical Center, which is the only hospital in the Territory, will have in effect a written review plan which meets the requirements of 42 CFR 456 and 405.1035, except as waived or modified by the Secretary of DHHS. The plan describes how the UR/QAR functions will be performed including the items outlined in (a) - (g).

a. UR/Quality Assurance Review (UR/QAR) Personnel

AUR/QAR committee will perform the required UR/QAR function. In addition a review coordinator may be used to perform reviews with questionable cases referred to the physician advisors and/or committee.

b. Review Personnel Organization and Composition

The committee must be composed of two, or more physicians, include other professional personnel, as appropriate, and be a committee of the hospital medical staff. The committee may not include any individual who is directly responsible for the care of a patient whose care is being reviewed, who is a member of the patient's family, or who has a financial interest in the system or financially benefits in any way. The review coordinator should be experienced in health care delivery and preferably be a RN.

c. Information Requirements

Each patient record will include information needed by the committee to adequately perform its functions. This information will include, at least:

Patient's name and hospital number
Patient's attending physician
Date of admission
Justification for admission
Patient's plan of care
Reasons and plan for medical, and surgical procedures

The committee will keep records which will be distributed to appropriate individuals.

The identities of all patients in the records and reports are kept confidential.

TRANSMITTAL #	85-1	EFFECTIVE	10-1-85
REC'D NO		SUPERSEDED BY TRANSM #	
APPROVED	10-9-85	EFFECTIVE	

d. Admission and Continued Stay Review

Review will be performed by the Inequal criteria on admission. If both SI/IS (Severity of Illness and Intensity of Service) criteria are not met, the admission will be sent to a physician advisor for review. Utilizing medical judgement, the physician may approve or deny the case.

Continued stay review will be performed every working day, evaluating care on the basis of acute SNF,ICF levels of care. Quality questions raised will be directed to the attending physician and/or physician advisor.

e. Notification of Adverse Decision

Written or verbal notices of any adverse final decision on the need for admission or continued stay will be provided to:

The Director of Department of Health
The attending physician
The Medicaid agency
The patient
The patient's next of kin, or sponsor,
if possible
The business office

f. Time Limits for Final Decision and Notification of Adverse Decision

A physician will make the final decision on a patient's need for admission and continued stay within 1 working day after referral.

Any adverse final decision will be given on the date of the decision.

g. Medical Care Evaluation Studies

1) General requirements

The hospital will have at least one medical care evaluation study in progress at any time and complete at least one study each calendar year. The purpose of these evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with

TRANSMITTAL # <u>22-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D NO _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>10-9-85</u>	EFFECTIVE _____

patient needs and professionally recognized standards of health care, they should emphasize identification and analysis of patterns of patient care and suggest appropriate changes needed to maintain consistently high quality patient care.

2) Study results and analysis

The plan will describe the methods that the committee uses to select and conduct medical care evaluation studies. For each study conducted, the committee will document the study results; and how the results have been, or will be, used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services. For each study the committee will analyze its findings and take action as needed to:

Correct, or investigate further, any deficiencies or problems in the review process for admission or continued stay cases;

Recommend more effective and/or efficient hospital care procedures; or

Designate certain providers or categories of admissions for review prior to admission.

3) Study Contents

Each medical care evaluation study will:

Identify and analyze medical or administrative factors related to the hospital's patient care.

Include analysis of, at least: admissions, duration of stay, ancillary services, drugs and biologicals provided; and professional services performed in the hospital, and

If indicated, contain recommendations for changes beneficial to patient, staff, the hospital, and the community.

TRANSMITTAL # <u>85-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D NO _____	SUPERSEDED BY TRANS # _____
APPROVED <u>10-9-85</u>	EFFECTIVE _____

Data sources

Data that the committee uses to perform studies will be obtained from one or more of the following sources:

American Samoa Cooperative Health Information System
Medical records or other appropriate hospital data
External organizations that compile data
Fiscal agents
Other appropriate agencies

Additional Quality Assurance Activities

Additional Quality Assurance activities will be conducted by the various hospital committees such as the Tissue Committee, Medical Records Committee, Pharmacy Committee, and Infection Control, etc.

TRANSMITTAL # <u>25-1</u> EFFECTIVE <u>10-1-85</u>
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APPROVED <u>10-9-85</u> EFFECTIVE _____

Revision:

State American Samoa

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

<u>Citation</u>	<p><input type="checkbox"/> The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</p>
Section 1902(a)(42)(B)(i) of the Social Security Act	<p><input checked="" type="checkbox"/> The State is seeking an exception to establishing such program for the following reasons:</p>
Section 1902(a)(42)(B)(ii)(I) of the Act	<p>Under 1902 (j) Waiver, American Samoa is not required to do enrollment of eligible people in its Medicaid Program. No Medicaid cards are issued. They don't bill or get billed. Medicaid funds come in a form of annual capped block grant. There is only one hospital in the Territory and is government-owned, financed, and operated. Health care is predominantly provided by the government. Procuring a Recovery Audit Contract is not a feasible option for American Samoa.</p>
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	<p><input type="checkbox"/> The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.</p>
	<p>Place a check mark to provide assurance of the following:</p>
	<p><input type="checkbox"/> The State will make payments to the RAC(s) only from amounts recovered.</p>
	<p><input type="checkbox"/> The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.</p>
	<p>The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):</p>
	<p><input type="checkbox"/> The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.</p>
	<p><input type="checkbox"/> The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published</p>

TN No. 10-001
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FEB 10 2011

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Effective Date: 1/01/2011

	rate.
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	<p>_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p>
Section 1902 (a)(42)(B)(ii)(III) of the Act	<p>_____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):</p>
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	<p>_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p>
Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act	<p>_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.</p>
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	<p>_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.</p>
	<p>_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p>

FEB 10 2011

TN No. 10-001
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 TN No. _____

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Effective Date: 1/01/2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: American Samoa

Citation
1902(a)(69) of
the Act,
P.L. 109-171
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.
The Medicaid agency assures it complies with such requirements
determined by the Secretary to be necessary for carrying out the
Medicaid Integrity Program established under section 1936 of the
Act.

TN No. _____
Supersedes
TN No. _____

Approval Date: OCT 27 2008 Effective Date: June 2, 2008

Medicaid State Plan Preprint

State/ Territory: American Samoa

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN No. 11-001

Supersedes

TN No.11-001 Approval Date: AUG 23 2011 Effective Date: July 1, 2011

ATTACHMENT
4.19-A

American Samoa Medicaid State Agency

**FUNDING AND REIMBURSEMENT PROTOCOL FOR MEDICAID
INPATIENT HOSPITAL COST**

American Samoa Medicaid Agency will reimburse LBJ Tropical Medical Center at cost for Medicaid inpatient hospital services. LBJ Tropical Medical Center is the only certified provider of hospital services in the Territory and is operated by American Samoa Medical Center Authority (ASMCA), a government agency. LBJ uses the CMS-2552 cost report for its Medicare program and submits this cost report each year to the Medicare contractor. LBJ will utilize the protocol outlined below to determine the allowable Medicaid hospital costs to be certified as public expenditures. LBJ and the American Samoa Government use the annual period from October 1 through September 30 as their fiscal year.

I. Summary of CMS-2552-10

Worksheet A:

Worksheet A is the hospital's trial balance of total expenditures by cost center.

The primary groupings of cost centers are:

- i. General Service;
- ii. Routine;
- iii. Ancillary;
- iv. Outpatient;
- v. Other Reimbursable and Special Purpose; and
- vi. Non-Reimbursable.

Worksheet A also includes A-6 reclassifications (which move costs from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare cost and reimbursement principles.

Worksheet B:

Worksheet B allocates overhead costs (identified in General Service Cost Centers, lines 1-23 of Worksheet A) to all cost centers, including non-reimbursable cost centers identified in lines 190-194 and their subscripts.

TN # _____ 12-007

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Supersedes TN # 12-003

Effective Date: 10/01/2017

Worksheet C:

Worksheet C computes the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records and reported on Worksheet C. The cost-to-charge ratios are used in the Worksheet D series.

Worksheet D:

Worksheet D series apportions the total costs from Worksheet B to different payers/programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Routine cost centers are apportioned based on per diem amounts, while ancillary cost centers are apportioned based on cost-to-charge ratios. Note however for American Samoa, cost apportionment to Medicaid services using Worksheet D methodology needs to be modified since American Samoa employs a presumptive eligibility percentage to determine Medicaid matching. See Section 2 - Eligibility of the American Samoa Medicaid State Plan.

Notes:

For purposes of utilizing the CMS-2552 cost report to determine Medicaid reimbursement described in the subsequent instructions, the following terms are defined:

- The term "finalized" refers to the cost report that is settled by the Medicare contractor with the issuance of a Notice of Program Reimbursement.
- The term "as-filed" (or "filed") refers to the cost report that is submitted by the hospital to the Medicare contractor and is typically due five months after the close of the cost reporting period.
- Any revision to the finalized CMS-2552 cost report as a result of Medicare appeal or reopenings will be incorporated into the final determination.

TN # 12-007

Approval Date: 07/24/2017

Supersedes TN # 12-003

Effective Date: 10/01/2017

**II. Certified Public Expenditures - Determination of Allowable Medicaid
Hospital Costs - Transitional Methodology**

This transitional methodology will be used to determine LBJ's allowable Medicaid hospital costs where the hospital does not have the capability to report patient charges by cost center and by payer classes. If interim payments are made for a given service period under this transitional methodology but the cost report filed for the service period provides for patient charges by cost center and by payer classes, the interim payments must be reconciled to the allowable Medicaid hospital costs during the interim reconciliation and final reconciliation processes in accordance with Section III of this State plan.

To determine LBJ's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by LBJ through the certified public expenditures (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

1) Interim Medicaid Inpatient Hospital Payment

The Territory will make interim Medicaid inpatient hospital payments to approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The process of determining the allowable Medicaid inpatient hospital costs eligible for FFP begins with the use of LBJ's most recently filed Medicare 2552 cost report.

- a. Total allowable hospital costs, consistent with Medicare cost principles, are reported in the CMS-2552-10, Worksheet B, Part I, Column 26, Line 118. The total allowable hospital costs on Line 118 should not include costs related to non-hospital services; LBJ does not operate any hospital-based providers such as a distinct part nursing facility.

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- b. Additional hospital costs, for hospital services covered and reimbursable under the American Samoa Medicaid State plan, are added from the following lines of Worksheet B, Part I, Column 26:

- i. Epogen
- ii. Dental Clinic
- iii. Outpatient Prescription Drug
- iv. Off-Island Medical Services

While these costs are classified for Medicare cost reporting purposes in non-reimbursable cost centers, these are costs pertaining to covered hospital medical services under the American Samoa State plan.

Additionally, hospital-based physician professional costs which have been removed on Worksheet A-8-2, Column 4, Line 200 are added to total hospital costs.

For any of the above costs which are added to the allowable hospital costs as determined for Medicare purposes, American Samoa and LBJ need to ensure that these costs are consistent with Medicare cost principles.

- c. The allowable hospital costs are apportioned to Medicaid hospital services by multiplying allowable hospital costs by American Samoa's Medicaid Claiming Percentage as established in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.D.
- d. Emergency services provided to ineligible non-citizens/non-nationals may be added to allowable Medicaid hospital costs determined above. For cost centers that have been identified and approved by CMS as eligible for the provision of emergency services, those costs may be claimed at an emergency claiming percentage. The emergency claiming percentage is derived as:
- i. The number of non-citizens/non-nationals minus the number of lawfully present pregnant women and lawfully present individuals under 21, as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1, multiplied

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- by the percentage of American Samoans that live below 400% of the FPL as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2. divided by;
- ii. The total population of American Samoa as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1.
 - iii. The allowable cost from Worksheet B, Part I, Column 26, for the identified cost centers, are multiplied by the emergency claiming percentage to arrive at the emergency hospital costs that can be added to the allowable Medicaid hospital costs determined in step c above.
- e. Total allowable Medicaid hospital costs are reduced by Medicaid patient care revenues collected to arrive at net allowable hospital costs; Medicaid patient care revenues are derived by applying the Medicaid Claiming Percentage to all patient care revenues. Alternatively, to the extent that LBJ is able to carve-out any actual non-Medicaid patient revenue such as Medicare revenues, then the remaining patient care revenues will be multiplied by an adjusted proxy percentage to arrive at the Medicaid patient care revenues used as offset. The numerator of the proxy percentage is the number of presumed American Samoa Medicaid-eligible individuals, and the denominator is the total number of American Samoa individuals minus the population representing the non-Medicaid categories carved out by LBJ from total patient revenues.

The emergency hospital cost in step d. are also reduced by any applicable patient care revenues. Unless the hospital is able to identify specifically the patient care revenues related to the emergency services furnished to ineligible non-citizens/non-nationals who are under 400% of the FPL (excluding lawfully present pregnant women and lawfully present individuals under 21), the offset is determined by applying the emergency claiming percentage to all patient care revenues. Alternatively, to the extent that LBJ is able to carve-out any actual non-applicable (i.e., not pertaining to the ineligible non-citizens/non-nationals) patient revenue such as Medicare revenues, then the remaining patient care revenues will

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be multiplied by an adjusted proxy percentage to arrive at the ineligible non-citizens/non-nationals patient care revenues used as offset. The numerator of the proxy percentage is the number of American Samoa non-citizens/non-nationals, minus the number of lawfully present pregnant women and lawfully present individuals under 21, multiplied by the percentage who are under 400% of FPL (see step d.i above), and the denominator is the total number of American Samoa individuals (see step d.ii above) minus the population representing the non-applicable categories carved out by LBJ from total patient revenues.

- f. The net Medicaid allowable hospital costs determined in previous step is allocated to Medicaid inpatient hospital services by applying LBJ's inpatient hospital percentage, which is the ratio of LBJ's total inpatient hospital patient revenues (Worksheet G-2, Column 1, Line 28) to LBJ's total hospital patient revenues (Worksheet G-2, Column 3, Line 28).
- g. The Medicaid allowable hospital costs from the latest prior period cost report may then be trended for cost inflation to the current period by applying the CMS hospital market basket. The inflated prior period costs serve as an estimate of the current service period expenditure. This amount is divided by twelve and will be claimed as the interim monthly inpatient hospital payment amount. The federal share of the monthly inpatient hospital payment amount will be paid to the hospital on a monthly basis.

2) Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments

LBJ's interim Medicaid inpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as filed to the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid inpatient hospital costs will be computed using the same methodology described in steps a-f above but using cost data from the as-filed cost report for the respective expenditure period. Additionally the revenue offsets in step e would be updated to account for revenues for services furnished during the expenditure period. The Medicaid inpatient hospital cost will be compared to

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the interim Medicaid inpatient hospital payments made. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The Medicare CMS-2552 is due to the Medicare contractor five months after the close of the hospital's cost reporting period. The interim reconciliation will be performed and completed within six months of the filing of the Medicare CMS-2552.

3) Final Reconciliation of Interim Medicaid Inpatient Hospital Payments

LBJ's final Medicaid inpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as finalized by the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid inpatient hospital costs will be computed using the same methodology described in steps a-f above but using cost data from the finalized cost report for the respective expenditure period. Additionally the revenue offsets in step e would be updated to account for revenues for services furnished during the expenditure period. The Medicaid inpatient hospital cost will be compared to the interim Medicaid inpatient hospital payments made, including any interim reconciliation amounts. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The final reconciliation will be performed and completed within six months of the Medicare contractor's finalization of the Medicare CMS-2552 with the issuance of a Notice of Program Reimbursement.

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III. Certified Public Expenditures - Determination of Allowable Medicaid Hospital Costs

Where LBJ has in place a patient accounting system to record patient charges by cost centers and by payer classes and files a Medicare 2552 cost report accordingly to the Medicare contractor, the allowable Medicaid hospital costs would be computed as follows.

To determine LBJ's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by LBJ through the certified public expenditures (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

1) Interim Medicaid Inpatient Hospital Payment

The Territory will make interim Medicaid inpatient hospital payments to approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The process of determining the allowable Medicaid inpatient hospital costs eligible for FFP begins with the use of LBJ's most recently filed Medicare 2552 cost report.

- a. To determine the interim Medicaid payment rate, the most recently filed Medicare 2552 cost report will be used to determine an overall ratio of costs to charges (RCC) for routine and ancillary services.

The specifics follow:

Determine RCC Costs.

- i. Compute total costs by using CMS 2552-10 Worksheet C, Part I, Column 1, Line 202, Subtotal.

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Deduct any cost center for non-hospital costs, including but not limited to:

Line 44, skilled nursing facility

Line 45, nursing facility

Line 46, other long term care

Line 88, rural health center

Line 89, federal qualified health center

Other non-hospital cost centers such as: home health agency, comprehensive outpatient rehabilitation facility, ambulatory surgery center, and hospice.

Add costs from the following cost centers, which are treated as non-reimbursable for Medicare cost reporting purposes but are reimbursable for Medicaid:

Epogen

Dental Clinic

Outpatient Prescription Drugs

Off Island Medical Services

Hospital-Based Physicians (professional component costs from worksheet A-8-2)

Result is total adjusted RCC costs.

The costs from the CMS 2552-10 used in the above computation must be consistent with Medicare cost principles.

- ii. Compute total charges by using CMS 2552-10 Worksheet C, Part I, Column 8, Line 202, Subtotal.

Deduct any cost center for non-hospital costs, including but not limited to:

Line 44, skilled nursing facility

Line 45, intermediate care facility

Line 46, other long term care

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Line 88, rural health center
Line 89, federal qualified health center
Other non-hospital cost centers such as: home health agency,
comprehensive outpatient rehabilitation facility, ambulatory
surgery center, and hospice.

Add charges from the following cost centers, which are treated as
non-reimbursable for Medicare cost reporting purposes but are
reimbursable for Medicaid:

Epogen
Dental Clinic
Outpatient Prescription Drugs
Off Island Medical Services
Hospital-Based Physicians (if not already included in
hospital departmental charges)

Result is total adjusted RCC charges.

The charges used in the above computation are consistent with
Medicare cost reporting requirements and represent uniform gross
charges charged to all payers.

- iii. Divide total adjusted cost by total adjusted charges to arrive
at the RCC.

- b. The RCC computed above is used as the interim payment rate and applied
to Medicaid inpatient hospital charges for the current service period. The
Medicaid inpatient hospital charges must pertain to inpatient hospital
services as covered by the American Samoa State plan. Given that
American Samoa does not perform individual Medicaid eligibility
determination, LBJ is recording all charges pertaining to American Samoa
residents, who have not been determined as ineligible non-citizens/non-
nationals and do not have other insurance coverage, as "Medicaid." Since
only a portion of these American Samoa residents can actually be
presumed to be Medicaid eligible per Section 2 of the American Samoa
Medicaid State plan, it is necessary to further apply the Medicaid

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Claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan to determine the allowable Medicaid costs. Section 2, Paragraph 1.E also includes separate percentages for the claiming of costs pertaining to lawfully present pregnant women and lawfully present individuals under 21.

- c. The allowable Medicaid costs computed in Step b above are offset by the applicable payments received by LBJ for these individuals described in Step b. The amount of the offset is the actual inpatient payment amount multiplied by the Medicaid Claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.
- d. The RCC computed above, as the interim payment rate, is also applied to other inpatient hospital charges in the current service period for which Medicaid is a secondary payer to other primary coverage for American Samoa residents who have not been determined as ineligible non-citizens/non-nationals. The inpatient hospital charges must pertain to inpatient hospital services as covered by the American Samoa State plan. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is further applied to the costs of other primary payer services. The result is the allowable costs pertaining to those services for which Medicaid is a secondary payer. Any charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan.
- e. The allowable Medicaid costs computed in Step d above are offset by the applicable payments received for individuals with other primary payer coverage (except for Medicare). The amount of the offset is the actual payment amount received for inpatient services furnished to individuals with other primary payer coverage (other than Medicare), multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan. Payments from all sources pertaining to the other primary payer services included in Step d are to be included.

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- f. The RCC computed above, as the interim payment rate, is also applied to charges related to inpatient emergency services furnished to ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21. Again, because LBJ would not have isolated those ineligible non-citizens/non-nationals emergency charges to only those for ineligible non-citizens/non-nationals who are below 400% FPL, the resulting emergency service cost should be multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2).
- g. The allowable Medicaid costs computed in Step f above are offset by the applicable payments received for the ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. The amount of the offset is the actual payment amount for inpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, services (or if identifiable, the actual payment amount specific to inpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services) multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2). Payments from all sources pertaining to the ineligible non-citizens/non-nationals services included in Step f are to be included.
- h. The sum of the net Medicaid cost from Steps c, e, and g may be trended for cost inflation to the current period using the CMS hospital market basket to arrive at the estimated reimbursable Medicaid inpatient hospital costs for the current service period. American Samoa will claim these as certified public expenditures on a monthly basis. The federal share of the monthly inpatient hospital payment amount will be paid to the hospital on a monthly basis.

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2) Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments

LBJ's interim Medicaid inpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as filed to the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid inpatient hospital costs will be computed using the same methodology described in steps a-g above but using cost data from the as-filed cost report for the respective expenditure period. Medicaid charges and revenue offsets would be updated as necessary to fully account for the charges and revenues for services furnished during the expenditure period. The Medicaid inpatient hospital cost will be compared to the interim Medicaid inpatient hospital payments made. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The Medicare CMS-2552 is due to the Medicare contractor five months after the close of the hospital's cost reporting period. The interim reconciliation will be performed and completed within six months of the filing of the Medicare CMS-2552.

3) Final Reconciliation of Interim Medicaid Inpatient Hospital Payments

LBJ's final Medicaid inpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as finalized by the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's final Medicaid inpatient hospital costs will be computed using cost data from the finalized cost report for the respective expenditure period.

Furthermore, the final reconciliation would compute Medicaid cost using the cost reporting apportionment process as prescribed by the CMS-2552-10. In other words, LBJ's allowable costs must be apportioned to Medicaid using a cost-center specific apportionment process.

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- a. For each routine cost center, a routine per diem for the cost center is computed in Worksheet D-1 of the 2552. The routine per diem is applied to the number of Medicaid days for each routine cost center. The inpatient days used must only pertain to inpatient hospital services covered by the American Samoa State plan. The result is the Medicaid inpatient hospital cost for each routine cost center.
 - b. For each ancillary cost center, an ancillary RCC for the cost center is computed in Worksheet C, Part 1, Column 9 of the 2552. The ancillary RCC is applied to the Medicaid charges for each ancillary cost center. The inpatient ancillary charges used must only pertain to inpatient hospital services covered by the American Samoa State plan. The result is the Medicaid inpatient hospital cost for each ancillary cost center.
 - c. As discussed in the Interim Payment section, it is necessary to further adjust the total "Medicaid" inpatient hospital cost by multiplying the computed cost from Steps a and b by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan and then offset by an amount equal to the inpatient "Medicaid" payment received multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa State plan.
 - d. Also as discussed in the Interim Payment section, steps a to c are repeated for those inpatient days and inpatient charges for which Medicaid is the secondary payer to other primary coverage. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is applied to the cost of other primary payer services. Any days and charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan. The payment offset again would equal to the total payments received for the inpatient other primary payer services multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.

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- e. Also as discussed in the Interim Payment section, steps a to c are repeated for those inpatient days and inpatient charges pertaining to emergency services furnished to ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. While the hospital may be able to identify ineligible non-citizens/non-nationals (excluding lawfully present pregnant women and lawfully present individuals under 21) inpatient days and inpatient charges relating specifically to emergency service cost centers (as agreed to by CMS), those ineligible non-citizens/non-nationals have not been determined to otherwise meet Medicaid eligibility. Therefore, for inpatient hospital costs pertaining to ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services, the costs are applied the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2). The payment offset again would equal to the total payments received for the inpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, services (or if identifiable, the total payments received for the inpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services) multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2).

The Medicaid inpatient hospital cost will be compared to the interim Medicaid inpatient hospital payments made, including any interim reconciliation amounts. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The final reconciliation will be performed and completed within six months of the Medicare contractor's finalization of the Medicare CMS-2552 with the issuance of a Notice of Program Reimbursement.

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**PAYMENT RATES
FOR OFF-ISLAND INPATIENT MEDICAL SERVICES**

1. Off-Island rates

(a) For all U.S. jurisdictions, Medicaid will pay based on the providers' Medicare rate for the service, reimbursable on a claims basis.

(b) For out-of-country providers, Medicaid will pay based on negotiated rates not to exceed 100% of the out of country provider's usual customary charges.

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ATTACHMENT
4.19-B

American Samoa Medicaid State Agency

**FUNDING AND REIMBURSEMENT PROTOCOL FOR MEDICAID
OUTPATIENT HOSPITAL COST**

American Samoa Medicaid Agency will reimburse LBJ Tropical Medical Center at cost for Medicaid outpatient hospital services. LBJ Tropical Medical Center is the only certified provider of hospital services in the Territory and is operated by American Samoa Medical Center Authority (ASMCA), a government agency. LBJ uses the CMS-2552 cost report for its Medicare program and submits this cost report each year to the Medicare contractor. LBJ will utilize the protocol outlined below to determine the allowable Medicaid hospital costs to be certified as public expenditures. LBJ and the American Samoa Government use the annual period from October 1 through September 30 as their fiscal year.

I. Summary of CMS-2552-10

Worksheet A:

Worksheet A is the hospital's trial balance of total expenditures by cost center. The primary groupings of cost centers are:

- i. General Service;
- ii. Routine;
- iii. Ancillary;
- iv. Outpatient;
- v. Other Reimbursable and Special Purpose; and
- vi. Non-Reimbursable.

Worksheet A also includes A-6 reclassifications (which move costs from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare cost and reimbursement principles.

Worksheet B:

Worksheet B allocates overhead costs (identified in General Service Cost Centers, lines 1-23 of Worksheet A) to all cost centers, including non-reimbursable cost centers identified in lines 190-194 and their subscripts.

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Worksheet C:

Worksheet C computes the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records and reported on Worksheet C. The cost-to-charge ratios are used in the Worksheet D series.

Worksheet D:

Worksheet D series apportions the total costs from Worksheet B to different payers/programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Routine cost centers are apportioned based on per diem amounts, while ancillary cost centers are apportioned based on cost-to-charge ratios. Note however for American Samoa, cost apportionment to Medicaid services using Worksheet D methodology needs to be modified since American Samoa employs a presumptive eligibility percentage to determine Medicaid matching. See Section 2 - Eligibility of the American Samoa Medicaid State Plan.

Notes:

For purposes of utilizing the CMS-2552 cost report to determine Medicaid reimbursement described in the subsequent instructions, the following terms are defined:

- The term "finalized" refers to the cost report that is settled by the Medicare contractor with the issuance of a Notice of Program Reimbursement.
- The term "as-filed" (or "filed") refers to the cost report that is submitted by the hospital to the Medicare contractor and is typically due five months after the close of the cost reporting period.
- Any revision to the finalized CMS-2552 cost report as a result of Medicare appeal or reopening will be incorporated into the final determination.

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**II. Certified Public Expenditures - Determination of Allowable Medicaid
Hospital Costs - Transitional Methodology**

This transitional methodology will be used to determine LBJ's allowable Medicaid hospital costs where the hospital does not have the capability to report patient charges by cost center and by payer classes. If interim payments are made for a given service period under this transitional methodology but the cost report filed for the service period provides for patient charges by cost center and by payer classes, the interim payments must be reconciled to the allowable Medicaid hospital costs during the interim reconciliation and final reconciliation processes in accordance with Section III of this State plan.

To determine LBJ's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by LBJ through the certified public expenditures (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

1) Interim Medicaid Outpatient Hospital Payment

The Territory will make interim Medicaid outpatient hospital payments to approximate the Medicaid outpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid outpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The process of determining the allowable Medicaid outpatient hospital costs eligible for FFP begins with the use of LBJ's most recently filed Medicare 2552 cost report.

- a. Total allowable hospital costs, consistent with Medicare cost principles, are reported in the CMS-2552-10, Worksheet B, Part I, Column 26, Line 118. The total allowable hospital costs on Line 118 should not include costs related to non-hospital services; LBJ does not operate any hospital-based providers such as a distinct part nursing facility.

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b. Additional hospital costs, for hospital services covered and reimbursable under the American Samoa Medicaid State plan, are added from the following lines of Worksheet B, Part I, Column 26:

- i. Epogen
- ii. Dental Clinic
- iii. Outpatient Prescription Drug
- iv. Off-Island Medical Services

While these costs are classified for Medicare cost reporting purposes in non-reimbursable cost centers, these are costs pertaining to covered hospital medical services under the American Samoa State plan.

Additionally, hospital-based physician professional costs which have been removed on Worksheet A-8-2, Column 4, Line 200 are added to total hospital costs.

For any of the above costs which are added to the allowable hospital costs as determined for Medicare purposes, American Samoa and LBJ need to ensure that these costs are consistent with Medicare cost principles.

c. The allowable hospital costs are apportioned to Medicaid hospital services by multiplying allowable hospital costs by American Samoa's Medicaid Claiming Percentage as established in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.D.

d. Emergency services provided to ineligible non-citizens/non-nationals may be added to allowable Medicaid hospital costs determined above. For cost centers that have been identified and approved by CMS as eligible for the provision of emergency services, those costs may be claimed at an emergency claiming percentage. The emergency claiming percentage is derived as:

- i. The number of non-citizens/non-nationals minus the number of lawfully present pregnant women and lawfully present individuals under 21, as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1, multiplied

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- by the percentage of American Samoans that live below 400% of the FPL as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2. divided by
- ii The total population of American Samoa as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1.
 - iii. The allowable cost from Worksheet B, Part I, Column 26, for the identified cost centers, are multiplied by the emergency claiming percentage to arrive at the emergency hospital costs that can be added to the allowable Medicaid hospital costs determined in step c above.
- e. Total allowable Medicaid hospital costs are reduced by Medicaid patient care revenues collected to arrive at net allowable hospital costs; Medicaid patient care revenues are derived by applying the Medicaid Claiming Percentage to all patient care revenues. Alternatively, to the extent that LBJ is able to carve-out any actual non-Medicaid patient revenue such as Medicare revenues, then the remaining patient care revenues will be multiplied by an adjusted proxy percentage to arrive at the Medicaid patient care revenues used as offset. The numerator of the proxy percentage is the number of presumed American Samoa Medicaid-eligible individuals, and the denominator is the total number of American Samoa individuals minus the population representing the non-Medicaid categories carved out by LBJ from total patient revenues.

The emergency hospital cost in step d. are also reduced by any applicable patient care revenues. Unless the hospital is able to identify specifically the patient care revenues related to the emergency services furnished to ineligible non-citizens/non-nationals who are under 400% of the FPL (excluding lawfully present pregnant women and lawfully present individuals under 21), the offset is determined by applying the emergency claiming percentage to all patient care revenues. Alternatively, to the extent that LBJ is able to carve-out any actual non-applicable (i.e., not pertaining to the ineligible non-citizens/non-nationals) patient revenue such as Medicare revenues, then the remaining patient care revenues will

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be multiplied by an adjusted proxy percentage to arrive at the ineligible non-citizens/non-nationals patient care revenues used as offset. The numerator of the proxy percentage is the number of American Samoa non-citizens/non-nationals, minus the number of lawfully present pregnant women and lawfully present individuals under 21, multiplied by the percentage who are under 400% of FPL (see step d.i above), and the denominator is the total number of American Samoa individuals (see step d.ii above) minus the population representing the non-applicable categories carved out by LBJ from total patient revenues.

- f. The net Medicaid allowable hospital costs determined in previous step is allocated to Medicaid outpatient hospital services by applying LBJ's outpatient hospital percentage, which is the ratio of LBJ's total outpatient hospital patient revenues (Worksheet G-2, Column 2, Line 28) to LBJ's total hospital patient revenues (Worksheet G-2, Column 3, Line 28).
- g. The Medicaid allowable hospital costs from the latest prior period cost report may then be trended for cost inflation to the current period by applying the CMS hospital market basket. The inflated prior period costs serve as an estimate of the current service period expenditure. This amount is divided by twelve and will be claimed as the interim monthly outpatient hospital payment amount. The federal share of the monthly outpatient hospital payment amount will be paid to the hospital on a monthly basis.

2) Interim Reconciliation of Interim Medicaid Outpatient Hospital Payments

LBJ's interim Medicaid outpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as filed to the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid outpatient hospital costs will be computed using the same methodology described in steps a-f above but using cost data from the as-filed cost report for the respective expenditure period. Additionally the revenue offsets in step e would be updated to account for revenues for services furnished during the expenditure period. The Medicaid outpatient hospital cost will be compared to the interim Medicaid outpatient hospital payments made. Any underpayment

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will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The Medicare CMS-2552 is due to the Medicare contractor five months after the close of the hospital's cost reporting period. The interim reconciliation will be performed and completed within six months of the filing of the Medicare CMS-2552.

3) Final Reconciliation of Interim Medicaid Outpatient Hospital Payments

LBJ's final Medicaid outpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as finalized by the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid outpatient hospital costs will be computed using the same methodology described in steps a-f above but using cost data from the finalized cost report for the respective expenditure period. Additionally the revenue offsets in step e would be updated to account for revenues for services furnished during the expenditure period. The Medicaid outpatient hospital cost will be compared to the interim Medicaid outpatient hospital payments made, including any interim reconciliation amounts. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The final reconciliation will be performed and completed within six months of the Medicare contractor's finalization of the Medicare CMS-2552 with the issuance of a Notice of Program Reimbursement.

III. Certified Public Expenditures - Determination of Allowable Medicaid Hospital Costs

Where LBJ has in place a patient accounting system to record patient charges by cost centers and by payer classes and files a Medicare 2552 cost report

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accordingly to the Medicare contractor, the allowable Medicaid hospital costs would be computed as follows.

To determine LBJ's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by LBJ through the certified public expenditures (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

1) Interim Medicaid Outpatient Hospital Payment

The Territory will make interim Medicaid outpatient hospital payments to approximate the Medicaid outpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid outpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The process of determining the allowable Medicaid outpatient hospital costs eligible for FFP begins with the use of LBJ's most recently filed Medicare 2552 cost report.

- a. To determine the interim Medicaid payment rate, the most recently filed Medicare 2552 cost report will be used to determine an overall ratio of costs to charges (RCC) for routine and ancillary services.

The specifics follow:

Determine RCC Costs.

- i. Compute total costs by using CMS 2552-10 Worksheet C, Part I, Column 1, Line 202, Subtotal.

Deduct any cost center for non-hospital costs, including but not limited to:

Line 44, skilled nursing facility
Line 45, nursing facility
Line 46, other long term care

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Line 88, rural health center
Line 89, federal qualified health center
Other non-hospital cost centers such as: home health agency
comprehensive outpatient rehabilitation facility, ambulatory
surgery center, and hospice.

Add costs from the following cost centers, which are treated as
non-reimbursable for Medicare cost reporting purposes but are
reimbursable for Medicaid:

Epogen
Dental Clinic
Outpatient Prescription Drugs
Off Island Medical Services
Hospital-Based Physicians (professional component costs
from worksheet A-8-2)

Result is total adjusted RCC costs.

The costs from the CMS 2552-10 used in the above computation
must be consistent with Medicare cost principles.

- ii. Compute total charges by using CMS 2552-10 Worksheet C, Part I,
Column 8, Line 202.

Deduct any cost center for non-hospital costs, including but not
limited to:

Line 44, skilled nursing facility
Line 45, intermediate care facility
Line 46, other long term care
Line 88, rural health center
Line 89, federal qualified health center
Other non-hospital cost centers such as: home health agency,
comprehensive outpatient rehabilitation facility, ambulatory
surgery center, and hospice.

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Add charges from the following cost centers, which are treated as non-reimbursable for Medicare cost reporting purposes but are reimbursable for Medicaid:

Epogen
Dental Clinic
Outpatient Prescription Drugs
Off Island Medical Services
Hospital-Based Physicians (if not already included in hospital departmental charges)

Result is total adjusted RCC charges.

The charges used in the above computation are consistent with Medicare cost reporting requirements and represent uniform gross charges charged to all payers.

- iii. Divide total adjusted cost by total adjusted charges to arrive at the RCC.

- b. The RCC computed above is used as the interim payment rate and applied to Medicaid outpatient hospital charges for the current service period. The Medicaid outpatient hospital charges must pertain to outpatient hospital services as covered by the American Samoa State plan. Given that American Samoa does not perform individual Medicaid eligibility determination, LBJ is recording all charges pertaining to American Samoa residents, who have not been determined as ineligible non-citizens/non-nationals and do not have other insurance coverage, as "Medicaid." Since only a portion of these American Samoa residents can actually be presumed to be Medicaid eligible per Section 2 of the American Samoa Medicaid State plan, it is necessary to further apply the Medicaid Claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan to determine the allowable Medicaid costs. Section 2, Paragraph 1.E also includes separate percentages for the claiming of costs pertaining to lawfully present pregnant women and lawfully present individuals under 21.

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- c. The allowable Medicaid costs computed in Step b above are offset by the applicable payments received by LBJ for these individuals described in Step b. The amount of the offset is the actual outpatient payment amount multiplied by the Medicaid Claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.
- d. The RCC computed above, as the interim payment rate, is also applied to other outpatient hospital charges in the current service period for which Medicaid is a secondary payer to other primary coverage for American Samoa residents who have not been determined as ineligible non-citizens/non-nationals. The outpatient hospital charges must pertain to outpatient hospital services as covered by the American Samoa State plan. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is further applied to the costs of other primary payer services. The result is the allowable costs pertaining to those services for which Medicaid is a secondary payer. Any charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan.
- e. The allowable Medicaid costs computed in Step d above are offset by the applicable payments received for individuals with other primary payer coverage (except for Medicare). The amount of the offset is the actual payment amount received for outpatient services furnished to individuals with other primary payer coverage (other than Medicare), multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan. Payments from all sources pertaining to the other primary payer services included in Step d are to be included.
- f. The RCC computed above, as the interim payment rate, is also applied to charges related to outpatient emergency services furnished to ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21. Again, because LBJ would not have isolated those ineligible non-citizens/non-nationals emergency

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charges to only those for ineligible non-citizens/non-nationals who are below 400% FPL, the resulting emergency service cost should be multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2).

- g. The allowable Medicaid costs computed in Step f above are offset by the applicable payments received for the ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. The amount of the offset is the actual payment amount for outpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, services (or if identifiable, the actual payment amount specific to outpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services) multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2). Payments from all sources pertaining to the ineligible non-citizens/non-nationals services included in Step f are to be included.
- h. The sum of the net Medicaid cost from Steps c, e, and g may be trended for cost inflation to the current period using the CMS hospital market basket to arrive at the estimated reimbursable Medicaid outpatient hospital costs for the current service period. American Samoa will claim these as certified public expenditures on a monthly basis. The federal share of the monthly outpatient hospital payment amount will be paid to the hospital on a monthly basis.
- i. Finally, to the extent that the Medicaid charges used above includes charges for drugs that are eligible for claiming under the Enhanced Allotment Plan (EAP) for Medicare prescription drug coverage, the amount claimed under EAP is to be deducted from the claimable Medicaid expenditure computed above.

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2) Interim Reconciliation of Interim Medicaid Outpatient Hospital Payments

LBJ's interim Medicaid outpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as filed to the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid outpatient hospital costs will be computed using the same methodology described in steps a-g and i above but using cost data from the as-filed cost report for the respective expenditure period. Medicaid charges and revenue offsets would be updated as necessary to fully account for the charges and revenues for services furnished during the expenditure period. The Medicaid outpatient hospital cost will be compared to the interim Medicaid outpatient hospital payments made. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The Medicare CMS-2552 is due to the Medicare contractor five months after the close of the hospital's cost reporting period. The interim reconciliation will be performed and completed within six months of the filing of the Medicare CMS-2552.

3) Final Reconciliation of Interim Medicaid Outpatient Hospital Payments

LBJ's final Medicaid outpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as finalized by the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's final Medicaid outpatient hospital costs will be computed using cost data from the finalized cost report for the respective expenditure period.

Furthermore, the final reconciliation would compute Medicaid cost using the cost reporting apportionment process as prescribed by the CMS-2552-10. In other words, LBJ's allowable costs must be apportioned to Medicaid using a cost-center specific apportionment process.

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- a. For each ancillary cost center, an ancillary RCC for the cost center is computed in Worksheet C, Part 1, Column 9 of the 2552. The ancillary RCC is applied to the Medicaid charges for each ancillary cost center. The outpatient ancillary charges used must only pertain to outpatient hospital services covered by the American Samoa State plan. The result is the Medicaid outpatient hospital cost for each ancillary cost center.
 - b. As discussed in the Interim Payment section, it is necessary to further adjust the total "Medicaid" outpatient hospital cost by multiplying the computed cost from Steps a by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan and then offset by an amount equal to the outpatient "Medicaid" payment received multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa State plan.
 - c. Also as discussed in the Interim Payment section, steps a and b are repeated for those outpatient charges for which Medicaid is the secondary payer to other primary coverage. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is applied to the cost of other primary payer services. Any charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan. The payment offset again would equal to the total payments received for the outpatient other primary payer services multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.
 - d. Also as discussed in the Interim Payment section, steps a and b are repeated for those outpatient charges pertaining to emergency services furnished to ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. While the hospital may be able to identify ineligible non-citizens/non-nationals (excluding lawfully present pregnant women and lawfully present individuals under 21) outpatient charges relating specifically to emergency service cost centers (as agreed to by CMS), those ineligible non-

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citizens/non-nationals have not been determined to otherwise meet Medicaid eligibility. Therefore, for outpatient hospital costs pertaining to ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services, the costs are applied the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2). The payment offset again would equal to the total payments received for the outpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, services (or if identifiable, the total payments received for the outpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services) multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2).

- e. Finally, to the extent that the Medicaid charges used above includes charges for drugs that are eligible for claiming under EAP, the amount claimed under EAP is to be deducted from the claimable Medicaid expenditure computed above,

The Medicaid outpatient hospital cost will be compared to the interim Medicaid outpatient hospital payments made, including any interim reconciliation amounts. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The final reconciliation will be performed and completed within six months of the Medicare contractor's finalization of the Medicare CMS-2552 with the issuance of a Notice of Program Reimbursement.

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Reimbursement For Federally Qualified Health Centers (FQHC)

The Medicaid agency will make payments for outpatient services to the covered providers within this section using an encounter rate equal to \$150.00.

Encounter Defined

An encounter is a face-to-face contact for the provision of medical, mental health or dental services between a patient and the FQHC to diagnose and treat physical, mental, and dental health issues.

Multiple medical encounters within the FQHC, which take place on the same day at a single location, constitute a single visit.

A mental health encounter is defined as a face-to-face visit with a certified or licensed mental health care professional at the FQHC for the provision of mental health services. Multiple mental health encounters with more than one mental health care practitioner in the FQHC or with the same mental health care practitioner, which take place on the same day at a single location, constitute a single visit. Mental health care services that are integrated in the delivery of medical care shall be deemed a medical encounter and constitute a single visit.

A dental encounter is defined as a face-to-face visit with a dentist where preventive, curative or emergency dental services are rendered. Multiple dental encounters with more than one dental practitioner in the FQHC or with the same dental practitioner, which take place on the same day at a single location, constitute a single visit.

Billable Units

An FQHC can bill for one medical encounter, one dental encounter, and one mental health encounter per patient per day or for \$150 for one service, \$300 for two services and \$450 for three services.

**PAYMENT RATES
FOR OFF-ISLAND INPATIENT MEDICAL SERVICES**

1. Off-Island rates

(a) For all U.S. jurisdictions, Medicaid will pay based on the providers' Medicare rate for the service, reimbursable on a claims basis. For medical services, transportation and accommodations where there are no Medicare rates, Medicaid will pay based on the negotiated rates not to exceed 100% of the provider's usual customary charges.

(b) For out-of-country providers, Medicaid will pay medical services, including transportation and accommodations, reimbursable on a claims basis, based on the negotiated rates not to exceed 100% of the out of country provider's usual customary charges.

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Effective Date April 1, 2019

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF
CARE

(a) *Medically Necessary Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)*

- (1) If the item of DMEPOS is covered by Medicare, the Medicaid reimbursement will be the current Hawaii non-rural Medicare fee schedule (MFS) rate for the covered item, unless there is documentation that the MFS rate is insufficient for the item covered under the HCPCS code and the item is required by the Medicaid population. In such case, manual pricing will be utilized.
- (2) Manual pricing is defined as, when there is no MFS rate available, the provider is reimbursed the current Manufacturer Suggested Retail Price (MSRP) less the current percentage outlined in (3) of this section.
- (3) Manual pricing is reasonable when one HCPCS code covers a broad range of items with a broad range of costs, since a single fee may not be a reasonable fee for all items covered under the HCPCS code, resulting in access-to-care issues. Examples include: 1) HCPCS codes with a description of not otherwise covered, unclassified, or other miscellaneous items; and 2) HCPCS codes covering customized items. If manual pricing is used, the provider is reimbursed the documented MSRP less 10%. If there is no MSRP, the manufacturer's documented invoice cost is used as the basis for manual pricing.
- (4) Prior authorization form provided by the Medicaid program along with supporting documentation for DMEPOS services must be submitted to the Medicaid program for payment of DMEPOS services. Incomplete forms or missing documentation will be denied payment.
- (5) The Medicaid Program does not pay DMEPOS providers separately for services in this category that are included as part of the payment for another treatment program, e.g., inpatient treatment, or provided and covered under another territory or federal program.

**METHODS & STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

(a) *Personal Care Aide Services*

- (1) Payment for such services are reimbursed at a daily fixed per diem rate of \$66.00. All providers will submit monthly claims to Medicaid for personal care services. Effective date for the fixed per diem rate for PCA services is October 1, 2020.
- (2) No payment is made for services beyond the scope of the program or unit of services exceeding Medicaid's authorization. Payments to residential providers are for personal care services only, and do not include room and board services that are provided. Payment is made for services described in Attachment 3.1-A.

**METHODS & STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

(b) Optometry Services/ Eyeglass Services

- (1) Fee Schedule Rates for optometry and eyeglasses services are set as of 01/01/2022 and are effective for dates of service on and after that date.

Service Type	Fee Schedule Amount
Comprehensive Eye Exam	\$85.00
Contact Lens Fitting	\$120.00
Lens Fitting	\$35.00
Rigid Gas Permeable Contact Lens Fitting	\$185.00
Refraction	\$40.00
Eyeglasses	\$225.00
Rigid Gas Permeable Contact Lens (1 pair)	\$380.00
Soft Contact Lens (2-year supply)	\$300.00
Sunglasses	\$200.00
Frame Repair	\$15.00
Nose Pad Replacement	\$10.00
Lens Replacement	\$110.00

- (2) No payment is made for services beyond the scope of the program or unit of services exceeding Medicaid’s authorization. Payment is made for services described in Attachment 3.1-A

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**METHODS & STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

(a) Dialysis Services

- (1) Payments rates based on the Medicare CMS Prospective Payment System rates at the time of service(s).
- (2) Coinsurance and copayments for dialysis services shall be covered pursuant to Section 3.2 and Supplement 1 of Attachment 4.19-B.
- (3) No payment is made for services beyond the scope of the program or unit of services exceeding Medicaid's authorization. Payment is made for services described in Attachment 3.1-A

***SUPPLEMENTAL 1
TO ATTACHMENT
4.19-B***

American Samoa Medicaid State Agency

Revision: HCFA-PM-93-5 (MB)

MAY 1993

State: American Samoa

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance

(b) Deductible/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n),

Supplement 1 to ATTACHMENT 4.19-B

1905(a) and 1916 of the Act

describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902

(i) Qualified Medicare

(a)(10)(E)(i) and 1905(p)(3) of the Act

Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

√ For the entire range of services available under Medicare Part B.

— Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

TN No. 12-006

Supersedes

TN No. N/A

Approval Date SEP 12 2012

Effective Date April 1, 2012

Revision: HCFA-PM-91-4

(BPD)

Supplement 1 to ATTACHMENT 4.19-B

AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: American SamoaMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CAREPayment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 of this attachment (see 3. above).

Revision: HCFA-PM-91-4

(BPD)
4.19-B

Supplement 1 to ATTACHMENT

AUGUST 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: American Samoa

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance
	Part B	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance
Other Medicaid Recipients	Part A	<u>NR</u>	Deductibles	<u>NR</u>	coinsurance
	Part B	<u>NR</u>	Deductibles	<u>NR</u>	coinsurance
Dual Eligible (QMB Plus)	Part A	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance
	Part B	<u>NR</u>	Deductibles	<u>NR</u>	Coinsurance

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Supplement 1 to ATTACHMENT 4.19-B

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: American Samoa

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

Payment of Medicare Part A and Part B Deductible/Coinsurance

Presumptive Eligibility is a special method American Samoa utilizes that does not involve individual eligibility determination based on personal income and citizenship status. Rather, aggregate population data regarding income levels and citizenship is utilized to perform calculations to determine the number of presumed eligible Medicaid beneficiaries, and the percentage of allowable costs incurred at LBJ Tropical Medical Center (LBJ) that are eligible for Federal Financial Participation.

It is assumed that the income distribution of Medicare beneficiaries mirrors that of the general population. Therefore, it is assumed that the percentage of Medicare beneficiaries who are dually eligible for Medicaid is the same as the percentage of American Samoans who fall at or below 200% FPL (as determined in Item 1(B)(2)(a) of Section 2). As a result, it is presumed that this same determined percentage of all Medicare Part-A and Part-B deductible/coinsurance are allowable costs for Medicaid reimbursement. American Samoa Medicaid Office will apply the same percentage determined in Item 1(B)(2)(a) of the Annual Determination of presumed eligibility as the claiming percentage for all Medicare Part-A and Part-B deductibles/coinsurance in order to determine the allowable reimbursement. For detailed information on determining both the number of presumed eligible Medicaid beneficiaries and those beneficiaries who are presumed to be dually eligible for Medicaid and Medicare, please refer the eligibility of the State Plan under Section 2.

Page 3

TN No. 12-006

Supersedes

TN No. N/A

Approval Date _____

SEP 12 2012

Effective Date April 1, 2012

HCFA ID: 7982E

SECTION 5

American Samoa Medicaid State Agency

SECTION 5: PERSONNEL ADMINISTRATION

- A. The American Samoa Government (ASG) has a merit system and an affirmative action plan for its personnel. The Medicaid State Agency, as part of ASG, will adhere and be in compliance with these requirements.

SECTION 6

American Samoa Medicaid State Agency

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: American Samoa

SECTION 6 FINANCIAL ADMINISTRATION

Citation 6.1 Fiscal Policies and Accountability
42 CFR 433.32
AT-79-29

The Medicaid agency and, where applicable, governmental agencies and providers maintain an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accordance with applicable Federal requirements.

State funds are used to pay all of the non-Federal share of total expenditures under this plan, except when the Territory claims the waiver of \$200,000 of local matching funds under 48 USC 1469(a)(d) for Medicaid and/or CHIP, in accordance with CMS policy.

A. Administration and Financial Reporting

American Samoa Medicaid agency submits the following reports to the Centers of Medicare and Medicaid Services (CMS) Region IX Office in San Francisco, and the CMS Central Office in Baltimore at the intervals specified in the referenced sections of this plan:

- a. Annual Determination of presumed eligible (see section 2 B)
- b. Completed forms CMS 37. Medicaid Program Budget Report in its entirety for each quarterly submission (See section B). The period to be reported in all estimates is the Federal Fiscal Year October 1 through September 30.
- c. Forms CMS 64, 64.9 Base, 64.9C1 and 64.90FWA, 64.21U and 64.10 Base quarterly expenditure reports.

B. Submission of Quarterly Budget Estimates

Budget estimates from American Samoa Medicaid Agency shall be reported prior to the beginning of each quarter on Form CMS 37, Medicaid Program Budget Report for Medical Assistance Payments and Administration costs. This report provides American Samoa's funding requirements for the upcoming Federal Fiscal Year and quarter.

Submit quarterly Forms CMS-37 to both CMS Regional Office and CMS Central Office no later than May 15, August 15, November 15, and February

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TN No: 86-001

Approval Date JUN 21 2012 Effective Date: January 1, 2012

15 in accordance with the submission schedule in Section 2602 of the State Medical Manual.

C. Cost Reporting

Refer to Attachments 4.19-A and 4.19-B.

D. CMS 64, Quarterly Statement of Expenditures for the Medical Assistance Program Reporting

Medicaid State Agency will submit the completed CMS 64 and its attachments within 30 days after the end of each quarter, e.g. April 30, July 30, October 30 and January 30.

1. Forms CMS 64.9 Base and 64.21U Statements of Medical assistance Expenditures by type of service for the Medical Assistance Program

Medicaid Agency will use the Forms CMS 64.9 Base, 64.21U, 64.9P, 64.21UP, 64.9Waiver EAP, and 64.9P Waiver EAP to report current and prior periods, respectively, allowable medical assistance payment expenditures under the appropriate individual category of service line.

2. Report Submittal Procedure

Medicaid agency will submit the completed Form CMS 64, Summary Sheet, for the Medical Assistance Expenditures and/or the State and local administrative expenditures for the Medical Assistance Program to both CMS Regional Office in San Francisco and the Central Office in Baltimore through a paperless system known as MBES/CBES. Medicaid Agency will submit supporting documentation to the CMS Regional Office in San Francisco.

E. Methodology for Determining Medicaid/CHIP/EAP Costs

1. Methods and Standards

To meet the requirements of 42 CFR Part 447, subpart C, and section 1902(e)(7) with respect to payment for inpatient hospital services, the Attachment 4.19-A under SPA-12-003 describes the methods and standards in detail used to determine rates for payment for inpatient hospital services.

In addition to the inpatient hospital services, the Medicaid Agency will

meet the requirements of 42 CFR Part 447, Subpart D, with respect to payment for all other types of services provided under the plan. The Attachment 4.19-B under SPA 12-004 describes the methods and standards used for the payment of Medicaid hospital outpatient services.

To meet the requirements of 42 CFR 423.907 and 1935(e) with respect to eligibility and payment for the Enhanced Allotment Program, the MMA EAP Plan portion of the American Samoa Plan describes the methods and standards used for the payment of covered Part D drugs for low-income Part D eligible individuals.

TN No: 12-002
Supersedes
TN No: 88-001

JUN 21 2012
Approval Date _____ Effective Date: January 1, 2012

SECTION 7

American Samoa Medicaid State Agency

SECTION 7: GENERAL

A. PLAN AMENDMENTS

1. This plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material changes in any phase of the American Samoa law, organization, policy, or State Agency operations

American Samoa will transmit these changes to the HCFA San Francisco Regional Office attached to the Form HCFA-179 (3-80). These changes should be submitted within 90 calendar days from the proposed effective date.

Note: The Reports outlined in Sections 2 and 6 are not considered plan amendments for the purposes of this part.

2. The HCFA Region IX Office will advise American Samoa in writing of any plan amendments required due to changes in Federal laws or regulations.
3. American Samoa may request plan changes on its own initiative at any time, as long as the provisions of Title 19 Section 1902(j) and the Secretary's waiver are complied with.
4. Significant changes to this State Plan which are not consistent with the Secretary's waiver shall be submitted to the Secretary of DHHS as a modification to the waiver, rather than as a State plan amendment.

B. NON-DISCRIMINATION

The Medicaid Plan assures that no person shall be subjected to discrimination on the grounds of race, color, national origin,

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83-1 EFFECTIVE 1/1/80
SUPERSEDED BY TR USA # 83-1
10-3-80 EFFECTIVE 10-1-80

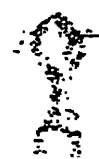
religion, or handicap, or denied the benefits of this financial assistance. It further assures compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973.

C. TERRITORIAL GOVERNOR'S REVIEW

The Medicaid Agency will provide the Office of the Governor with the opportunity to review amendments, any new State Plan and subsequent amendments, and long-range program planning projections or other periodic reports. Any comments will be transmitted to the Health Care Financing Administration with such comments.

TRANSMIT	83-1	10/1/82
REC'D IN		TRANS # 23-9
APPROVED	10-3-83	EXPIRE 10-1-83

~~26~~
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I do hereby certify that I am authorized to submit this plan on behalf
of the:

DEPARTMENT OF HEALTH

Designated Single State Agency

8 Dec. 1982
Date


Signature

Director of Health
Title

TRANSMITTAL # <u>83-1</u>	EFFECTIVE <u>10/1/82</u>
REF ID # _____	SUPERSEDED BY TRANS # <u>83-3</u>
APPROVED <u>10-3-82</u>	EFFECTIVE <u>10-1-82</u>

Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

<i>Describe shorter period here.</i>

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. ____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

- 1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

- 2. ____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. ____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. ____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

- 3. ____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in

accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

- 3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

- 1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

- 2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

- 3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

- 4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

- 5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

Please describe.

Drug Benefit:

- 6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

- 7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

- 8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

- 9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

- 1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. Published fee schedules –

Effective date (enter date of change): _____

Location (list published location):

- b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

- 2. The agency increases payment rates for the following services:

FQHC services furnished by American Samoa FQHC at government-authorized quarantine location.

- a. Payment increases are targeted based on the following criteria:

Services during eligible medical encounters furnished by American Samoa FQHC at a government-authorized quarantine location either in American Samoa or off-island will be paid an enhanced encounter rate from March 1, 2020 to the end of the PHE. A medical encounter and a billable unit are defined in Attachment 4.19-B, page 15.

- b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

Up to the Medicare payments for equivalent services.

By the following factors:

The encounter rate is increased from \$150 to 200.

Payment for services delivered via telehealth:

- 3. For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. Are not otherwise paid under the Medicaid state plan;
- b. Differ from payments for the same services when provided face to face;

- c. Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
 - i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

- 4. Other payment changes:

Effective March 1, 2020 to the end of the PHE, off-island dialysis treatment services by Hawaii provider at a government-authorized quarantine location will be increased from Medicare fee schedule to \$750 per treatment.

Effective March 1, 2020 to the end of the PHE, dialysis treatment services by American Samoa non-hospital provider under the physician services benefit would be paid at Medicare fee schedule rates.

Effective March 1, 2020 to the end of the PHE, for individuals quarantined in a government-authorized quarantine location in American Samoa upon return from off-island medical referral services and prior to being transported home from provision of medical services, transportation and related accommodations including meals, where there are no Medicare rates, will be paid based on negotiated rates not to exceed 100% of provider’s usual customary charges.

Section F – Post-Eligibility Treatment of Income

- 1. The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. The individual’s total income
 - b. 300 percent of the SSI federal benefit rate
 - c. Other reasonable amount:
- 2. The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

ATTACHMENTS 7.7
A-C

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

The state assures coverage of COVID-19 vaccines and administration of the vaccines.¹

The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

¹ The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.
TN No: 23-0001 Approval Date: 06/28/2023
Supersedes: NEW Effective Date: 03/11/2021

Under the authority of the 1902(j) waiver, COVID vaccine and vaccine administration shall only be offered and covered at the American Samoa Department of Health’s Federally Qualified Health Center (FQHC) and LBJ Tropical Medical Center (LBJTMC). COVID vaccine and vaccine administration shall be covered off-island for patients receiving authorized medical services through the Medicaid Off-island Medical Referral Program.

In the event of a public health emergency requiring pre-travel COVID vaccination for entry into American Samoa, COVID vaccine and vaccine administration shall be covered under Medicaid authorized providers for all bona fide residents of American Samoa.

Reimbursement

 X The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

- **COVID-19 vaccine administration qualified as an eligible FQHC “encounter”. FQHC are reimbursed via Patient Encounter payment methodology located in Attachment 4.19-B.**
- **LBJTMC are reimbursed via the Certified Public Expenditure Methodology located in Attachment 4.19-A & 4.19-B**

 The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

 The state’s rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

- Medicare national average, OR
- Associated geographically adjusted rate.

 The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

TN No: 23-0001
Supersedes: NEW

Approval Date: 06/28/2023
Effective Date: 03/11/2021

The state's rate is as follows and the state's fee schedule is published in the

following location :

The state's fee schedule is the same for all governmental and private providers.

The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

Eligible services are reimbursed via the State's Medicare rates and customary charges for out-of-country providers located in Attachment 4.19-B.

The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location :

PRA Disclosure Statement Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No: 23-0001
Supersedes: NEW

Approval Date: 06/28/2023
Effective Date: 03/11/2021

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

X The state assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

X The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Under the authority of the 1902(j) waiver, COVID testing and testing administration of the testing shall only be offered and covered at the American Samoa Department of Health’s Federally Qualified Health Center (FQHC) and LBJ Tropical Medical Center (LBJTMC). Home tests are not covered. COVID testing and administration shall be covered off-island for patients receiving authorized medical services through the Medicaid Off-island Medical Referral Program.

In the event of a public health emergency requiring pre-travel COVID testing for entry into American Samoa, COVID testing and testing administration shall be covered under the AS Medicaid authorized providers for all bona fide residents of American Samoa.

 Applies to the state’s approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

X The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

TN No: 23-0001
Supersedes: NEW

Approval Date: 06/28/2023
Effective Date: 03/11/2021

Additional Information (Optional):

Reimbursement

 X The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

- **COVID-19 testing administration qualified as an eligible FQHC “encounter”. FQHC are reimbursed via Patient Encounter payment methodology located in Attachment 4.19-B.**
 - **LBJTMC are reimbursed via the Certified Public Expenditure Methodology located in Attachment 4.19-A & 4.19-B**

 The state is establishing rates for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

 The state’s rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

- Medicare national average, OR
- Associated geographically adjusted rate.

 The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state’s rate is as follows and the state’s fee schedule is published in the following location :

 X The state’s fee schedule is the same for all governmental and private providers.

TN No: 23-0001
Supersedes: NEW

Approval Date: 06/28/2023
Effective Date: 03/11/2021

The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Eligible off-island COVID testing administration are reimbursed via the State's Medicare rates and customary charges for out-of-country providers located in Attachment 4.19-B.

Additional Information (Optional):

The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure Statement Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No: 23-0001
Supersedes: NEW

Approval Date: 06/28/2023
Effective Date: 03/11/2021

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

X The state assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

X The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

 Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

X The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Under the authority of the 1902(j) waiver, COVID treatment shall only be covered at the American Samoa Department of Health's Federally Qualified Health Center (FQHC) and the LBJ Tropical Medical Center (LBJTMC). COVID treatment shall be covered only for patients who are receiving medical treatment off-island through the Medicaid Off-island Medical Referral Program.

TN No: 23-0001
Supersedes: NEW

Approval Date: 06/28/2023
Effective Date: 03/11/2021

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

X The state assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

X The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

 Applies to the state’s approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

X The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Under the authority of the 1902(j) waiver, COVID treatment shall only be covered at the American Samoa Department of Health’s Federally Qualified Health Center (FQHC) and the LBJ Tropical Medical Center (LBJTMC). COVID treatment shall be covered only for patients who are receiving medical treatment off-island through the Medicaid Off-island Medical Referral Program.

Reimbursement

X The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

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List references to Medicaid state plan payment methodologies that describe the rates for

- **COVID-19 treatment qualified as an eligible FQHC “encounter”. FQHC are reimbursed via Patient Encounter payment methodology located in Attachment 4.19-B.**
- **LBJTMC are reimbursed via the Certified Public Expenditure Methodology located in Attachment 4.19-A & 4.19-B**

COVID-19 treatment for each applicable Medicaid benefit:

___ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state’s rates or fee schedule is the same for all governmental and private providers.

The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

Eligible off-island COVID treatment are reimbursed via the State’s Medicare rates and customary charges for out-of-country providers located in Attachment 4.19-B.

***PRA Disclosure Statement** Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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