

SECTION IV

GENERAL PROGRAM ADMINISTRATION

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.

16 (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 _____

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.

ASG

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 rehabilitative 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 #	85-1	EFFECTIVE	10-1-85
REC'D NO		SUPERSEDED BY TRANSM #	
APPROVED	10-9-85	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 # <u>85-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D NO _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>10-9-85</u>	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>88-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D RO _____	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 TRANSM # _____
APPROVED <u>10-9-85</u>	EFFECTIVE _____

4) 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

3. 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>85-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D NO _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>10-9-85</u>	EFFECTIVE _____

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

<p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act</p> <p>Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act</p>	<p>rate.</p> <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> <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> <p>_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p> <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> <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
 Supersedes
 TN No. _____

Approval Date: _____

Effective Date: 1/01/2011