

# State Plan Amendment

## Section VI

### Financial Administration

June 6, 2014

Mr. Falema'o Phil Pili, Treasurer  
American Samoa Government  
Department of Treasury  
3<sup>rd</sup> Floor, A.P. Lutali Building  
Pago Pago, AS 96799

Dear Mr. Pili:

Enclosed are two copies of the Indirect Cost Negotiation Agreement offered by the Interior Business Center (IBC). If you agree with the contents, please sign and return two copies of the agreement to IBC to complete the acceptance process. IBC will then sign and send one of the signed original agreements to you.

As a recipient of federal funds, you are required to submit Indirect Cost Proposals on an annual basis. Proposals are due within 6 months after the close of your fiscal year end and are processed on a first-in, first-out basis. For information and updates on filing indirect cost proposals, please visit our Web site at [http://www.doi.gov/ibc/services/Indirect\\_Cost\\_Services](http://www.doi.gov/ibc/services/Indirect_Cost_Services).

Common fiscal year end dates and proposal due dates are listed below:

Fiscal Year End Date	Proposal Due Date
September 30 <sup>th</sup>	March 31 <sup>st</sup>
December 31 <sup>st</sup>	June 30 <sup>th</sup>
June 30 <sup>th</sup>	December 31 <sup>st</sup>

If you have any questions concerning the negotiation agreement or require additional information, please contact our office for assistance.

Sincerely,

Deborah A. Moberly  
Office Chief

Enclosures: Supplement and Negotiation Agreement

J:\Other (Non-Profit, Guam,VI,Puerto Rico)\All Others (including For-Profit)\American Samoa Government (Amsgg047)\FY 2014\Amsg-Na.14.docx

**American Samoa Government  
FY 2012 Carryforwards and FY 2014 Rate Computations**

**Supplement**

<b>Title/Description</b>	<b>DOE Unrestricted</b>	<b>All Others</b>
FY 2012 Direct Salaries Bases	\$25,430,847	\$34,150,469
FY 2012 Indirect Cost Rates	16.11%	21.71%
FY 2012 Recoverable Indirect Costs	<u>\$4,096,909</u>	<u>\$7,414,067</u>
FY 2012 Indirect Costs (Including CSCAP)	\$5,782,668	\$8,945,838
FY 2012 CSCAP Over 3% Limitation		-53,243
FY 2010 Overrecovery Carryforwards to FY 2012	-788,218	-940,419
FY 2012 Indirect Cost Pools	<u>4,994,450</u>	<u>7,952,176</u>
FY 2012 Recoverable Indirect Costs	-4,096,909	-7,414,067
FY 2012 Underrecovery Carryforwards to FY 2014	897,541	538,109
FY 2014 Indirect Costs (Including CSCAP)	5,782,668	8,945,838
FY 2014 Indirect Cost Pools	<u>\$6,680,209</u>	<u>\$9,483,947</u>
FY 2014 Direct Salaries Bases	<u>\$25,430,847</u>	<u>\$34,150,469</u>
FY 2014 Indirect Cost Rates	<u>26.27%</u>	<u>27.77%</u>

**State and Local Governments  
Indirect Cost Negotiation Agreement**

EIN: 97-0000676

**Organization:**

American Samoa Government  
Department of Treasury  
3<sup>rd</sup> Floor, A.P. Lutali Building  
Pago Pago, AS 96799

**Date:**

Report No(s) :

Filing Ref.:  
Last Negotiation Agreement  
dated November 5, 2013

The indirect cost rates contained herein are for use on grants, contracts, and other agreements with the Federal Government to which 2 CFR 225 (OMB Circular A-87) applies, subject to the limitations in Section II.A. of this agreement. The rates were negotiated by the U.S. Department of the Interior, Interior Business Center, and the subject organization in accordance with the authority contained in 2 CFR 225.

**Section I: Rates**

Type	Effective Period		Rate	Locations	Applicable To
	From	To			
Fixed Carryforward	10/01/13	09/30/14	27.77%*	All	All Others except DOE
Fixed Carryforward	10/01/13	09/30/14	26.27%*	All	DOE Unrestricted
Fixed Carryforward	10/01/13	09/30/14	11.27%**	All	DOE Restricted

\*Base: Total direct salaries and wages, excluding fringe benefits.

\*\*Base: Modified total direct costs.

Note: The restricted rate is reviewed and approved by the USDOE who will provide the administrative support and technical assistance in case of an appeal or other disagreement regarding the restricted rate. The restricted rate is applicable to all Federal programs, which require the use of a restricted rate as defined by 34 CFR 75.563 and CFR 76.563.

Treatment of fringe benefits: Fringe benefits applicable to direct salaries and wages are treated as direct costs; fringe benefits applicable to indirect salaries and wages are treated as indirect costs.

**Section II: General**

Page 1 of 3

A. Limitations: Use of the rate(s) contained in this agreement is subject to any applicable statutory limitations. Acceptance of the rate(s) agreed to herein is predicated upon these conditions: (1) no costs other than those incurred by the subject organization were included in its indirect cost rate proposal, (2) all such costs are the legal obligations of the grantee/contractor, (3) similar types of costs have been accorded consistent treatment, and (4) the same costs that have been treated as indirect costs have not been claimed as direct costs (for example, supplies can be charged directly to a program or activity as long as these costs are not part of the supply costs included in the indirect cost pool for central administration).

**B. Audit:** All costs (direct and indirect, federal and non-federal) are subject to audit. Adjustments to amounts resulting from audit of the cost allocation plan or indirect cost rate proposal upon which the negotiation of this agreement was based will be compensated for in a subsequent negotiation.

**C. Changes:** The rate(s) contained in this agreement are based on the organizational structure and the accounting system in effect at the time the proposal was submitted. Changes in organizational structure, or changes in the method of accounting for costs which affect the amount of reimbursement resulting from use of the rate(s) in this agreement, require the prior approval of the responsible negotiation agency. Failure to obtain such approval may result in subsequent audit disallowance.

**D. Rate Type:**

1. **Fixed Carryforward Rate:** The fixed carryforward rate is based on an estimate of the costs that will be incurred during the period for which the rate applies. When the actual costs for such periods have been determined, an adjustment will be made to the rate for future periods, if necessary, to compensate for the difference between the costs used to establish the fixed rate and the actual costs.

2. **Provisional/Final Rates:** Within 6 months after year end, a final indirect cost rate proposal must be submitted based on actual costs. Billings and charges to contracts and grants must be adjusted if the final rate varies from the provisional rate. If the final rate is greater than the provisional rate and there are no funds available to cover the additional indirect costs, the organization may not recover all indirect costs. Conversely, if the final rate is less than the provisional rate, the organization will be required to pay back the difference to the funding agency.

3. **Predetermined Rate:** The predetermined rate contained in this agreement is based on estimated costs which will be incurred during the period for which the rate applies and is normally not subject to subsequent carry-forward adjustments. However, if material changes occur in the grantee/contractor's cost structure, adjustments to the rate may be necessary to compensate for the effects of such changes.

**E. Agency Notification:** Copies of this document may be provided to other federal offices as a means of notifying them of the agreement contained herein.

**F. Record Keeping:** Organizations must maintain accounting records that demonstrate that each type of cost has been treated consistently either as a direct cost or an indirect cost. Records pertaining to the costs of program administration, such as salaries, travel, and related costs, should be kept on an annual basis.

**G. Reimbursement Ceilings:** Grantee/contractor program agreements providing for ceilings on indirect cost rate(s) or reimbursement amounts are subject to the ceilings stipulated in the contract or grant agreements. If the ceiling rate is higher than the negotiated rate in Section I of this agreement, the negotiated rate will be used to determine the maximum allowable indirect cost.

H. Use of Other Rate(s): If any federal programs are reimbursing indirect costs to this grantee/contractor by a measure other than the approved rate(s) in this agreement, the grantee/contractor should credit such costs to the affected programs, and the approved rate should be used to identify the maximum amount of indirect cost allocable to these programs.

I. Central Service Costs: Where central service costs are estimated for the calculation of indirect cost rate(s), adjustments will be made to reflect the difference between provisional and final amounts.

J. Other:

1. The purpose of an indirect cost rate is to facilitate the allocation and billing of indirect costs. Approval of the indirect cost rate does not mean that an organization can recover more than the actual costs of a particular program or activity.

2. Programs received or initiated by the organization subsequent to the negotiation of this agreement are subject to the approved indirect cost rate if the programs receive administrative support from the indirect cost pool. It should be noted that this could result in an adjustment to a future rate.

3. New indirect cost proposals are necessary to obtain approved indirect cost rate(s) for future fiscal or calendar years. The proposals are due in our office 6 months prior to the beginning of the year to which the proposed rate(s) will apply.

Section III: Acceptance

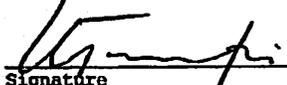
Listed below are the signatures of acceptance for this agreement:

By the State & Local Government:

By the Cognizant Federal Government Agency:

American Samoa Government  
State/Local Government

U.S. Department of the Interior  
Agency

 /s/  
Signature  
Veligitone P. Tomunaipa'a  
Name (Type or Print)

\_\_\_\_\_/s/  
Signature  
Deborah A. Moberly  
Name

Deputy Treasurer  
Title

Office Chief  
Office of Indirect Cost Services  
Title  
U.S. Department of the Interior  
Interior Business Center  
Agency

June 09, 2014  
Date

\_\_\_\_\_  
Date  
Negotiated by Mark W. Stout  
Telephone (916) 566-7270

Restricted Rate Negotiated by  
Phillip Luster of USDOE  
Telephone (202) 245-8069



Region IX

Division of Medicaid &amp; Children's Health Operations

90 Seventh Street, Suite 5-300 (5W)

San Francisco, CA 94103-6706

JUL 26 2012

Antere'a Puleasi  
Medicaid Program Director  
L.B.J. Tropical Medical Center  
Pago Pago, American Samoa 96799

Dear Mr. Puleasi:

We received your request for a technical page correction to State Plan Amendment (SPA) Number AS 12-002, which was approved on June 21, 2012. Your technical page correction changed the superseded SPA number to be consistent with our files.

Enclosed are the following updated SPA pages that should be incorporated into your approved State Plan:

**Section 6.1, page 25-27**

If you have any questions, please contact Tom Schenck at (415) 744-3589 or at [tom.schenck@cms.hhs.gov](mailto:tom.schenck@cms.hhs.gov).

Sincerely,

A handwritten signature in cursive script, reading "Gloria Nagle", is positioned above the typed name.

Gloria Nagle, Ph.D., M.P.A.

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

cc: Mary Rydell, CMS Pacific Area Representative

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, 64.9CI 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

TN No: 12-002  
Supersedes  
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

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

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

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 6: FINANCIAL ADMINISTRATION

### A. REPORTING REQUIREMENTS

American Samoa will submit the following reports to the HCFA/CMS Regional Office in San Francisco, the Secretary, and the HCFA/CMS Central Office in Baltimore at the intervals specified in the referenced sections of this plan:

- a. Medicare/Medicaid Modified Cost Report—(See section 6.D)
- b. Annual Determination of presumed eligible (see section 2.B)
- c. Complete forms HCFA 25-A, C,D,F,G,H,I,J(1), and J(2). Medicaid Program Budget Reports in their entirety for each quarterly submission (see section 6.B). The period to be reported in all estimates is the Federal Fiscal Year October 1, through September 30.
- d. Form HCFA/CMS 64 and HCFA 64.9 Quarterly Expenditures Reports. (See section 6.C)
- e. American Samoa Table 6, Fiscal Year End Reconciliation of Estimates vs Actual Medicaid Cost. (See section 6.D).

### B. SUBMISSION OF QUARTERLY BUDGET ESTIMATES

1. Budget estimates from ASG shall be reported prior to the beginning of each quarter on Form HCFA-25, (Form HCFA/CMS-37) Medicaid Program Budget Report for Medical Assistance Payments and Administration Costs. This report provides ASG's funding requirements for the upcoming quarter and certifies the availability of the Territory's quarterly grant award advance.
2. Submit quarterly Forms HCFA-25 (Form HCFA/CMS-37) to both the HCFA/CMS Central Office and HCFA/CMS Regional Office no later than May 15, November 15, and February 15 in accordance with the submission schedule in Section 2602 of the State Medical Manual.

Send the original and two copies of Form HCFA-25 and supporting schedules to:

David McNally, Director  
Division of State Agency Financial Management  
Budget Branch, DSAFM, BPO  
P.O.Box 26678  
Baltimore, MD 21207

Send one copy of the report Related Schedules and inquiries to:  
Harry Barbra, Associate Regional Administrator

Division of Financial Operations,  
Health Care Financing Administration,  
100 Van Ness Avenue, 20<sup>th</sup> Floor,  
San Francisco, California 94102

C. COST REPORTING

ASG will submit its annual Medicare/Medicaid cost report to HMSA, ASG's fiscal intermediary. The reported expenditures will be supported by ASG's accounting records. ASG will submit this report to HMSA as soon as possible, but no later than 90 days after the fiscal year end. (See Methodology for Determining Medicaid Costs- Section 6F).

Note: Inability to develop and file cost reports does not waive the two year time limit established by Section 1132 of the Social Security Act nor is it a reason for allowing the claim under the "good cause" exception.

D. HCFA 64, QUARTERLY STATEMENT OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM

1. Reporting Due Dates

The submission of these completed forms will be 30 days after the end of each quarter, e.g., April 30, July 30, October 30 and January 30.

2. Form HCFA-64.9 Statement of Medical Assistance Expenditures by Type of Service for the Medical Assistance Program

ASG will use the Form HCFA 64.9 to report current period allowable medical assistance expenditures under "line 1.V., Other Care Services."

3. Report submittal procedures

The signed original and two copies of the Form HCFA-64, Summary Sheet, for the Medical Assistance Expenditures and/or the State and Local Administration and Training Expenditures for the Medical Assistance, including the supporting computation forms and schedules will be forwarded to:

David McNally, Director  
Division of State Agency Financial Management  
Grants Branch, DSAFM, BPO  
P.O. Box 26678  
Baltimore, MD 21207

One copy will also be sent to:

Harry Barbra, Associate Regional Administrator  
Division of Financial Operations  
Health Care Financing Administration  
100 Van Ness Avenue, 20<sup>th</sup> Floor  
San Francisco, CA 94102

Also inquiries concerning reported expenditures will be made to the Associate Regional Administrator, Division of Financial Operations.

E. TABLE 6, FISCAL YEAR END RECONCILIATION OF ESTIMATED VERSUS ACTUAL COSTS

ASG will submit this Table 6 as an attachment to the annual HCFA-64 discussed in D above. The initial Table 6 will be due no later than 90 days after the end of the Fiscal Year. The revised Table 6 will be due no later than 30 days after the receipt from HMSA of the Notice of Program Reimbursement (NPR).

F. METHODOLOGY FOR DETERMINING MEDICAID COSTS

1. General Description

The Department of Health is the only provider of medical services in American Samoa. Therefore, reimbursement to the Department, and the provider of all medical services, will be on a per capita rate basis. The medical services covered by this per capita rate methodology will be those specified in Section 3.1 of this state plan.

2. Methods and Standards

(a) Per capita Rate Formula:

$$\frac{\text{LBS, DOH, DHSS, Total Health Department Allowable Cost}}{\text{Population (excludes tourists and illegal aliens)}} = \text{Per Capita Rate.}$$

(1) The (Health Department's) total allowable costs will be obtained from the modified Medicare/Medicaid Cost Report. Allowable costs, as a result, are determined in accordance with Medicare principles and meet the requirements of 447.253(b)(1), and (b) (2), and 447.271. The Public Health Clinic, Vital Statistics, Cafeteria, and other non-patient related activities, and their related departmental overhead are non-allowable and must be excluded from department costs in determining allowable costs. The basic computation for allowable costs follows:

Service

Sum of :

- Inpatient, Hospital
- Inpatient, Medical Staff
- Outpatient, Medical Staff
- Outpatient, Hospital
- Renal dialysis
- Dental

MEDICAID  
ASG TABLE 6  
FISCAL YEAR END RECONCILIATION OF ESTIMATED  
VERSUS ACTUAL MEDICAID COSTS

- A. Report of Fiscal Year Ending: \_\_\_\_\_
- B. Federal Financial Participation (FFP) Limitation \$ \_\_\_\_\_
- C. Reconciliation for this FY is determined as follows:
1. Estimated Number of Eligible (source: Presumed eligible Report) \_\_\_\_\_
  2. Actual Per Capita Cost (source: W/S E-5) \$ \_\_\_\_\_
  3. Line 1 x Line 2 = Total Annual Cost of Medicaid Medical Services \$ \_\_\_\_\_
  4. Actual Administrative Medicaid Costs for this FY \$ \_\_\_\_\_
  5. Line 3 + Line 4 = Total Actual Medicaid Costs for this FY \$ \_\_\_\_\_
  6. Actual Patient Care Revenues Excluding Medicare, CHAMPUS, and Federal Employees Group Health insurance \$ \_\_\_\_\_
  7. Line 6 x % of Total Population Medicaid Eligible = Medicaid Share of Patient Care Revenues \$ \_\_\_\_\_
  8. Line 5-Line 7 = Actual Net Medicaid Costs \$ \_\_\_\_\_
  9. Line 8 x 50% FFP = Maximum Federal Share \$ \_\_\_\_\_
  10. Total Grant Awards Received for this FY (source: HCFA 64's) \$ \_\_\_\_\_
  11. Settlement (make only one entry)
    - a) If the amount in Line 9 is less than Line 10, enter differences as amount due federal(carry over to reduce Grant Award in the next FY) \$ \_\_\_\_\_
    - b) If the amount in Line 9 and Line 10 are equal, enter \$0 due ) \$ \_\_\_\_\_
    - c) If the amount in Line 9 is greater than Line 10 but less than the FFP Limitation, then enter the differences between FFP Limitation less Line 8 as due ASG \$ \_\_\_\_\_
    - d) If the amount in Line 9 is greater than Line 10 and equal to or greater than the FFP limitation, then enter \$0 due: \$ \_\_\_\_\_

MEDICAID  
~~ASG TABLE 6 D~~  
FISCAL YEAR END RECONCILIATION OF ESTIMATED  
VERSUS ACTUAL MEDICAID COSTS

A. Report of Fiscal Year Ending: \_\_\_\_\_

B. Federal Financial Participation (FFP) Limitation \$ \_\_\_\_\_

C. Reconciliation for this FY is determined as follows:

1. Estimated Number of Eligibles (source: Presumed Eligible Report) \_\_\_\_\_

2. Actual Per Capita Cost (source: W/S E-5) \$ \_\_\_\_\_

3. Line 1 x Line 2 = Total Annual Cost of Medicaid Medical Services \$ \_\_\_\_\_

4. Actual Administrative Medicaid Costs for this FY \$ \_\_\_\_\_

5. Line 3 + Line 4 = Total Actual Medicaid Costs for this FY \$ \_\_\_\_\_

6. Actual Patient Care Revenues Excluding Medicare, CHAMPUS, and Federal Employees Group Health Insurance \$ \_\_\_\_\_

7. Line 6 x % of Total Population Medicaid Eligible = Medicaid Share of Patient Care Revenue \$ \_\_\_\_\_

8. Line 5 - Line 7 = Actual Net Medicaid Costs \$ \_\_\_\_\_

9. Line 8 x 50% FFP = Maximum Federal Share \$ \_\_\_\_\_

10. Total Grant Awards Received for this FY (source: HCFA 64's) \$ \_\_\_\_\_

11. Settlement (make only one entry)

a) If the amount in Line 9 is less than Line 10, enter differences as amount due federal (carry over to reduce Grant Award in the next FY) \$ \_\_\_\_\_

b) If the amount in Line 9 and Line 10 are equal, enter \$0 due \$ \_\_\_\_\_

c) If the amount in Line 9 is greater than Line 10 but less than the FFP limitation, then enter the difference between FFP limitation less Line 8 as due ASG \$ \_\_\_\_\_

d) If the amount in Line 9 is greater than Line 10 and equal to or greater than the FFP limitation, then enter \$0 due: \$ \_\_\_\_\_

34-29

TRANSMITTAL # <u>85-1</u>	EFFECTIVE <u>10-1-85</u>
REC'D RO _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>10-9-85</u>	EFFECTIVE _____

TRANSMITTAL # <u>86-1</u>	EFFECTIVE _____
REC'D RC _____	SUPERSEDED BY TRANSM # _____
APPROVED <u>12-6-85</u>	EFFECTIVE <u>10-1-85</u>

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



JUN 11 2014

Sandra King Young  
Medicaid Program Director  
ASTICA Executive Building  
P.O. Box 998383  
Tafuna, American Samoa 96799

RE: American Samoa State Plan Amendment 12-003

Dear Ms. King Young:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 12-003. This amendment, effective January 1, 2012, establishes a cost reimbursement methodology for inpatient hospital services provided by LBJ Tropical Medical Center.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment TN 12-003 is approved effective January 1, 2012. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Mark Wong at 415-744-3561 or [mark.wong@cms.hhs.gov](mailto:mark.wong@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Mann".

Cindy Mann  
Director

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER: <b>12-003</b>	2. STATE <b>American Samoa</b>
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE <b>January 1, 2012</b>	

FROM: HEALTH CARE FINANCING ADMINISTRATION  
TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT  
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

FEDERAL STATUTE/REGULATION CITATION:  
**Revisions to State Plan Section VI under title XIX of the  
Social Security Act, 42 CFR part 440, Section 1902 (e)  
42 CFR 447 Subpart C**

7. FEDERAL BUDGET IMPACT:  
a. FFY 2012      \$ 0  
b. FFY 2013      \$ 0

PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
**Attachment 4.19-A, Pages 1-14**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

~~Section VI - FINANCIAL ADMINISTRATION~~

**Section VI - Attachment 4.19 - A**

SUBJECT OF AMENDMENT: Amendment to the State Plan to include the requirements of 42 CFR Part 447 and  
Section 1902 (e) (7) with respect to payment for inpatient hospital services.

GOVERNOR'S REVIEW (Check One):  
 GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      The Governor's Office does not  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      wish to review the State Plan Amendment.

SIGNATURE OF STATE AGENCY OFFICIAL:  
*[Signature]*  
TYPED NAME:  
**Ninatua Andy Pulstasi**  
TITLE:  
**Medicaid Director**  
DATE SUBMITTED:  
**03/28/2012**

16. RETURN TO:  
**American Samoa Medicaid Office  
Office of the Governor  
American Samoa Government  
P.O. Box 998383  
American Samoa 96799**

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED:	18. DATE APPROVED: <b>JUN 11 2014</b>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JAN 01 2012</b>	20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>
21. TYPED NAME: <b>Penny Thompson</b>	22. TITLE: <b>Deputy Director, Policy &amp; FINANCIAL Mgt. (MCS)</b>
23. REMARKS: <b>Pen and ink changes made to Boxes 6, 8, 9, and 15 by CMS regional office with American Samoa concurrence on 6/4/2014.</b>	

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT****STATE: AMERICAN SAMOA****ATTACHMENT 4.19-A****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:

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**TN No. 12-003****Supersedes** Approval Date: JUN 11 2014 Effective Date: 01/01/2012**TN No. N/A ATTACHMENT 4.19-A**

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.

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.

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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):

### *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.
- 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:

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- 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.C.
- d. Emergency services provided to unqualified aliens 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 ineligible non-citizens as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1, multiplied by the percentage of American Samoans that live below 200% of the FPL as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2.  
divided by

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- ii The total population of American Samoa as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1.

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 unqualified aliens (who are under 200% of the FPL), 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 unqualified aliens) patient revenue such as Medicare revenues, then the remaining patient care revenues will be multiplied by an adjusted proxy percentage to arrive at the unqualified alien patient care revenues used as offset. The numerator of the proxy percentage is the number of American Samoa unqualified aliens multiplied by the percentage who are under 200% 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

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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.

#### ***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 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.

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***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.

**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):

***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

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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 - First Step

1. 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

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)

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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.

2. 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

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.

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

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- 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 legal American Samoa residents who 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.D of the American Samoa Medicaid State plan to determine the allowable Medicaid costs.
- c. The allowable Medicaid costs computed in Step b above are offset by the applicable payments received by LBJ for these individuals (American Samoa legal residents who do not have other insurance coverage). The amount of the offset is the actual inpatient payment amount multiplied by the Medicaid Claiming percentage per Section 2, Paragraph 1.D 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 legal American Samoa residents. 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.D 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

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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.D 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 inpatient emergency services furnished to unqualified aliens. Again, because LBJ would not have isolated those unqualified alien emergency charges to only those for unqualified aliens who are below 200% FPL, the resulting emergency service cost should be multiplied by the percentage of American Samoans below 200% 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 unqualified aliens. The amount of the offset is the actual payment amount for inpatient unqualified alien services (or if identifiable, the actual payment amount specific to inpatient unqualified alien emergency services) multiplied by the percentage of American Samoans below 200% 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 unqualified alien 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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***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.

***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.

- 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

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- 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.D 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.D 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.D 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.D of the American Samoa Medicaid State plan.
- 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 unqualified aliens. While the hospital may be able to identify unqualified alien inpatient days and inpatient charges relating

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Approval Date: JUN 11 2014 Effective Date: 01/01/2012

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specifically to emergency service cost centers (as agreed to by CMS), those unqualified aliens have not been determined to otherwise meet Medicaid eligibility. Therefore, for inpatient hospital costs pertaining to unqualified alien emergency services, the costs are applied the percentage of American Samoans below 200% 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 unqualified aliens services (or if identifiable, the total payments received for the inpatient unqualified alien emergency services) multiplied by the percentage of American Samoans below 200% 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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DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
San Francisco Regional Office  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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JUN 06 2014

Sandra King Young  
Medicaid Program Director  
ASTICA Executive Building  
P.O. Box 998383  
Tafuna, American Samoa 96799

Dear Ms. King Young,

Enclosed is an approved copy of American Samoa State Plan Amendment (SPA) 12-004. This amendment updates the State Plan to establish a cost reimbursement methodology for out-patient hospital services provided by LBJ Tropical Medical Center. The response to the Request for Additional Information (RAI) letter was submitted to the Centers for Medicare and Medicaid Services (CMS) on May 12, 2014.

Enclosed are the following approved State Plan pages to be incorporated within your approved State Plan:

- Attachment 4.19-B, pages 1-14

If you have any questions, please have your staff contact Peter Banks at (415) 744-3782 or at [Peter.Banks@cms.hhs.gov](mailto:Peter.Banks@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink that reads "Gloria Nagle". The signature is written in a cursive, flowing style.

Gloria Nagle, Ph.D., MPA  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Irene Cheng, CMS

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

DR: HEALTH CARE FINANCING ADMINISTRATION  
REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

TYPE OF PLAN MATERIAL (Check One):  
 NEW STATE PLAN  
 AMENDMENT TO BE CONSIDERED AS NEW PLAN  
 AMENDMENT (Separate Transmittal for each amendment)

1. TRANSMITTAL NUMBER: 12-004  
2. STATE: American Samoa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)  
4. PROPOSED EFFECTIVE DATE: January 1, 2012

FEDERAL STATUTE/REGULATION CITATION:  
42 CFR part 440, Section 1902(e)  
42 CFR part 447.5-subpart F 6/5/14

PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Attachment 4.19-B, pages 1-14 6/5/14  
~~Section VI - FINANCIAL ADMINISTRATION~~

7. FEDERAL BUDGET IMPACT:  
a. FFY 2012 \$0  
b. FFY 2013 \$0

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if applicable):  
6/5/14  
~~Section VI - Attachment 4.19-B~~

SUBJECT OF AMENDMENT: Amendment to the State Plan to include the requirements of 42 CFR Part 447 and section 1902 (e) (7) with respect to payment for outpatient hospital services.

GOVERNOR'S REVIEW (Check One):  
 GOVERNOR'S OFFICE REPORTED NO COMMENT  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

16. RETURN TO:  
American Samoa Medicaid Office  
Office of the Governor  
American Samoa Government  
P.O. Box 998383  
American Samoa 96799

TYPED NAME: Nimiton Andy Puliasi  
TITLE: Medicaid Director  
DATE SUBMITTED: 3/28/12 6/5/14

18. DATE APPROVED: MAY 12 2014  
19. DAY APPROVED: JUN 06 2014

20. SIGNATURE OF REGIONAL OFFICIAL: [Signature]  
21. TYPED NAME: [Name]  
22. TITLE: [Title]

REMARKS:

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: AMERICAN SAMOA

## ATTACHMENT 4.19-B

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.

**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.

## 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):

### *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.
- 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.C.
- d. Emergency services provided to unqualified aliens 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 ineligible non-citizens as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.1, multiplied by the percentage of American Samoans that live below 200% 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.

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 unqualified aliens (who are under 200% of the FPL), 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 unqualified aliens) patient revenue such as Medicare revenues, then the remaining patient care revenues will be multiplied by an adjusted proxy percentage to arrive at the unqualified alien patient care revenues used as offset. The numerator of the proxy percentage is the number of American Samoa unqualified aliens multiplied by the percentage who are under 200% 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.

#### *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 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.

#### *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 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):

#### ***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 - First Step

1. 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

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.

2. 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.

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.

3. 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 legal American Samoa residents who 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.D of the American Samoa Medicaid State plan to determine the allowable Medicaid costs.

- c. The allowable Medicaid costs computed in Step b above are offset by the applicable payments received by LBJ for these individuals (American Samoa legal residents who do not have other insurance coverage). The amount of the offset is the actual outpatient payment amount multiplied by the Medicaid Claiming percentage per Section 2, Paragraph 1.D 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 legal American Samoa residents. 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.D 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.D 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 unqualified aliens. Again, because LBJ would not have isolated those unqualified alien emergency charges to only those for unqualified aliens who are below 200% FPL, the resulting emergency service cost should be multiplied by the percentage of American Samoans below 200% 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 unqualified aliens. The amount of the offset is the actual payment amount for outpatient unqualified alien services (or if identifiable, the actual payment amount specific to outpatient unqualified alien emergency services) multiplied by the percentage of American Samoans below 200% 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 unqualified alien 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.

*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.

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TN No. 12-004 Supersedes

Approval Date: **JUN 06 2014**

Effective Date: 01/01/2012

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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.

*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.

- 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.D 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.D 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.D 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.D 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 unqualified aliens. While the hospital may be able to identify unqualified alien outpatient charges relating specifically to emergency service cost centers (as agreed to by CMS), those unqualified aliens have not been determined to otherwise meet Medicaid eligibility. Therefore, for outpatient hospital costs pertaining to unqualified alien emergency services, the costs are applied the percentage of American Samoans below 200% 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 unqualified aliens services (or if identifiable, the total payments received for the outpatient unqualified alien emergency services) multiplied by the percentage of American Samoans below 200% 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.

# **SECTION 3.2**

# **MEDICARE**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX

Division of Medicaid & Children's Health Operations

90 Seventh Street, Suite 5-300 (5W)

San Francisco, CA 94103-6706

SEP 12 2012

Antere'a Puleasi  
Medicaid Program Director  
Medicaid Office  
ASTICA Executive Building  
P.O. Box 998383  
Tafuna, American Samoa 96799

Dear Mr. Puleasi:

I am writing to inform you that American Samoa's State Plan Amendment (SPA) No. 12-006 has been approved. This SPA was submitted to my office on June 15, 2012, and provides for the coordination of Medicaid and Medicare for the reimbursement of Medicare cost-sharing expenses incurred by American Samoa's dual-eligible population. The coordination of these programs is authorized by Sections 1902(n)(1) through (3). The approval is effective April 1, 2012 as requested.

Attached are copies of the new State Plan pages to be incorporated within your approved State plan:

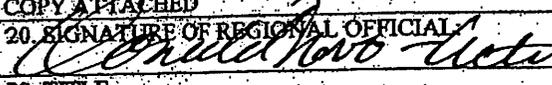
- Section 3.2, page 2-6
- Supplement 1 to Attachment 4.19-B, pages 1-3

If you have any questions, please contact Tom Schenck at (415) 744-3589, or [tom.schenck@cms.hhs.gov](mailto:tom.schenck@cms.hhs.gov).

Sincerely,

Gloria Nagle, Ph.D., MPA  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Mary Rydell, CMS Pacific Area Representative

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  12-006	2. STATE  American Samoa
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  April 1, 2012	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 1902(n)(1)through (3)		7. FEDERAL BUDGET IMPACT: a. FFY 2012      \$ 1,000,000 b. FFY 2013      \$ 2,000,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Supplement 1 to Attachment 4.19-B, pg. 1-3 Section 3.2, pg. 2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT:  SPA to amend the State Plan to include section 3.2, Coordination of Medicaid with Medicare and other insurance, and the supplement 1 to Attachment 4.19-B.			
11. GOVERNOR'S REVIEW (Check One):			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input type="checkbox"/> OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Niutoa Andy Puleasi Medicaid State Agency P.O. Box 998383 Office of the Governor American Samoa Government Pago Pago, American Samoa 96799	
13. TYPED NAME: Niutoa Andy Puleasi			
14. TITLE: Medicaid Director			
15. DATE SUBMITTED: June 15, 2012 <i>(TWS)</i>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: June 15, 2012		18. DATE APPROVED: SEP 12 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2012		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Gloria Nagle, Ph.D., MPA		22. TITLE: Associate Regional Administrator	
23. REMARKS: Pen and Ink Change, box 15			