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State/Territory Name: American Samoa

State Plan Amendment (SPA) #: 12-004

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

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.

Sincerely,

[redacted]

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

cc: Irene Cheng, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-004

2. STATE American Samoa

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 January 1, 2012

5. 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)*

6. 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 part 447 Subpart F PB 6/5/14

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

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

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Section VI – Attachment 4.19 – B~~ PB 6/5/14

10. 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.**

11. 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
☐ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Niuatoa Andy Puletasi

14. TITLE: Medicaid Director

15. DATE SUBMITTED: 3/28/12 PB 6/5/14

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: MAY 12 2014

18. DATE APPROVED: JUN 06 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2012

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

23. REMARKS: Pen and ink changes made changes to Sections #6, #8 and #15

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.

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.