# Table of Contents

**State/Territory Name: American Samoa**

**State Plan Amendment (SPA) #: 12-007**

This file contains the following documents in the order listed:

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**

July 24, 2017

Sandra King Young
ASTCA Executive Building
Suite 304
PO Box 998383
Pago Pago, AS 96799

Dear Ms. King Young:

Enclosed is an approved copy of American Samoa State Plan Amendment (SPA) 12-007. The SPA updates Section 2 (Eligibility) and Attachments 4.19-A and B to allow for the coverage of lawfully residing pregnant women and children under Section 214 of CHIPRA. The SPA was originally submitted to my office on December 5, 2012 and a response to the Request for Additional Information (RAI) letter was submitted on May 25, 2017.

The approval is effective October 1, 2017. Attached are copies of the following pages to be incorporated into your State Plan:

- Section 2 Pgs. 7-19
- Attachment 4.19-A Pgs. 1-14a
- Attachment 4.19-B Pgs. 1-14a

If you have any questions, please contact Cindy Lemesh by phone at (415) 744-3571 or by email at Cynthia.Lemesh@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES OMB NO. 0938-0193

FORM APPROVED

| **TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**<br><br>**FOR: Centers for Medicare and Medicaid Services** | 1. TRANSMITTAL NUMBER: 12-007 | 2. STATE: American Samoa |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>October 1, 2017 | |

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: | 7. FEDERAL BUDGET IMPACT: |
|---|---|
| 42 CFR 435.406~~.3.~~ CHIPRA, Section 214 | ~~FY2017 - $626,230~~ FFY 2018 - $305,711<br>~~FY2018 - $626,230~~ FFY 2019 - $305,711 |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: |
| Section--2 Pgs. 7-19; Attachment 4.19-A Pgs. ~~1-15;~~ 1-14a Attachment 4.19-B Pgs. 1-14a. | Section 2--Pgs. 7, 8, 9, 9a, 9b, 9c, 9d, 9e, 9f, 9g; Attachment 4.19-A Pgs. 1-14, Attachment 4.19-B Pgs. 1-14. |

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to elect to cover lawfully residing non-resident children below 21 years and non-resident pregnant women, under the American Samoa Medicaid program.

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. SIG [redacted] NCY OFFICIAL: | 16. RETURN TO: |
|---|---|
| 13. TYP [redacted]<br>Sandra King Young | Sandra King Young, Director<br>American Samoa Medicaid Agency<br>P.O. Box 998383<br>Office of the Governor<br>American Samoa Government<br>Pago Pago, American Samoa 96799 |
| 14. TITLE:<br>Medicaid Director | |
| 15. DATE SUBMITTED:<br>December 5, 2012 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: 12/5/12 | 18. DATE APPROVED: July 24, 2017 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/17 | 20. SIGNATURE OF REGIONAL OFFICIAL: /s/ |
| 21. TYPED NAME: Henrietta Sam-Louie | 22. TITLE: Associate Regional Administrator |

23. REMARKS:
Pen-and-ink changes made to Boxes 6, 7, and 8 by CMS regional office on 7/13/2017, with concurrence from American Samoa.

# SECTION 2—ELIGIBILITY

## I. PRESUMPTIVE ELIGIBILITY CONCEPT

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

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

#### *1) Medicaid*

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

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

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

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

***2) CHIP***

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

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

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

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

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

***3) EAP***

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

***4) Future Process***

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

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

## B. Population and Demographic Data Determinations

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

a) **Total population for computation year:** The existing data of mid-year population count by ASG Department of Commerce for the computation year will be utilized to determine the total American Samoan population.

b) **Estimate of non-citizens, who are also non-US nationals[1]:** The most recent data providing the number of non-citizens and non-nationals and their immigration status (i.e., AS permanent resident, temporary resident, undocumented) by population, if available, residing in the Territory during the computation year will be obtained from the ASG Immigration Office in the Attorney General's Office.

c) **Estimate of Medicare beneficiaries:** Data on the number of Medicare beneficiaries residing in the Territory during the computation year will be obtained from Centers for Medicare and Medicaid Services (CMS). If the Territory has its own data from a survey conducted by ASG agency or other recognized authority as approved by CMS, such data can be utilized.

d) **Estimate of lawfully present Pregnant Women and a separate estimate of lawfully present Individuals under 21:** Data that the Territory has from a survey conducted by an ASG agency or other recognized authority as approved by CMS can be utilized.

### *2) Determination of Income and Age Levels:*

a) **The percentage of American Samoans that live below 400% of FPL** will be determined using the most recent U.S. Census data[2].

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

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

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

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

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

The report will consist of the following steps:

***1) Calculation of Presumed Eligible Medicaid/CHIP Population***

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

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

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

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

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

***2) Stratification of Presumed Eligible CHIP Populations***

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

The necessary calculations will be:

(i) (Potentially eligible Medicaid/CHIP population)

Minus (-)

(lawfully present individuals under 21 years of age)

Minus (-)

(lawfully present pregnant women)

Multiply by (x)

(Percentage of American Samoans under 19 years of age)

Multiply by (x)

(Percentage of American Samoans with income between 100-200% FPL)

Equal (=)

***(Presumed eligible CHIP population subgroup A)***

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

Multiply by (x)

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

Multiply by (x)

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

Equal (=)

***(Presumed eligible CHIP population subgroup B)***

(iii) (Presumed eligible CHIP population subgroup A)

Plus (+)

(Presumed eligible CHIP population subgroup B)

Equal (=)

***(Presumed eligible CHIP population)***

***3) Calculation of Presumed Eligible Medicaid Population***

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

(Presumed Medicaid/CHIP eligible population)
Minus (-)
(Presumed CHIP eligible)
Equal (=)
***(Presumed eligible Medicaid population***)

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

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

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

(Estimate of Medicare Beneficiaries)
Multiplied by (x)
(Estimated percentage of individuals falling below 400% FPL)
Equal (=)
***(Presumed dual-eligible Medicaid/Medicare population)***

***5) Calculation of Presumed Eligible Medicaid Primary Population***

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

(Presumed eligible Medicaid population)
Less (-)
(Presumed dual-eligible Medicaid/Medicare population)
Equal (=)
***(Presumed Eligible Medicaid Primary population)***

***6) Calculation of EAP Presumed Eligible Population***

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

(Estimate of Medicare Beneficiaries)

Multiplied by (x)

(Estimated percentage of individuals falling below 150% FPL)

Equal (=)

***(Presumed Eligible EAP population)***

**D. Determination of Claiming Percentages**

***1) Calculation of Medicaid Claiming Percentage***

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

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

***2) Calculation of CHIP Claiming Percentage***

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

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

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

***3) Calculation of EAP Claiming Percentage***

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

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

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

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

(Percentage of American Samoans under 19 years of age)
Multiplied by (x)
(Percentage of American Samoans with income between 100%-200% FPL)
Equal (=)
***(CHIP Claiming Percentage)***

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

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

(Percentage of American Samoans below 400% FPL)
Minus (-)
(CHIP Claiming Percentage)
Equal (=)
***(Medicaid Claiming Percentage)***

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

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

(Percentage of American Samoans below 19 years of age divided by percentage of American Samoans under 21 years of age)
Multiply by (x)
(Percentage of American Samoans with income below 200% FPL)
Equal (=)
***(CHIP Claiming Percentage for Lawfully Present Individuals Under 19 years of age)***

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

(Percentage of American Samoans below 400% FPL)
Minus (-)
(CHIP Claiming Percentage for Lawfully Present Individuals Under 19)

Equal (=)

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

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

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

(Percentage of American Samoans below 400% FPL)
Equal (=)
***(Medicaid Claiming Percentage for Lawfully Present Pregnant Women)***

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

***6) Calculation of EAP Claiming Percentage***

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

**F. Submittal of Eligible Computations to the Regional Office**

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

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

## II. CMS APPROVAL ROLE

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

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

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

## I. Summary of CMS-2552-10

Worksheet A:

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

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

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

Worksheet B:

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

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.

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

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

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

***1) Interim Medicaid Inpatient Hospital Payment***

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

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

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

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

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

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

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

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

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

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

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

by the percentage of American Samoans that live below 400% of the FPL as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2. divided by;

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

iii. The allowable cost from Worksheet B, Part I, Column 26, for the identified cost centers, are multiplied by the emergency claiming percentage to arrive at the emergency hospital costs that can be added to the allowable Medicaid hospital costs determined in step c above.

e. Total allowable Medicaid hospital costs are reduced by Medicaid patient care revenues collected to arrive at net allowable hospital costs; Medicaid patient care revenues are derived by applying the Medicaid Claiming Percentage to all patient care revenues. Alternatively, to the extent that LBJ is able to carve-out any actual non-Medicaid patient revenue such as Medicare revenues, then the remaining patient care revenues will be multiplied by an adjusted proxy percentage to arrive at the Medicaid patient care revenues used as offset. The numerator of the proxy percentage is the number of presumed American Samoa Medicaid-eligible individuals, and the denominator is the total number of American Samoa individuals minus the population representing the non-Medicaid categories carved out by LBJ from total patient revenues.

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

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

f. The net Medicaid allowable hospital costs determined in previous step is allocated to Medicaid inpatient hospital services by applying LBJ's inpatient hospital percentage, which is the ratio of LBJ's total inpatient hospital patient revenues (Worksheet G-2, Column 1, Line 28) to LBJ's total hospital patient revenues ( Worksheet G-2, Column 3, Line 28).

g. The Medicaid allowable hospital costs from the latest prior period cost report may then be trended for cost inflation to the current period by applying the CMS hospital market basket. The inflated prior period costs serve as an estimate of the current service period expenditure. This amount is divided by twelve and will be claimed as the interim monthly inpatient hospital payment amount. The federal share of the monthly inpatient hospital payment amount will be paid to the hospital on a monthly basis.

***2) Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments***

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

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

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

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

***3) Final Reconciliation of Interim Medicaid Inpatient Hospital Payments***

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

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

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

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

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

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

***1) Interim Medicaid Inpatient Hospital Payment***

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

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

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

The specifics follow:

Determine RCC Costs.

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

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

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

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

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

Result is total adjusted RCC costs.

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

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

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

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

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

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

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

Result is total adjusted RCC charges.

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

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

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

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

c. The allowable Medicaid costs computed in Step b above are offset by the applicable payments received by LBJ for these individuals described in Step b. The amount of the offset is the actual inpatient payment amount multiplied by the Medicaid Claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.

d. The RCC computed above, as the interim payment rate, is also applied to other inpatient hospital charges in the current service period for which Medicaid is a secondary payer to other primary coverage for American Samoa residents who have not been determined as ineligible non-citizens/non-nationals. The inpatient hospital charges must pertain to inpatient hospital services as covered by the American Samoa State plan. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is further applied to the costs of other primary payer services. The result is the allowable costs pertaining to those services for which Medicaid is a secondary payer. Any charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan.

e. The allowable Medicaid costs computed in Step d above are offset by the applicable payments received for individuals with other primary payer coverage (except for Medicare). The amount of the offset is the actual payment amount received for inpatient services furnished to individuals with other primary payer coverage (other than Medicare), multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan. Payments from all sources pertaining to the other primary payer services included in Step d are to be included.

f. The RCC computed above, as the interim payment rate, is also applied to charges related to inpatient emergency services furnished to ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21. Again, because LBJ would not have isolated those ineligible non-citizens/non-nationals emergency charges to only those for ineligible non-citizens/non-nationals who are below 400% FPL, the resulting emergency service cost should be multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2.

g. The allowable Medicaid costs computed in Step f above are offset by the applicable payments received for the ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. The amount of the offset is the actual payment amount for inpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, services (or if identifiable, the actual payment amount specific to inpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services) multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2). Payments from all sources pertaining to the ineligible non-citizens/non-nationals services included in Step f are to be included.

h. The sum of the net Medicaid cost from Steps c, e, and g may be trended for cost inflation to the current period using the CMS hospital market basket to arrive at the estimated reimbursable Medicaid inpatient hospital costs for the current service period. American Samoa will claim these as certified public expenditures on a monthly basis. The federal share of the monthly inpatient hospital payment amount will be paid to the hospital on a monthly basis.

***2) Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments***

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

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

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

***3) Final Reconciliation of Interim Medicaid Inpatient Hospital Payments***

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

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

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

a. For each routine cost center, a routine per diem for the cost center is computed in Worksheet D-1 of the 2552. The routine per diem is applied to the number of Medicaid days for each routine cost center. The inpatient days used must only pertain to inpatient hospital services covered by the American Samoa State plan. The result is the Medicaid inpatient hospital cost for each routine cost center.

b. For each ancillary cost center, an ancillary RCC for the cost center is computed in Worksheet C, Part 1, Column 9 of the 2552. The ancillary RCC is applied to the Medicaid charges for each ancillary cost center. The inpatient ancillary charges used must only pertain to inpatient hospital services covered by the American Samoa State plan. The result is the Medicaid inpatient hospital cost for each ancillary cost center.

c. As discussed in the Interim Payment section, it is necessary to further adjust the total "Medicaid" inpatient hospital cost by multiplying the computed cost from Steps a and b by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan and then offset by an amount equal to the inpatient "Medicaid" payment received multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa State plan.

d. Also as discussed in the Interim Payment section, steps a to c are repeated for those inpatient days and inpatient charges for which Medicaid is the secondary payer to other primary coverage. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is applied to the cost of other primary payer services. Any days and charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan. The payment offset again would equal to the total payments received for the inpatient other primary payer services multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.

e. Also as discussed in the Interim Payment section, steps a to c are repeated for those inpatient days and inpatient charges pertaining to emergency services furnished to ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. While the hospital may be able to identify ineligible non-citizens/non-nationals (excluding lawfully present pregnant women and lawfully present individuals under 21) inpatient days and inpatient charges relating

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

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

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

**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):

***1) Interim Medicaid Outpatient Hospital Payment***

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

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

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

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

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

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

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

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

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

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

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

by the percentage of American Samoans that live below 400% of the FPL as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2. divided by

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

iii. The allowable cost from Worksheet B, Part I, Column 26, for the identified cost centers, are multiplied by the emergency claiming percentage to arrive at the emergency hospital costs that can be added to the allowable Medicaid hospital costs determined in step c above.

e. Total allowable Medicaid hospital costs are reduced by Medicaid patient care revenues collected to arrive at net allowable hospital costs; Medicaid patient care revenues are derived by applying the Medicaid Claiming Percentage to all patient care revenues. Alternatively, to the extent that LBJ is able to carve-out any actual non-Medicaid patient revenue such as Medicare revenues, then the remaining patient care revenues will be multiplied by an adjusted proxy percentage to arrive at the Medicaid patient care revenues used as offset. The numerator of the proxy percentage is the number of presumed American Samoa Medicaid-eligible individuals, and the denominator is the total number of American Samoa individuals minus the population representing the non-Medicaid categories carved out by LBJ from total patient revenues.

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

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

f. The net Medicaid allowable hospital costs determined in previous step is allocated to Medicaid outpatient hospital services by applying LBJ's outpatient hospital percentage, which is the ratio of LBJ's total outpatient hospital patient revenues (Worksheet G-2, Column 2, Line 28) to LBJ's total hospital patient revenues ( Worksheet G-2, Column 3, Line 28).

g. The Medicaid allowable hospital costs from the latest prior period cost report may then be trended for cost inflation to the current period by applying the CMS hospital market basket. The inflated prior period costs serve as an estimate of the current service period expenditure. This amount is divided by twelve and will be claimed as the interim monthly outpatient hospital payment amount. The federal share of the monthly outpatient hospital payment amount will be paid to the hospital on a monthly basis.

***2) Interim Reconciliation of Interim Medicaid Outpatient Hospital Payments***

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

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

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

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

***3) Final Reconciliation of Interim Medicaid Outpatient Hospital Payments***

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

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

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

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

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

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

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

***1) Interim Medicaid Outpatient Hospital Payment***

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

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

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

The specifics follow:

Determine RCC Costs.

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

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

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

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

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

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

Result is total adjusted RCC costs.

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

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

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

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

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

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

Result is total adjusted RCC charges.

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

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

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

c. The allowable Medicaid costs computed in Step b above are offset by the applicable payments received by LBJ for these individuals described in Step b. The amount of the offset is the actual outpatient payment amount multiplied by the Medicaid Claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.

d. The RCC computed above, as the interim payment rate, is also applied to other outpatient hospital charges in the current service period for which Medicaid is a secondary payer to other primary coverage for American Samoa residents who have not been determined as ineligible non-citizens/non-nationals. The outpatient hospital charges must pertain to outpatient hospital services as covered by the American Samoa State plan. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is further applied to the costs of other primary payer services. The result is the allowable costs pertaining to those services for which Medicaid is a secondary payer. Any charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan.

e. The allowable Medicaid costs computed in Step d above are offset by the applicable payments received for individuals with other primary payer coverage (except for Medicare). The amount of the offset is the actual payment amount received for outpatient services furnished to individuals with other primary payer coverage (other than Medicare), multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan. Payments from all sources pertaining to the other primary payer services included in Step d are to be included.

f. The RCC computed above, as the interim payment rate, is also applied to charges related to outpatient emergency services furnished to ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21. Again, because LBJ would not have isolated those ineligible non-citizens/non-nationals emergency

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

g. The allowable Medicaid costs computed in Step f above are offset by the applicable payments received for the ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. The amount of the offset is the actual payment amount for outpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, services (or if identifiable, the actual payment amount specific to outpatient ineligible non-citizens/non-nationals, excluding lawfully present pregnant women and lawfully present individuals under 21, emergency services) multiplied by the percentage of American Samoans below 400% FPL (as identified in Section 2-Eligibility of the American Samoa Medicaid State Plan, Paragraph 1.B.2). Payments from all sources pertaining to the ineligible non-citizens/non-nationals services included in Step f are to be included.

h. The sum of the net Medicaid cost from Steps c, e, and g may be trended for cost inflation to the current period using the CMS hospital market basket to arrive at the estimated reimbursable Medicaid outpatient hospital costs for the current service period. American Samoa will claim these as certified public expenditures on a monthly basis. The federal share of the monthly outpatient hospital payment amount will be paid to the hospital on a monthly basis.

i. Finally, to the extent that the Medicaid charges used above includes charges for drugs that are eligible for claiming under the Enhanced Allotment Plan (EAP) for Medicare prescription drug coverage, the amount claimed under EAP is to be deducted from the claimable Medicaid expenditure computed above.

***2) Interim Reconciliation of Interim Medicaid Outpatient Hospital Payments***

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

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

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

***3) Final Reconciliation of Interim Medicaid Outpatient Hospital Payments***

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

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

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

a. For each ancillary cost center, an ancillary RCC for the cost center is computed in Worksheet C, Part 1, Column 9 of the 2552. The ancillary RCC is applied to the Medicaid charges for each ancillary cost center. The outpatient ancillary charges used must only pertain to outpatient hospital services covered by the American Samoa State plan. The result is the Medicaid outpatient hospital cost for each ancillary cost center.

b. As discussed in the Interim Payment section, it is necessary to further adjust the total "Medicaid" outpatient hospital cost by multiplying the computed cost from Steps a by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan and then offset by an amount equal to the outpatient "Medicaid" payment received multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa State plan.

c. Also as discussed in the Interim Payment section, steps a and b are repeated for those outpatient charges for which Medicaid is the secondary payer to other primary coverage. Given that American Samoa does not perform individual Medicaid eligibility determination, the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan is applied to the cost of other primary payer services. Any charges related to services where Medicare is the primary payer are to be excluded from this step, since Medicaid payment responsibility for those services is made under Attachment 4.19-B, Supplement 1 of the American Samoa Medicaid State plan. The payment offset again would equal to the total payments received for the outpatient other primary payer services multiplied by the Medicaid claiming percentage per Section 2, Paragraph 1.E of the American Samoa Medicaid State plan.

d. Also as discussed in the Interim Payment section, steps a and b are repeated for those outpatient charges pertaining to emergency services furnished to ineligible non-citizens/non-nationals excluding lawfully present pregnant women and lawfully present individuals under 21. While the hospital may be able to identify ineligible non-citizens/non-nationals (excluding lawfully present pregnant women and lawfully present individuals under 21) outpatient charges relating specifically to emergency service cost centers (as agreed to by CMS), those ineligible non-

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

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

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

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