

## **Table of Contents**

**State/Territory Name: American Samoa**

**State Plan Amendment (SPA) #: 18-002**

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



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

---

September 10, 2018

Sandra King Young, Director  
American Samoa Medicaid Agency  
P.O. Box 998383 Office of the Governor  
American Samoa Government  
Pago Pago, American Samoa 96799

Dear Ms. Young:

We have reviewed the proposed State Plan Amendment (SPA) 18-002, which was submitted to the Centers for Medicare & Medicaid Services (CMS) San Francisco Regional Office on June 21, 2018. This SPA updates 4.19-B and 3.1-A to authorize the coverage and payment of Medically Necessary Durable Medical Equipment, Prosthetics, Orthotics and Supplies as part of the American Samoan Medicaid State Plan.

Based on the information provided, we are approving SPA 18-002 with an effective date of April 1, 2018, as requested. We are enclosing the approved Form CMS-179 and the following Medicaid state plan pages to be incorporated into your State Plan:

- Pages 7 and 7a to Attachment 3.1-A
- Page 16 to Attachment 4.19-B

If you have any additional questions or need further assistance, please contact Ronna Bach at (415) 744-3677 or [ronna.bach1@cms.hhs.gov](mailto:ronna.bach1@cms.hhs.gov).

Sincerely,

/s/

Hye Sun Lee  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosure

|  |  |  |                                   |
|--|--|--|-----------------------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>   |  | 1. TRANSMITTAL NUMBER:<br><b>18-002</b>  | 2. STATE<br><b>American Samoa</b> |
| <b>FOR: Centers for Medicare and Medicaid Services</b>   |  | 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><b>April 1, 2018</b>   |                                   |
| 5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):   |  |  |                                   |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT  |  |  |                                   |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )   |  |  |                                   |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br><br><b>42 CFR 447, Subpart F</b>  |  | 7. FEDERAL BUDGET IMPACT:<br><br><b>FY 2018 \$75,000</b><br><b>FY 2019 \$100,000</b>   |                                   |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br><b>Attachment 3.1-A - Page 7, 7a</b><br><b>Attachment 4.19-B - Page 16</b>  |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):<br><br><b>Attachment 3.1-A - Page 7</b>  |                                   |
| 10. SUBJECT OF AMENDMENT:<br><b>The purpose of this State Plan Amendment is to create a DMEPOS payment method and establish local coverage of DMEPOS in the State Plan for local Medicaid patients.</b>                |  |  |                                   |
| 11. GOVERNOR'S REVIEW ( <i>Check One</i> ):  |  |  |                                   |
| <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  | <input type="checkbox"/> OTHER, AS SPECIFIED:<br>The Governor's Office does not wish to review the State Plan  |                                   |
| Amendment.   |  |  |                                   |
| 12. SIGNATURE OF AGENCY OFFICIAL:<br>  |  | 16. RETURN TO:   |                                   |
| 13. TYPE OF AGENCY OFFICIAL:<br><b>Sandra King Young</b>   |  | <b>Sandra King Young, Director</b><br><b>American Samoa Medicaid Agency</b><br><b>P.O. Box 998383</b><br><b>Office of the Governor</b><br><b>American Samoa Government</b><br><b>Pago Pago, American Samoa 96799</b> |                                   |
| 14. TITLE:<br><b>Medicaid Director</b>   |  |  |                                   |
| 15. DATE SUBMITTED:<br><b>June 21, 2018</b>  |  |  |                                   |
| <b>FOR REGIONAL OFFICE USE ONLY</b>  |  |  |                                   |
| 17. DATE RECEIVED: June 21, 2018   |  | 18. DATE APPROVED: September 10, 2018  |                                   |
| PLAN APPROVED – ONE COPY ATTACHED  |  |  |                                   |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2018   |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br><br>/s/   |                                   |
| 21. TYPED NAME: Hye Sun Lee  |  | 22. TITLE: Acting Associate Regional Administrator, Division of Medicaid & Children's Health Operations  |                                   |
| 23. REMARKS:   |  |  |                                   |

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

B. Benefit Limitations

1. Covered Services

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

2. Not Covered Services

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

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

7.a. **Medical Supplies, Equipment and Appliances**

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

A. Provider Eligibility Requirements

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

B. Benefit Limitations

1. Covered Services

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

2. Not Covered Services

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

8. ***Private Nursing Duty***

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

Currently, this service is not provided on-island.

A. Provider Eligibility Requirements

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

---

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES**

**OTHER TYPES OF CARE**

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

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