REVISION:

State/Territory: Guam

SECTION 3 – SERVICES: GENERAL PROVISIONS

Citation
Part 440,
Subpart B and
1902(e)(5),
1905(a)(18)
through (20), and
1920 of the Act,
P.L. 99-272
(Sections 9501,
9505 and 9526)
and 1902(a),
1902(a)(47),
1902(e)(7)
through (9), and
1920 of the Act,
P.L. 99-509
(Secs. 9401(d),
9403, 9406
through 9408)
and P.L. 99-514
(Sec. 1895(c)(3)

3.1 Amount, Duration, and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42CFR Part 440, Subpart B and sections 1902(a), 1902(a)(47), 1902(e)(5), (7), (8) and (9), 1905(a)(18) through (20), 1905(p), 1915(g)(2), and 1920 of the Act.

(1) (i) Each item or service listed in section 1905(a)(l) through (5) of the Act, as defined in 42 CFR Part 440, Subpart A is provided for the categorically needy.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided for the categorically needy to the extent that nurse-midwives are authorized to practice under State law or regulation.
Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

1902(e)(5) of the
Act, P.L. 99-272
(Section 9501)

(iii) For any women who, while pregnant, were eligible for, applied for, and received medical assistance under the approved State plan, all pregnancy-related and postpartum services will continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

[X] (iv) For pregnant women, services for any other medical condition that may complicate the pregnancy are provided.

Revision: HCFA-PM-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: GUAM

Citation	
1902(a)(10), clause (VII) of the matter following (E) of the Act, P.L. 99-509 (Sec. 9401(c))	3.1 (a) (1) (Continued) (v) Medical assistance furnished to optional categorically needy pregnant women (during pregnancy and during 60 days after the pregnancy ends) under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act is limited to services related to pregnancy (including prenatal, delivery, and postpartum services) and to other conditions that may complicate pregnancy.
1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)	/_/ (vi) Ambulatory prenatal care for pregnant women during a presumptive eligibility period is provided to categorically needy individuals as indicated in item 3.6 of this plan.
	(vii) Home health services are provided to categorically needy recipients entitled to skilled nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act, P.L. 99-509 (Section 9401(d))	(viii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (F) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act, P.L. 99-509 (Section 9408)	/_/ (ix) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1903(v)of the Act P.L. 99-509 (Section 9406)	(x) Emergency services necessary to treat an illegal alien for an emergency medical condition, as defined in section 1903(v)(3) of the Act, are provided.

<u>ATTACHMENT 3.1-A</u> identifies the medical and remedial services provided to the categorically needy and specifies all limitations on the amount, duration and scope of those services.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1.a. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: / / No limitations /X/ With limitations*

b. Provided: /X/ Abortion /X/ With limitations

2.a.1 Outpatient hospital services.

Provided: / / No limitations /X/ With limitations*

a.2 Provided /X/ Abortion /X/ With limitations

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

3. Other laboratory and x-ray services.

Provided: / / No limitations /X/ With limitations*

4.a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: / / No limitations /X/ With limitations*

b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

Provided: /X/ Limited to Federal requirements / / In excess of Federal requirements*

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: /X/ No limitations /_/ With limitations*

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Provided: /_/ No limitations /X/ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Chiropracters' services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Other practitioners' services.

/ / Provided: Identified on attached sheet with description of limitations, if any.

/X/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

10. Dental services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Occupational therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

Plan

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services

[X] Provided [ ] No limitations [ ] With limitations*

[ ] Not provided

c. Preventive services

[X] Provided [ ] No limitations [ ] With limitations*

[ ] Not provided

d. Rehabilitative services

[X] Provided [ ] No limitations [ ] With limitations*

[ ] Not provided

14. Services for individuals age 65 or older in institutions for mental diseases

a. Inpatient hospital services

[ ] Provided [ ] No limitations [ ] With limitations*

[X] Not provided

b. Skilled nursing facility services

[ ] Provided [ ] No limitations [ ] With limitations*

[X] Not provided

c. Intermediate care facility services

[ ] Provided [ ] No limitations [ ] With limitations*

[X] Not provided

*Description provided on attachment.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Intermediate care facility services

a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

17. Nurse-midwife services.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

*Description provided on attachment.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

/__/ Provided: /__/ With limitations

/ X/ Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

/X/ Provided: + /__/ No limitations /__/ With limitations*

b. Services for any other medical conditions that may complicate pregnancy.

/X/ Provided: + /__/ No limitations /__/ With limitations*

/__/ Not provided.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/__/ Provided: /__/ No limitations /__/ With limitations*

/ X/ Not provided.

+ List of major categories of services (e.g., inpatient hospital, physician, etc.) that are available as pregnancy-related services, and description of additional coverage of these services, if applicable, provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

d. Skilled nursing facility services for patients under 21 years of age.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

e. Emergency hospital services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

ATTACHMENT 3.1-A

Attachment 3.1-A identifies the medical and remedial services provided to the categorically needy and specifies all limitations on the amount, duration and scope of those services.

1. Inpatient Hospital Services

Inpatient hospital services include those items and services ordinarily furnished by an approved hospital for the care and treatment of inpatients which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment with disorders other than tuberculosis and mental diseases.

A. Provider Eligibility Requirements

An approved hospital is one which meets all of the following conditions:

1. Licenses as a general hospital by the State of Guam; and

2. Qualified to participate under Title XVIII of the Social Security Act, and has in effect a hospital

utilization review plan applicable to all patients who received medical assistance under Title XIX; and

3. Signed agreement to participate with and abide by the rules and regulations of the Guam Medicaid Program.

B. Benefit Limitations

1. Covered Services

a. Maximum of continuous sixty (60) acute days inpatient hospitalization per confinement. If confinement is medically necessary after sixty (60) hospital days, prior authorization from Medicaid is required.

b. Semi-private room and board or private rooms when medically necessary.

c. Coronary and intensive care.

d. Telemetry care.

e. Surgery and anesthesia. Prior authorization

is required for one (1) day before the surgery hospitalization, in which patient needs to be admitted to the hospital one (1) day or more before the scheduled surgery.

f. Operating and delivery room.

g. Laboratory and other diagnostic tests.

h. Diagnostic radiology.

i. Drugs prescribed by physician.

j. One (1) doctor visit per day except for consultation. Additional visit is allowed only if medically necessary.

k. Surgical and medical supplies that are medically necessary.

l. Physical and occupational therapy when provided by qualified and registered therapist.

m. Inhalation therapy.

n. Off-island diagnostic and/or therapeutic procedures not available on Guam. The treatment must be certain to save life or significantly alter an adverse prognosis. Palliation will not qualify nor will experimental procedures. Services may be on an inpatient or outpatient basis depending upon the medical necessity. In any case, Medicaid <u>covers for medical and transportation services only.</u> Transportation includes air travel and needed ambulance service only. Off-island care must be prior authorized by Medicaid. The attending physician is required to submit a written request to Medicaid including a detailed description of the patient's health problems and the reasons for the referral. Also, he/she should indicate the treatment needed, the physician and institution to whom the patient is to be referred and evidence that the off-island consultant will accept the patient transfer. In case of malignant diseases, a recommendation from the Tumor Board of Guam Memorial Hospital should be included with the request. The Medicaid Review Board for medical services is the

approving entity for off-island care. When necessary, the attending physician will be invited to the Board meeting. For emergency cases, payment will be determined on a case-by-case basis.

o. Diabetes, and related services and supplies.

p. Kidney dialysis treatment and other related services.

q. Care for tuberculosis, or lytico (Amyotropic Lateral Sclerosis) and bodig (Parkinson Disease) and related services.

2. Not Covered Services

a. Cosmetic surgery.

b. Mental disorders and psychiatric services. (Paid by local funds).

c. Private duty nursing services.

d. Personal comfort on or patient's convenience items.

e. Any services or items requiring prior authorization, where authorization has not been obtained, or has been denied.

f. Any services or items which are not medically required for the diagnosis or treatment of a disease, injury or condition.

g. Admission primarily for rest care, custodial or convalescent care, etc.

h. Routine services covered in the room and board which includes nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made.

2.a. <u>Outpatient Hospital Services</u>

Outpatient services in general hospitals are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in an approved general hospital out-patient department.

A. Provider Eligibility Requirements

Same as requirement described under inpatient hospital services.

B. Benefit Limitations

1. Covered Services

a. Laboratory and diagnostic test.

b. Diagnostic radiology.

c. Emergency room.

d. Medical and surgical supplies.

e. Drugs which are prescribed by physicians and cannot be bought without a prescription.

f. Dialysis treatment and related services.

g. Hospital-based physician's services.

h. Physical, occupational and inhalation therapy. Prior authorization is required except for inhalation therapy provided in emergency room. To obtain a prior authorization from Medicaid,

The client should submit a copy of the attending physician's treatment plan which includes the name of the patient, diagnosis, type, frequency, and duration of treatment.

i. Computed tomography including head scan and body scan. Client who needs a head or body scan at Guam Memorial Hospital must carry a referral from the attending physician and request for a prior authorization from Medicaid.

j. Diabetes, and related services and supplies.

k. Care for Tuberculosis, or Lytico (Amyotrophic Lateral Sclerosis) and Bodig (Parkinson Disease) and related services.

l. Routine or annual physical examination.

m. Induced abortions when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed.

n. Any medically necessary services required for the diagnosis or treatment of a disease, injury or condition.

2. Not Covered Services

   a. Non-emergency use of emergency room.

   The emergency room visits are limited to urgent and life threatening situations as diagnosed by the emergency physician. If the emergency room visit was for a non-emergency service, the examination, treatment or diagnostic services of the medically necessary services will be covered.

2.b. Rural Health Clinic Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Not provided.

3. Laboratory and X-Ray Services

A. Independent Laboratory Services

Laboratory services mean professional and technical laboratory services ordered by a physician or other licensed practitioner within the scope of his practice as defined by the State Law.

1. Provider Eligibility Requirements

To qualify for participation as an independent laboratory under the Guam Medicaid Program, the following requirements must be:

a. Licensed as an independent laboratory by the State of Guam; and

b. Certified as an independent laboratory under the Title XVIII Medicare Program; and

c. Approved for participation as an independent laboratory provider by the Guam Medicaid Program.

2. Benefit Limitations

a. Covered Services

Laboratory procedures ordered by a physician.

b. Not Covered Services

Services inappropriate for the patient's diagnosis.

B. X-Ray Services

Radiological services are services provided by or under the direction of a physician within the scope of his practice as defined by State Law.

1. Benefit Limitation

a. Covered Services

1) Diagnostic and therapeutic x-ray procedures ordered by a physician.

2) Podiologist Services.

b. Not Covered Services

Services inappropriate for the patient diagnosis.

4.a. <u>Skilled Nursing Facility Services</u> (other than services in an institution for mental diseases)

A. Provider Eligibility Requirements

A skilled nursing facility must meet the following qualifications:

1. Licensed by the State of Guam.

2. Certified by the Health Standard Quality Bureau of Health Care Financing Administration in Region IX.

3. Approved to participate as a skilled nursing provider by the Guam Medicaid Program.

B. Benefit Limitations

1. Covered Services

a. Skilled nursing care for a maximum of 180 days

per year.

b. Skilled nursing care must be ordered by a physician, and provided on a daily basis by or under the supervision of technically or professionally trained personnel.

c. A physician must certify at the time of admission and recertify every thirty (30) days that services are required to be given on an inpatient basis at a skilled nursing level of care. A written plan of care must be established and periodically reviewed and evaluated by a physician and other personnel involved in the care of the patient.

2. Not Covered Services

a. Custodial care.

b. Personal comfort items.

c. Private duty nursing services.

d. Unskilled services.

4.b. <u>Early Periodic Screening, Diagnosis and Treatment Services (EPSDT)</u>

Early Periodic Screening, Diagnosis and Treatment services are screening and diagnostic services to determine physical or mental defects in recipients under age 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

A. Provider Eligibility Requirements

The following providers are authorized to provide Early Periodic Screening, Diagnosis and Treatment services:

1. All Medicaid approved practitioners, physicians, dentists, audiologists and optometrists.

2. Independent clinics and hospitals that have executed a signed agreement with the Medicaid Program.

B. Benefits Limitations

1. Covered Services

a. Early Periodic Screening, Diagnosis and

Treatment Services.

b. Screening examination (and rescreening) once in each of ten (10) age intervals.

c. Immunizations at the screening.

d. Refractive eye examination and eyeglass prescription by an ophthalmologist or optometrist once every two (2) years or when referred by screening. Prior authorization is required for both eye examination and eyeglasses.

e. Hearing test and hearing aid. Prior authorization is required for a hearing aid. Issuance and replacement is limited to once every three (3) years.

f. Necessary dental care is furnished to children three (3) years of age and over by the Public Health Dental Clinic if a referral is made by the Screener. Prior authorization is required for dental care provided by private Medicaid provider.

g. Medical care as covered under the State Plan.

h. Assistance with transportation to and from screening, diagnostic services and treatment.

i. Assistance with making medical appointments.

4.c. Family Planning Services and Supplies for Individuals of Child-Bearing Age

Provided with no limitations.

4.d. Tobacco-Use Cessation Treatments for Pregnant Women

A. Provider Eligibility Requirements

Qualified enrolled licensed Medicaid providers practicing within their scope of practice to provide tobacco counseling services to eligible Medicaid recipients.

B. Benefit Limitations

Provide counseling and medication coverage for at least two cessation attempts per year. Prior Authorization is required for counseling and medication.

1. Face-to-face counseling. Each cessation attempt is at least four sessions of at least 30 minutes each.

2. Prior Authorization is required for extended treatment duration past 90 days (24 weeks for varenieline) and number of cessation attempts exceeding 2 per year.

5. Physician's Services

Physician's services includes those medically necessary diagnostic or treatment services provided by or under the personal supervision of a physician and which are within the scope of practice of the physician's profession as defined by State Law. The services maybe furnished in the office, the patient's home, a hospital, skilled nursing facility or elsewhere.

A. Provider Eligibility Requirements

To participate as a provider in the Medicaid Program, a physician, doctor of medicine or osteopathy, must be licensed to practice medicine and surgery by the Guam Board of Medical Examiners and Commission of Licensure to practice the Healing Art of Guam.

B. Benefit Limitations

1. Covered Services

a. Medical and surgical services.

b. Injections and drugs dispensed by the physician.

c. Family planning services.

d. Services and supplies incidental to physician's services.

e. Kidney dialysis and related services.

f. Only one (1) hospital visit per day for consultation. Additional visit is allowed

only when justified by medical necessity.

g. Medically indicated circumcision. Prior authorization from Medicaid is required.

h. Diabetes, and related services and supplies.

i. Routine physical examination.

j. Care for tuberculosis, or lytico (Amyotrophic Lateral Sclerosis) and bodig (Parkinson Disease) and related services.

2. Not Covered Services

a. Cosmetic surgery.

b. Immunization and vaccines readily available free of charge at Public Health Clinic.

c. Chiropractor's services.

d. Acupuncture.

Physician's Services Provided for Sterilization Procedures Must Meet the Following Requirements in Order to be Eligible for

Medicaid Payment.

A. The recipient to be sterilized must not be declared mentally incompetent by a Federal, State or Local Court of Law.

B. The recipient to be sterilized must be at least twenty one (21) years old at the time of obtaining informed consent to sterilization.

C. The recipient to be sterilized must not be institutionalized in a corrective, penal, mental, or rehabilitation facility.

D. The recipient to be sterilized must give informed consent, in accordance with the Medicaid approved informed consent to sterilization form, not less than thirty (30) days nor more than one hundred eighty (180)days prior to signing of the informed consent for sterilization except in the case of premature delivery or emergency abdominal surgery. For these exceptions, at least seventy two (72) hours must pass between informed consent and the sterilization procedure.

In cases of premature delivery, informed consent must have been given at least thirty (30) days before the

expected delivery date.

E. The recipient to be sterilized, the person who obtained the consent, and the interpreter (if required) must sign the consent form at least thirty (30) days but not more than one hundred eighty (180) days prior to the sterilization. The physician performing the sterilization must sign and date the consent form after the sterilization has been performed.

F. Prior authorization is required for sterilization. A copy of the informed consent to sterilization and the prior authorization must be attached to the Medicaid claim when billing Medicaid for sterilization procedures.

Physician's Services for Hysterectomies Must Meet the Following Requirements in Order to Receive Medicaid Payment

A. Medicaid reimbursement for hysterectomies which are performed solely for the purpose of rendering the recipient incapable of reproducing is prohibited.

B. Medicaid reimbursement for a hysterectomy is allowed only when the surgery is medically necessary to treat injury or pathology.

C. The physician must inform the recipient that the hysterectomy is allowed only when the surgery is medically necessary to treat injury or pathology.

D. A completed copy of the approved acknowledgement of receipt of hysterectomy information form (Medicaid Form No. 005) must be attached to the Medicaid claim when billing for hysterectomy services.

Physician's Services for Abortion Procedures Must Meet the Following Requirements in Order to Receive Medicaid Payment

The physician must certify in writing that the life of the mother would be endangered if the fetus was carried to term. Prior authorization is required for abortion for pregnancies.

When billing for abortion services, a copy of the prior authorization from Medicaid must be attached to the Medicaid claim with a copy of the gross and microscopic pathological report indicative of the product of conception.

6. Medical care and other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

6.a. Podiatrist's Services

A Podiatrist is a health professional responsible for the examination, diagnosis, prevention, treatment, and care of conditions and functions of the human foot. A podiatrist performs surgical procedures, prescribes corrective devices and drugs and physical therapy as legally authorized in the State in which he or she is practicing.

Podiatry is the diagnosis, treatment, and prevention of conditions of human feet.

In order that only medically necessary podiatry services are reimbursed, the following foot care services are <u>considered not reasonable and necessary</u> for the diagnosis and/or treatment of illness or injury or to improve the functioning of a malformed body member:

1. Routine foot care such as:

   a. Cutting and/or removal of corns or calluses;

   b. Trimming of nails, routine hygienic care (preventive maintenance care ordinarily within the realm of self care); and

   c. Any services performed in the absence of localized illness, injury or symptoms involving the feet.

2. Evaluation or treatment of subluxation of the feet, regardless of underlying pathology. (Subluxation are structural malalignments of the joints other than fractures or complete dislocations that require treatment only by non-surgical methods).

3. The evaluation and treatment of flattened arches (including the prescription of supportive devices) regardless of the underlying pathology; exceptions:

   a. Treatment of warts is not excluded;

   b. Treatment of mycotic toe nails maybe covered if it is furnished not more often than 60 days or the billing physician documents the need for more frequent treatment;
   The same services though would be covered if they are furnished:

      1. As an incident to, at the same time as, or as a necessary integral part of a primary covered procedure performed on the foot; or

      2. As initial diagnostic services (regardless of the resulting diagnosis) in connection with a specific symptom or complaint that might arise

from a condition whose treatment would be covered.

Prior authorization is required for services outside of the scope of this provision.

6.b. Optometrist's Services

Optometric services are those services provided by an optometrist who is licensed and which are within the scope of his or her practice as defined by law.

A. Provider Eligibility Requirements

To participate as a provider in the Medicaid Program, an optometrist must be licensed to practice optometry by the Guam Board of Optometry.

1. The optical store must provide Medicaid a list of optometrists who are allowed to issue prescriptions under the store's name and a copy of their license.

2. Medicaid reserves the right to refuse eyeglasses prescription issued to optometrists not included in the above list for that particular optical store.

3. Eyeglasses prescribed by the optometrist must improve the client's vision. Based on complaints from the client regarding the problem of reading with the prescription, Medicaid reserves the right to bar that particular optometrist from participating in the program after a thorough investigation.

B. Benefit Limitations

1. Covered Services

a. Refractive eye examination once every two (2) years or when necessary by screening. Prior authorization is required.

When billing Medicaid, a copy of the prior authorization must be attached to the claims.

b. Prescription eyeglasses following examination.

6.c. Chiropractor's Services

Not provided.

6.d. Other Practitioner's Services

6.d. Other Practitioner's Services (Cont.)

A. Provider Eligibility Requirements

A participating public or private practitioner meeting the following requirements:

1. Anesthesiology Assistant, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist, Nurse Practitioner, Physician Assistant, Clinical Psychologist, or Individual, Marriage and Family Therapist. All practitioners listed above are certified and licensed by local Medical Licensure Law.

2. Approval for participation by the Guam Medicaid Program as a practitioner.

B. Benefit Limitations

1. Covered Services

   a. Mental disorders and psychological services for recipients below the age of 21 are covered without limitation. Recipients age 21 or older are covered on an outpatient basis for up to 20 sessions.

7. <u>Home Health Services</u>

A. Provider Eligibility Requirements

A participating Home Health Agency is a public or private agency or organization which meets the following requirements:

1. Certification as a Home Health Agency under Title XVIII Medicare Program and;

2. Approval for participation as a Home Health services provider by the Guam Medicaid Program.

B. Benefit Limitations

1. Covered Services

a. Nursing Care provided through Home Health Agency 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 through Home Health Agency under the supervision of a registered nurse when determined medically necessary by the physician as part of the patient's treatment plan.

c. Durable Medical Equipment (DME) and Supplies

Guam Medicaid Program covers supplies and standard medical equipment that meets the basic medical need of the recipient.

Motorized, customized or modified DMEs are not covered when it is determined that the standard equipment will meet the basic medicals needs of the recipient. Items classified as educational or rehabilitative by nature are not covered.

DMEs require Certificate of Medical Necessity and prior authorization.

8. Private Duty Nursing Services

Not provided.

9. Clinic Services

Clinic services are preventive, diagnostic, therapeutic, and rehabilitative or maintenance items or services furnished under the direction of a licensed professional practitioner (physician, dentist, and optometrist) in a facility not administered by a hospital but organized and operated to provide health services on an outpatient basis.

A. Provider Eligibility Requirements

Each independent clinic must be individually approved by the Guam Medicaid Program as a provider before it will be reimbursed for services rendered to Medicaid patients.

B. Benefit Limitations

Approved clinics may, to the extent of their specialty, provide only medically necessary services which are covered under Medicaid.

10. Dental Services

A. Provider Eligibility Requirements

Any dentist licensed to practice dentistry on Guam, who agrees to policies, regulations, and procedures as promulgated by the Guam Medicaid Program, and signs a provider agreement, is eligible to participate in the Dental Care aspects of the Guam Medicaid Program.

B. Benefit Limitations

Covered Services

1. Dental services necessary for relief of pain and infection.

2. Restoration of teeth and maintenance of dental health.

3. Orthodontia for only the medically necessary situations.

    a. Orthodontia related to post maxilla-facial intervention when the condition is caused by trauma, the treatment shall be limited to stabilization and movement only to accommodate prosthesis.

    b. Orthodontia for movement of teeth to accommodate post cleft palate treatment. The treatment shall be limited to those procedures necessary for the retention of prosthesis for swallowing, breathing and mastication.

C. Procedures

Initial dental care will be provided by the Dental Clinic of the Department of Public Health and Social Services (DPHSS). If necessary dental services, which are within the above Medicaid coverage cannot be provided by the Dental Clinic of the DPHSS, referrals with specific diagnosis and recommended treatment should be made to private providers and a prior authorization must be obtained from the Medicaid Office. A copy of the Prior Authorization must be attached to the claim when billing Medicaid.

In case the diagnosis made by the private provider is different from that of the DPHSS Dentist, a verification of diagnosis is needed from the DPHSS Dental Clinic before any prior authorization can be reissued.

11.a. Physical Therapy

Upon physician's referral, physical therapy services are provided without limitation on an inpatient and outpatient hospital basis. Physical Therapy services are not provided outside of the hospital setting.

All Physical Therapy providers and services meet the requirements of 42 CFR 440.110.

1. Provider Eligibility Requirements

   Any Physical Therapist (PT) licensed to practice Physical Therapy on Guam, who accepts Medicaid policies, regulations, and procedures and signs a provider agreement, is eligible to participate in the program.

   Physical Therapy Assistant (PTA) must possess all of the following qualifications:

   a. A minimum of an associate degree from an approved school for physical therapy assistant in the United States; and
   b. Transcripts from an approved school for physical therapy assistants, evidencing the successful completion of a two (2) year degree program, which must include supervised clinical experience.

   PTA works under the direct supervision of the PT and is not receiving direct reimbursement.

11.b. Occupational Therapy

Upon physician's referral, occupational therapy services are provided without limitation on an inpatient and outpatient hospital basis. Occupational Therapy services are not provided outside of the hospital setting.

All Occupational Therapy providers and services meet the requirements of 42 CFR 440.110.

1. Provider Eligibility Requirements

Any Occupational Therapist (OT) licensed to practice Occupational Therapy on Guam, who accepts Medicaid policies, regulations, and procedures and signs a provider agreement, is eligible to participate in the program.

Occupational Therapy Assistant (OTA) must possess all of the following qualifications:

a. An associate's degree or certificate in occupational therapy assistant from the U.S. or from a foreign program recognized by the National Board of Certification in Occupational Therapy.
b. Transcripts from the recognized educational institution, or by the nationally recognized professional association, evidencing a minimum of twelve (12) weeks, or one hundred and forty (140) hours of supervised fieldwork experience.

OTA works under the direct supervision of the OT and is not receiving direct reimbursement.

11.c. Speech Therapy, Audiology Services and Hearing Aids

A. Speech Therapy
Not Provided.

B. Audiology Services

Audiology services means hearing evaluation and basic audio assessment provided by a licensed Audiologist, upon physician's referral, to individuals with hearing disorders.

All audiology providers and services meet the requirements of 42 CFR 440.110.

1. Provider Eligibility Requirements

   Any audiologist licensed to practice Audiology on Guam, who accepts Medicaid policies, regulations, and procedures and signs a provider agreement, is eligible to participate in the program.

1. Benefit Limitations

   Covered Services

   a. Diagnostic audiological evaluation.

   b. Hearing evaluation and hearing aid.

      All evaluations must be referred by otolaryngologists. Written physician's order including diagnosis must be current and available upon request by Medicaid.

C. Hearing Aids

A hearing aid is an electroacoustic system scientifically designed to be head or body worn by an individual and consisting of a microphone, amplifier and ear phone as basic components with each component adapted to the need of the individual.

1. Provider Eligibility Requirement

Reimbursement for hearing aids shall be made only to providers who hold a currently valid license and has signed an agreement with the Guam Medicaid Program.

2. Benefit Limitations

a. Purchase of hearing aids will be allowed only on recommendation of a licensed Audiologist following a hearing aid evaluation which has been physician-referred.

b. Prior authorization is required for purchase of hearing aids. When billing Medicaid, a copy of the prior authorization must be attached to the claim.

c. Before authorization will be issued by Medicaid, a copy of a referral by a physician and an evaluation report by an audiologist should be first submitted to Medicaid.

d. No replacement will be made for hearing aids less that three (3) years old.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12.a. Prescribed Drugs

A. Provider Eligibility Requirements

Pharmacies licensed to operate on Guam may be eligible to participate in the Guam Medicaid Program provided they abide by all policies and procedures, have a licensed pharmacist on board, and have signed an agreement with the Medicaid Program.

B. Benefit Limitations

1. Covered Services

a. Drugs which are included in the Medicaid Drug Formulary or are prior authorized by Medicaid. The prescription must be dispensed by a licensed pharmacist.

b. Contraceptive or prescriptions for family planning purposes.

c. Prenatal vitamin/mineral supplements.

d. Smoking Cessation: All to include approved Food and Drug Administration (FDA) drugs.

2. Not Covered Services

a. Experimental Drugs.

b. Vitamins, vitamin/minerals.

c. Obesity control pharmaceutical.

d. Over-The-Counter (OTC) drugs except for drugs included in the Medicaid Drug Formulary for special reasons.

12.b. Dentures

Provided only when part of a post-trauma treatment.

12.c. Prosthetic Devices

Provided only for cardiac artificial valve, pace makers, and intra ocular lens for cataract clients.

12.d. **Eyeglasses**

Eyeglasses are lenses and/or frames prescribed by a physician skilled in the treatment of diseases of the eye (ophthalmologist) or by an optometrist; whichever the patient may select, to improve vision.

A. Benefit Limitations

1. Covered Services

a. Eyeglasses limited to one pair every two (2) years.

b. Repair or replacement of broken eyeglasses limited to once every two (2) years.

c. Prior authorization is required for both purchase and repair. When billing Medicaid, a copy of the prior authorization must be attached to the claim.

2. Not Covered Services

a. Eyeglasses with correction of below plus or minus (+ or -) .50 diopters or 10 cylinder axis.

b. Contact lenses.

c. Sunglasses

13.a. Diagnostic Services

A. Benefit Limitations

1. Covered Services:

a. Any "Diagnostic" medical procedures or supplies recommended by a licensed professional practitioner (physician, dentist, optometrist) within the scope of his practice under State Law to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

Performed only when deemed medically necessary. Documentation of diagnosis must be attached to the claims when billing Medicaid.

Approval Date: JAN 24 2002 Effective Date: OCT 1 2001

13.b. <u>Screening Services</u>

Not provided.

13.c. <u>Preventive Services</u>

A. Benefit Limitations

1. Covered Services

a. Pelvic Examination

Pelvic Examination means a preventive/screening examination, performed by a physician and associated laboratory test, furnished to a woman of childbearing age without signs or symptoms for the purpose of early detection of cervical cancer or other abnormalities and includes the physician's interpretation of the results of the procedure

The following limitations apply to coverage:

1) For female 16 years of age and above, one pelvic exam every 36 months;

Approval Date: JAN 2 4 [illegible] Effective Date: OCT 1 2001

2) For female age 16 and over with a history and/or family history of cervical cancer, transmitted diseases and/or other high risk factors, pelvic examination may be provided more frequent than 36 months subject to justification from a physician.

Prior authorization is required. When billing Medicaid, a copy of the prior authorization must be attached to the claim.

b. Screening Mammography

Screening mammography means a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

The following limitations apply to coverage:

1) The service must be, at a minimum, a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast.

2) For women 35-39 years of age, one baseline mammogram;

3) For women 40-49 years of age, one mammogram every two years;

4) For women 50 years of age or older, one mammogram every twelve months;

5) For women age 40 and over with a history and/or family history of breast cancer, one mammogram every twelve months.

Provider Eligibility Requirements: Supplier of screening mammography means facility that is certified or holds a provisional certification by Medicare and/or Food and Drug Administration as described in 21 CFR sec. 900.11 and 12.

c. Pap Smear

Once every 12 months or every 3 years after 3 consecutive satisfactory normal or negative Pap smear for female age 16 and over.

d. Flexible Sigmoidoscopy

Once every 48 months if age 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk.

e. Colonoscopy

Once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy.

f. Prostate Surface Antigen

Once every 12 months for men over age 50.

g. Tobacco-Use Cessation Treatments

Provider Eligibility Requirements: Qualified enrolled licensed Medicaid providers practicing within their scope of practice to provide tobacco counseling services to eligible Medicaid recipients.

A. Benefit Limitations

Provide counseling and medication coverage for at least two cessation attempts per year. Prior Authorization is required for counseling and medication.

1. Face-to-face counseling. Each cessation attempt is at least four sessions of at least 30 minutes each.

2. Prior Authorization is required for extended treatment duration past 90 days (24 weeks for varenieline) and number of cessation attempts exceeding 2 per year.

13d. Mental Health Rehabilitative Services

Mental health rehabilitative services are provided to children and adults as individual or group therapies and interventions. Services are designed to reduce mental disability and restore the individual to their best functional level possible within the community. Individuals under age 21 pursuant to the EPSDT benefit will receive all medically necessary services without limitations. Mental health services may be provided face to face in an office, by telephone, or in the community to the individual. This service includes:

Service Plan Development

- Service Plan Development – An individual written plan of service that has been developed using a wraparound planning process, assessment of the individual's emotional and behavioral needs. The wraparound planning utilizes a Child and Family Team to create and implement a highly individualized family-centered plan of service that consists of mental health treatment, non-mental health services and other needed services and supports. It's also a collaborative team planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies. The individual plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service and must be kept current and modified when needed (reflecting changes in the intensity of the individual's health and welfare needs or changes in the individual's preferences for support).

  Provider Eligibility Requirements-Social Worker qualifications:
  - Bachelor of Science degree in healthcare-related field, preferably major in social service or psychology.
  - Two years full-time experience, or equivalent, with persons with social, behavioral, or emotional disorders.
  - Knowledge of mental health challenges and community resources.
  - Knowledge and skills in CPR, First Aid, and Microsoft Office.

Therapy

- Individual Therapy – A session which individuals working one-on-one with a trained therapist— face to face in an office, by telephone, or in a confidential community environment —to explore their feelings, beliefs, or behaviors, work through challenging or influential memories, identify aspects of their lives that they would like to change, better understand themselves and others, set personal goals, and work toward desired change.

  Provider Eligibility Requirements-Psychiatrist, Clinical Psychologist, Individual, Marriage and Family Therapist qualifications:
  - Certified and licensed by Guam Medical Licensure Law. Certification by National Accrediting organization for their profession.

- Group Therapy – A session which a small group of people (generally six to ten) meet face-to-face with a trained group therapist to talk about a particular issue with which all of them is struggling—such as mental and emotional disorders, grief/bereavement, anger management, eating disorders, living with chronic depression or anxiety, recovering from childhood sexual abuse, etc., and medication management.

  Provider Eligibility Requirements- Psychiatrist, Clinical Psychologist, Individual, Marriage and Family Therapist qualifications:
  - Certified and licensed by Guam Medical Licensure Law. Certification by National Accrediting organization for their profession.

- Family Counseling - A session which the individual and their families meet face-to-face with a trained family therapist to talk about managing and overcoming mental and emotional disorders and problems with their family and relationships, to help the individuals understand their problems and develop strategies to improve their lives and medication management.

  Provider Eligibility Requirements- Psychiatrist, Clinical Psychologist, Individual, Marriage and Family Therapist qualifications:
  - Certified and licensed by Guam Medical Licensure Law. Certification by National Accrediting organization for their profession.

Medication Management

- Medication Management – Monitor medications usage to confirm that the individual is complying with a medication regimen, to include preventive medicine counseling and/or risk factor reduction interventions, patient is avoiding potentially dangerous drug interactions and other complications.

  Provider Eligibility Requirements- Psychiatrist, Clinical Psychologist, Individual, Marriage and Family Therapist qualifications:
  - Certified and licensed by Guam Medical Licensure Law. Certification by National Accrediting organization for their profession.

Rehabilitative

- Care Coordination – A process through which the individual and their families meet face-to-face with an experienced staff for the purpose of support in resolving and/or ameliorating the individual's emotional and behavioral needs by improving the individual's impairment for the scheduling, referral or coordination of the emergency medical services and transport, and other covered rehabilitative services.

  Provider Eligibility Requirements- Community Program Aide/Developmental Disability Aide qualifications:
  - 18 years of age, with high school diploma or equivalent.
  - One year full-time experience, or equivalent, with persons with social, behavioral, or emotional disorders.
  - Knowledge of mental health challenges and community resources.
  - Knowledge and skills in use of Microsoft Office.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

- Crisis Intervention - An unplanned, expedited service, lasting less than 24 hours to a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is a quick emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member to the greatest extent possible. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. This service includes:

Crisis Evaluation Plan

- Crisis Evaluation Plan – An individual written plan of service of the individual's behavioral health needs during the crisis.

  Provider Eligibility Requirements-Social Worker qualifications:
  - Bachelor of Science degree in healthcare-related field, preferably major in social service or psychology.
  - Two years full-time experience, or equivalent, with persons with social, behavioral, or emotional disorders.
  - Knowledge of mental health challenges and community resources.
  - Knowledge and skills in CPR, First Aid, and Microsoft Office.

Therapy

- Individual Therapy – A session which individuals work one-on-one with a trained therapist— face to face in an office, by telephone, or in a confidential community environment —to explore their feelings, beliefs, or behaviors, work through challenging or influential memories, identify aspects of their lives that they would like to change, better understand themselves and others, set personal goals, and work toward desired change.

  Provider Eligibility Requirements- Psychiatrist, Clinical Psychologist, Individual, Marriage and Family Therapist qualifications:
  Certified and licensed by Guam Medical Licensure Law. Certification by National Accrediting organization for their profession.

Medication Management

- Medication Management – Monitor medications usage to confirm that the individual is complying with a medication regimen, to include preventive medicine counseling and/or risk factor reduction interventions, patient is avoiding potentially dangerous drug interactions and other complications.

  Provider Eligibility Requirements- Psychiatrist, Clinical Psychologist, Individual, Marriage and Family Therapist qualifications:
  Certified and licensed by Guam Medical Licensure Law. Certification by National Accrediting organization for their profession.

Rehabilitative

- Care Coordination – A process through which the individual and their families meet face-to-face with an experienced staff for the purpose of support in resolving and/or ameliorating the individual's emotional and behavioral needs by improving the individual's impairment for the scheduling, referral or coordination of the emergency medical services and transport, and other covered rehabilitative services.

  Provider Eligibility Requirements- Community Program Aide/Developmental Disability Aide qualifications:
  - 18 years of age, with high school diploma or equivalent.
  - One year full-time experience, or equivalent, with persons with social, behavioral, or emotional disorders.
  - Knowledge of mental health challenges and community resources.
  - Knowledge and skills in use of Microsoft Office.

14. Services for Ages 65 or older for Mental Diseases
    Not provided.

15. Intermediate Care Facility
    Not provided.

16. Inpatient Psychiatric Facility Services
    Not provided.

17. Nurse-Midwife Services
    Provided with no limitations.

18. Hospice Care
    Hospice care is a service for the terminally ill patient who has a physician's certification that the individual has a medical prognosis that his or her life expectancy is six months or less. A plan of care must be established before services are provided, and services must be consistent with the plan of care in order to be covered. The following services are covered hospice services:

    - Nursing care provided by or under the supervision of a registered nurse.
    - Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.
    - Physicians' services performed by a physician (as defined in 42 CFR 440.50) except that the services of the hospice medical director of the physician of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.
    - Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust the individual's approaching death.

- Bereavement counseling consists of counseling services provided to the individual's family after the individual's death.
- Short-term inpatient care provided in Guam Memorial Hospital, which is a participating, Medicare certified facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided at Guam Memorial Hospital must conform to the written plan of care. General inpatient care at Guam Memorial Hospital may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care at Guam Memorial Hospital may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.
- Medical appliances and supplies including drugs and biological. Only drugs as define in 1861 of the Act and which are used primarily for the relief of pain and symptoms control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation of management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.
- Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.
- Physical therapy, occupational therapy services and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Hospice services are provided at the following levels of care:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

All inpatient hospice services are provided at Guam Memorial Hospital, a Medicare certified facility that additionally meets the special hospice standards regarding staffing and patient areas.

A. Provider Eligibility Requirements

1. Licensed by the Territory of Guam.
2. Certified or holds a provisional certification by Medicare.
3. A participating hospice meets the Medicare conditions of participation for hospices and has a valid provider agreement.

B. Benefit Limitations

Hospice care is given in periods of care, two 90-day periods followed by an unlimited number of 60 day periods. For each period of care, a doctor certification is required that the individual is terminally ill.

19. Case Management Services

Not provided.

20.a. Pregnancy-Related and Postpartum Services

Pregnant women, who were eligible for, applied for, and received medical assistance under the approved Guam Medicaid State Plan, will be provided all pregnancy-related and postpartum services until the end of the 60-day period beginning on the last date of their pregnancy.

20.b. Services that may complicate Pregnancy
Pregnant women services, including prenatal, delivery, and postpartum services, and any other medical conditions that may complicate the pregnancy, are provided.

21. Ambulatory Prenatal Care

Not provided.

22. Respiratory Care Services

Not provided.

23. Any other medical care and any other type of remedial care recognized under State Law, specified by the Secretary.

23.a. Transportation

Transportation and other related travel expenses determined to be medically necessary.

Emergency transportation service is covered in any emergency situation.

Transportation is furnished by vendors who are authorized by the Medicaid Program for reimbursement of transportation/travel costs.

A. Coverage

1. Round trip air transportation (economy fare) for off-island medical treatment. One (1) parent, or guardian, if the parent is unable to accompany the child, will be covered for minor recipients (17 years old and below and one (1) medical escort will be covered for recipients requiring assistance due to visual, orthopedic or mental impairments.

2. Emergency ambulance service and non-emergency medically necessary stretcher, wheelchair, bed-confined medical transportation service.

B. Benefit Limitations

1. Meals and lodging for medically necessary treatment that cannot be provided on Guam may be reimbursed at a reasonable per diem rate and requires Prior Authorization.

23. b. Services of Christian Science Nurses

Not provided.

23. c. Care and Services for Christian Science

Not provided.

23.d. Skilled Nursing Facility Services for under 21 Years Old

Skilled nursing facility services for clients under 21 years old means services that are provided to recipients under 21 years old on an inpatient basis by a skilled nursing facility.

A. Provider Eligibility Requirements (See 4.a.).

B. Benefit Limitations (See 4.a.).

23.e. Emergency Hospital Services

A. Emergency hospital services means:

1. Services necessary to prevent the death or serious impairment of the health of a recipient; and

2. Services provided by the most accessible hospital available that is equipped to furnish the services because of the threat to the life of health of the recipient even if the hospital does not currently meet:

   a. The conditions for participation under Medicare; or
   b. The definition of inpatient or outpatient hospital services under the Guam Medicaid State Plan.

B. Benefit Limitations

Emergency services, as described above, are provided to eligible recipients and individuals not eligible for Medicaid because of their immigration status if they meet all other eligibility criteria.

23. f. Personal Care Services in Recipient's Home

Not provided.

23. g. Birthing Center Services

A. Provider Eligibility Requirements

1. Physician & Certified Nurse Midwife licensed by local Medical Licensure Law.

2. The birthing center must meet the following qualifications:

   a) Licensed by the Territory of Guam.

   b) Approved to be a participating provider by the Guam Medicaid Program.

B. Benefit Limitations

Guam Medicaid-covered services to the care of recipients during low-risk pregnancies, deliveries and the postpartum period.

Gynecological services, family planning services, and Child Health Check-Up screenings (newborn evaluations only).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Guam

CASE MANAGEMENT SERVICES

Not Applicable

A. Target Group:

B. Areas of State in which services will be provided:

/_/ Entire State.

/_/ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/_/ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/_/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

E. Qualification of Providers:

State/Territory: Guam

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Guam

Citation	
Part 440, Subpart B	3.1 (a) (2) This State plan covers the medically needy.
	/X/ No.
	/_/ Yes. The services described below and in ATTACHMENT 3.1-B are provided.
	Services for the medically needy include:
1902(e)(5) of the Act, P.L. 99-272 (Section 9501)	(i) Prenatal care and delivery services for pregnant women.
	(ii) For women who, while pregnant, were eligible for, applied for, and received medical assistance under the approved State plan, all pregnancy-related and postpartum services will continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last day of pregnancy.
	/_/ (iii) For pregnant women, services for any other medical condition that may complicate the pregnancy.
1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)	/_/ (iv) Ambulatory prenatal care for pregnant women who are medically needy individuals is provided as indicated in item 3.6 of this plan.
	(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.
	/_/ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Guam

Citation	
	3.1 (a) (2) (Continued)
	(vi) Home health services to recipients entitled to skilled nursing facility services as indicated in item 3.1(b) of this plan.
	/X/ Not applicable; the plan does not cover skilled nursing facility services for the medically needy.
Part 440, Subpart B	(vii) /_/ Services in an institution for mental diseases.
	/_/ Services in an intermediate care facility for the mentally retarded.
1902(e)(9) of the Act, P.L. 99-509 (Section 9408)	/_/ (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(10)(C)(iv), 1902(e)(9)(C), and 1905(a)(19) and (20) of the Act, P.L. 99-509 (Section 9408) and P.L. 99-514 (Section 1895(c)(3))	Each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in section 1905(o), 1902(e)(9)(C), and 1915(g)(2) of the Act.
	/_/ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-87- 9 (BERC) OMB No.: 0938-0193
AUGUST1987

State/Territory: GUAM

Citation	
1903(v) of the Act, P.L. 99-509 (Section 9406)	3.1 (a) (2) (Continued) (ix) Emergency services necessary to treat an illegal alien for an emergency medical condition, as defined in section 1903(v)(3) of the Act, are provided. _

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them.

State/Territory: GUAM

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

The following ambulatory services are provided.

*Description provided on attachment.

State/Territory: GUAM

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/_/ Provided: /_/ No limitations /_/ With limitations*

2.a. Outpatient hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/_/ Provided: /_/ No limitations /_/ With limitations*

3. Other laboratory and X-ray services.

/_/ Provided: /_/ No limitations /_/ With limitations*

4.a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/_/ Provided: /_/ No limitations /_/ With limitations*

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

/_/ Provided: /_/ No limitations /_/ With limitations*

4.c. Family planning services and supplies for individuals of childbearing age.

/_/ Provided: /_/ No limitations /_/ With limitations*

5. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

/_/ Provided: /_/ No limitations /_/ With limitations*

*Description provided on attachment.

State/Territory: GUAM

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Optometrists' Services

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Chiropractors' Services

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Other Practitioners' Services

/_/ Provided: /_/ No limitations /_/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Home health aide services provided by a home health agency.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/_/ Provided: /_/ No limitations /_/ With limitations*

*Description provided on attachment.

State/Territory: GUAM

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

8. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/ With limitations*

9. Clinic services.

/_/ Provided: /_/ No limitations /_/ With limitations*

10. Dental services.

/_/ Provided: /_/ No limitations /_/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Occupational therapy.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/_/ Provided: /_/ No limitations /_/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Dentures.

/_/ Provided: /_/ No limitations /_/ With limitations*

*Description provided on attachment.

State/Territory: GUAM

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

c. Prosthetic devices.

/_/ Provided: /_/ No limitations /_/ With limitat ns*

d. Eyeglasses.

/_/ Provided: /_/ No limitations /_/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Screening services.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Preventive services.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Rehabilitative services.

/_/ Provided: /_/ No limitations /_/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Skilled nursing facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

*Description provided on attachment.

State/Territory: GUAM

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ____________

c. Intermediate care facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

/_/ Provided: /_/ No limitations /_/ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/_/ Provided: /_/ No limitations /_/ With limitations*

17. Nurse-midwife services.

/_/ Provided: /_/ No limitations /_/ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

*Description provided on attachment.

State/Territory: Guam

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

/_/ Provided: /_/ With limitations

/X/ Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

/_/ Provided:+ /_/ No limitations /_/ With limitations*

b. Services for any other medical conditions that may complicate pregnancy.

/_/ Provided:+ /_/ No limitations /_/ With limitations*

/X/ Not provided.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

+List of major categories of services (e.g., inpatient hospital, physician, etc.) that are available as pregnancy-related services, and description of additional coverage of these services, if applicable, provided on attachment.

State/Territory: Guam

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/_/ Provided: /_/ No limitations /_/ With limitations*

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Care and services provided in Christian Science sanitoria.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/_/ Provided: /_/ No limitations /_/ With limitations*

e. Emergency hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

Territory: GUAM

Citation
1902(a)(10)(E) and clause (VIII) of the matter following (E) and 1905(p)(3) of the Act, P.L. 99-509 (Section 9403)

3.1 (a) (3) Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.5 of this plan.

Sec. 245A(h) of the Immigration and Nationality Act, P.L. 99-603 (Section 201)

(4) Limited Coverage for Certain Aliens.

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(1) Are aged, blind, or disabled individuals as defined under OAA, AB, APTD, and AABD;

(2) Are children under 18 years of age; or

(3) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as described in §447.53(b), aliens granted lawful temporary resident status under Section 245A of the Immigration and Nationality Act who are not identified in item 3.1(a)(4)(i)(1) through (3) above who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-87-9 (BERC) OMB No.: 0938-0193
JULY 1997

Territory: Guam

Citation 3.1 (a) (4) (Continued)

Citation		
1902 (a) and 1903 (v) of the Act, and Section 401(b)(1)(A) of PL104-193	*(iii)*	*Limited Coverage for Certain Aliens: An alien who is ~~not~~ a qualified alien or who is a qualified alien, as defined in section 431(b) of PL 104-193, but is not eligible for Medicaid based on alienage status, and who would otherwise qualify for Medicaid is provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903 (v)(3) of the Act.*
Part 440, Subpart B and 1902(a) and (a) (10), 1903 (v) and 1915(g) of the Act, P.L. 99-272 (Sections 9501 and 9505) and P.L. 99-509 (Sections 9401(c), 9406, and 9408) Sec. 245A of the Immigration and Nationality Act, P.L. 99-603 (Section 201)	(5)	Except for those items or services for which sections 1902(a), (a) (10), and 1903 (v) of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act permit exceptions: (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person. (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy. ☐ Yes ☒ Not applicable. The medically needy are not covered.

TN No. 97-1
Supersedes
TN No. 87-9

Approval Date APR 10 1998

Effective Date JUL 01 1997
HCFA ID:2000P/0020P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

Territory: Guam

Citation

3.1 (a) (5) (Continued)

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ Yes.

/X/ Not applicable. The medically needy are not included in the plan.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Guam

Citation

3.1 (a) (5) (Continued)

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ Yes.

/X/ Not applicable. The medically needy are not included in the plan.

441.55
50 FR 43654

(a) (6) The Medicaid agency meets the requirements of 42 CFR 441.56 through 441.62 with respect to early and periodic screening, diagnosis and treatment (EPSDT) services.

/_/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Guam

Citation		
42 CFR Part 440, Subpart B 42 CFR 441.15 AT-78-90 AT-80-34	3.1(b)	Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

/ / Yes

/X/ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

/ / Yes, to all

/ / Yes, to individuals age 21 or over; SNF services are provided

/ / Yes, to individuals under age 21; SNF services are provided

/ / No; SNF services are not provided

/X/ Not applicable; the medically needy are not included under this plan

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Guam

Citation		
42 CFR 431.53 AT-78-90	3.1(c)	Assurance of Transportation Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-B.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Guam

Citation		
42 CFR 440.260 AT-78-90	3.1(d)	Methods and Standards to Assure Quality of Services The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

SUPERSEDED BY: TN # 85-2
APPROVED: JUNE 19, 1985 EFF: 1 APR 1985

ATTACH 3.1 - C

The State agency will establish and be responsible for a process(es) of Utilization Review for each item of care or service listed in Section 1905(a) of the Act that is included in the State Medical Assistance program in accordance with 45 CFR 250.20.

The Utilization Review Plan will meet the requirements of Section 1861(k) of the Social Security Act- with the same standards and procedures- where by the need for admission and continued hospitalization for each patient is determined on a timely basis.

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State provides benchmark benefits:

X Provided

☐ Not Provided

States can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State and would correlate to "Plan B" only.)

X Title of Alternative Benefit Plan A GUAM MEDICAID EARLY OPTION PLAN
☐ Title of Alternative Benefit Plan B
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

☐ **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State will provide the benefit package to the following populations:

☐ (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs should include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State will require to enroll in the alternative benefit plan;
- Each eligibility group the State will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • • • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • • • •		

☐ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

☐ (iii) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

X **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, States may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

X (i) The State has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Specify whether the benchmark will cover these individuals statewide or otherwise.

(ii) For optional populations/individuals [checked above in b(i)], describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

2. Description of the Benefits

X The State will provide the following alternative benefit package (check the one that applies).

a) **X** Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

☐ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X Secretary-approved Coverage – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

The Benchmark Benefit is the same covered services and eligibility as the State Plan.

b) ☐ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

- ☐ Inpatient and outpatient hospital services;
- ☐ Physicians' surgical and medical services;
- ☐ Laboratory and x-ray services;
- ☐ Coverage of prescription drugs
- ☐ Mental health services
- ☐ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;
- ☐ Emergency services
- ☐ Family planning services and supplies

(ii) ☐ Additional services

Insert below a full description of the benefits in the plan including any limitations.

(iii) ☐ The State assures that the benefit package has been determined to have an aggregate

actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

iv ☐ The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Vision services, and/or
- Hearings services

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ☐ Additional Benefits

Insert a full description of the additional benefits including any limitations.

3. Service Delivery System

Check all that apply.

X The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (See Attachment 4.19-B)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

X Through Benchmark only

☐ As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured in the same manner and under the same authority as in the State Plan.

X The State assures that effective January 1, 2014 any benchmark benefit plan provides at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

X The State assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

X The State will implement this State Plan amendment on January 1, 2012.

X Through Benchmark only

☐ As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured in the same manner and under the same authority as in the State Plan.

X The State assures that effective January 1, 2014 any benchmark benefit plan provides at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

X The State assures that family planning services and supplies are covered for individuals of child-bearing age.

6. **Economy and Efficiency of Plans**

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. **Compliance with the Law**

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. **Implementation Date**

X The State will implement this State Plan amendment on January 1, 2012.

Alternative Benefit Plan

Attachment 3.1-C- [X]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement
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V.20130917

Alternative Benefit Plan

Attachment 3.1-C- [X]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Alternative Benefit Plan

Describe:

Press Release: A Press Release through mass media to disseminate information on the enrollment for the Medicaid New Adult Group Program and the identification of individuals who have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration of their options to choose between the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and the Medicaid Program Plan (ABP defined by approved Medicaid state plan) by completing a Medically Frail Certification Form when submitting their application for the benefits or to see their case/eligibility worker for the form. The individual will be informed of their eligibility at the interview or processing of the form and their plan selection.

Notification/Flyer-Thru Interview: A letter/flyer will be provided at the initial/renewal interview of the application for benefits with a case/eligibility worker of the identification of individuals who have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration of their options to choose between to choose between the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and the Medicaid Program Plan (ABP defined by approved Medicaid state plan) by completing a Medically Frail Certification Form. The individual will be informed of their eligibility at the processing of the form and their plan selection.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Individuals can pick-up a Benefit Application/Change Report Form and the Medically Frail Certification (MFC) Form at the eligibility centers anytime or visit their eligibility worker anytime as their relationship is ongoing to ask question/guidance on the MFC Form.

If the individual is not currently enrolled in the program, the front desk staff will provide guidance on the completion of the application and MFC Form with instruction that the MFC Form has to be completed by their physician, and an appointment with an eligibility worker.

At the appointment interview and the individual has a completed Medically Frail Certification (MFC) Form, the individual will be notified during that time of their medically frail determination along with their right to choose between the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and the Medicaid Program Plan (ABP defined by approved Medicaid state plan). If the individual does not have a completed MFC Form and the eligibility worker will ask the following questions and if answered YES to the any: "Do you or a household member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration?, the individual will be provided a MFC Form with instruction that the MFC Form has to be completed by their physician and that it must be submitted within 10 days to complete their application process and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker. If the MFC is not submitted within 10 days, the individual can submit the MFC Form anytime as a CHANGE REPORT Form to their eligibility worker and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

If the individual is currently enrolled under the program, the front desk staff will provide guidance on the completion of a Change Report Form and MFC Form with instruction that the MFC Form has to be completed by their physician and to submit it upon completion anytime and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

The individual can submit a Change Report Form and the MFC Form at any time during their eligibility period and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

Alternative Benefit Plan

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Individuals can pick-up a Benefit Application/Change Report Form and the Medically Frail Certification (MFC) Form at the eligibility centers anytime or visit their eligibility worker anytime as their relationship is ongoing to ask question/guidance on the MFC Form.

If the individual is not currently enrolled in the program, the front desk staff will provide guidance on the completion of the application and MFC Form with instruction that the MFC Form has to be completed by their physician, and an appointment with an eligibility worker.

At the appointment interview and the individual has a completed Medically Frail Certification (MFC) Form, the individual will be notified during that time of their medically frail determination along with their right to disenroll from the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and enroll in the Medicaid Program Plan (ABP defined by approved Medicaid state plan). If the individual does not have a completed MFC Form and the eligibility worker will ask the following questions and if answered YES to the any: "Do you or a household member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration?, the individual will be provided a MFC Form with instruction that the MFC Form has to be completed by their physician and that it must be submitted within 10 days to complete their application process and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker. If the MFC is not submitted within 10 days, the individual can submit the MFC Form anytime as a CHANGE REPORT Form to their eligibility worker and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker.

If the individual is currently enrolled under the program, the front desk staff will provide guidance on the completion of a Change Report Form and MFC Form with instruction that the MFC Form has to be completed by their physician and to submit it upon completion anytime and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker.

The individual can submit a Change Report Form and the MFC Form at any time during their eligibility period and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☒ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☐ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

Alternative Benefit Plan

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

Medicaid appeals/fair hearing process is available to beneficiaries who disagree with their medical frailty determination.

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-C- X

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Individuals can pick-up a Benefit Application/Change Report Form and the Medically Frail Certification (MFC) Form at the eligibility centers anytime or visit their eligibility worker anytime as their relationship is ongoing to ask question/guidance on the MFC Form.

If the individual is not currently enrolled in the program, the front desk staff will provide guidance on the completion of the application and MFC Form with instruction that the MFC Form has to be completed by their physician, and an appointment with an eligibility worker.

At the appointment interview and the individual has a completed Medically Frail Certification (MFC) Form, the individual will be notified during that time of their medically frail determination along with their right to choose between the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and the Medicaid Program Plan (ABP defined by approved Medicaid state plan). If the individual does not have a completed MFC Form and the eligibility worker will ask the following questions and if answered YES to the any: "Do you or a household member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration?, the individual will be provided a MFC Form with instruction that the MFC Form has to be completed by their physician and that it must be submitted within 10 days to complete their application process and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker. If the MFC is not submitted within 10 days, the individual can submit the MFC Form anytime as a CHANGE REPORT Form to their eligibility worker and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

If the individual is currently enrolled under the program, the front desk staff will provide guidance on the completion of a Change Report Form and MFC Form with instruction that the MFC Form has to be completed by their physician and to submit it upon completion anytime and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

The individual can submit a Change Report Form and the MFC Form at any time during their eligibility period and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

☐ Self-identification

☐ Other

Alternative Benefit Plan

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☐ Self-identification

☒ Review at the time of eligibility redetermination

☐ Provider identification

☐ Change in eligibility group

☒ Other

Describe:

Individuals can pick-up a Benefit Application/Change Report Form and the Medically Frail Certification (MFC) Form at the eligibility centers anytime or visit their eligibility worker anytime as their relationship is ongoing to ask question/guidance on the MFC Form.

If the individual is not currently enrolled in the program, the front desk staff will provide guidance on the completion of the application and MFC Form with instruction that the MFC Form has to be completed by their physician, and an appointment with an eligibility worker.

At the appointment interview and the individual has a completed Medically Frail Certification (MFC) Form, the individual will be notified during that time of their medically frail determination along with their right to choose between the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and the Medicaid Program Plan (ABP defined by approved Medicaid state plan). If the individual does not have a completed MFC Form and the eligibility worker will ask the following questions and if answered YES to the any: "Do you or a household member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration?, the individual will be provided a MFC Form with instruction that the MFC Form has to be completed by their physician and that it must be submitted within 10 days to complete their application process and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker. If the MFC is not submitted within 10 days, the individual can submit the MFC Form anytime as a CHANGE REPORT Form to their eligibility worker and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

If the individual is currently enrolled under the program, the front desk staff will provide guidance on the completion of a Change Report Form and MFC Form with instruction that the MFC Form has to be completed by their physician and to submit it upon completion anytime and will be notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

The individual can submit a Change Report Form and the MFC Form at any time during their eligibility period and will be

Alternative Benefit Plan

notified of their medically frail determination along with their right to choose at the submission date by their eligibility worker.

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Ad hoc basis
- ○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals can pick-up a Benefit Application/Change Report Form and the Medically Frail Certification (MFC) Form at the eligibility centers anytime or visit their eligibility worker anytime as their relationship is ongoing to ask question/guidance on the MFC Form.

If the individual is not currently enrolled in the program, the front desk staff will provide guidance on the completion of the application and MFC Form with instruction that the MFC Form has to be completed by their physician, and an appointment with an eligibility worker.

At the appointment interview and the individual has a completed Medically Frail Certification (MFC) Form, the individual will be notified during that time of their medically frail determination along with their right to disenroll from the New Adult Benefit Plan (ABP defined by Section 1937 requirements) and enroll in the Medicaid Program Plan (ABP defined by approved Medicaid state plan). If the individual does not have a completed MFC Form and the eligibility worker will ask the following questions and if answered YES to the any: "Do you or a household member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or have a disability determination by the Social Security Administration?, the individual will be provided a MFC Form with instruction that the MFC Form has to be completed by their physician and that it must be submitted within 10 days to complete their application process and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker. If the MFC is not submitted within 10 days, the individual can submit the MFC Form anytime as a CHANGE REPORT Form to their eligibility worker and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker.

If the individual is currently enrolled under the program, the front desk staff will provide guidance on the completion of a Change Report Form and MFC Form with instruction that the MFC Form has to be completed by their physician and to submit it upon completion anytime and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker.

The individual can submit a Change Report Form and the MFC Form at any time during their eligibility period and will be notified of their medically frail determination along with their right to disenroll from New Adult Benefit Plan and enrollment to the Medicaid Program Plan at the submission date by their eligibility worker.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

Medicaid appeals/fair hearing process is available to beneficiaries who disagree with their medical frailty determination.

Alternative Benefit Plan

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-C- X

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: New Adult Benefit Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ◉ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ○ Secretary-Approved Coverage.

Plan name: GovGuam SelectCare 1500

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. Yes

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

2. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

Alternative Benefit Plan

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-C- X

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing **ABP4**

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☑ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-C-

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

GovGuam SelectCare 1500

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

GovGuam SelectCare 1500

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services

Collapse All

Field	Value
Benefit Provided:	Acupuncture
Source:	Base Benchmark State Employees
Authorization:	None
Provider Qualifications:	Medicaid State Plan
Amount Limit:	30 Visits Per Fiscal Year
Duration Limit:	None
Scope Limit:	None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	

Remove

Field	Value
Benefit Provided:	Aids Treatment
Source:	Base Benchmark State Employees
Authorization:	None
Provider Qualifications:	Medicaid State Plan
Amount Limit:	None
Duration Limit:	None
Scope Limit:	Approved FDA Treatment and Drugs only.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	

Remove

Field	Value
Benefit Provided:	Airfare Benefit
Source:	Base Benchmark State Employees
Authorization:	Prior Authorization
Provider Qualifications:	Other
Amount Limit:	None
Duration Limit:	None
Scope Limit:	None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered for Inpatient Services at a participating off-island hospital provider and services not available on Guam. One companion for services of the following specific procedures: open heart surgery, oncology surgery, aneurysmectomy, pneumonectomy, intra-cranial surgery, acute leukemia, gamma knife or if the level of care required is NICU Level III, or if the expected cost of the services exceeds $25,000.00.

One medical escort for the abovementioned specific procedures when medically necessary. Additional escort for the abovementioned specific procedures when medically necessary and unable to self-care.

Remove

Benefit Provided: Allergy Testing/Treatment

Source:

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: $500 Annually

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior Authorization and Justification are required for services above the $500 annual limit.

Benefit Provided: Ambulatory Surgi-Center Care

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Breast Reconstructive Surgery

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: In accordance with 1998 W.H.C.R.A.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Cataract Surgery

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Outpatient only, including conventional lens

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Chemotherapy

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Chiropractic Care

Source: Base Benchmark State Employees

Alternative Benefit Plan

Authorization: None

Provider Qualifications: Medicaid State Plan

Remove

Amount Limit: 30 visits per Fiscal Year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Elective Surgery

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Non-emergency Outpatient Surgeries.

Benefit Provided: Orthopedic conditions

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Internal and External Prosthesis.

Alternative Benefit Plan

Benefit Provided: Physician Care & Services

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Primary Care Visits, Specialist Care Visits, Voluntary Second Surgical Opinion, Home Health Care Visit, Hospice Care (not covered off-island; maximum 180 days and requires Prior Authorization), Outpatient Laboratory, X-ray Services, Injections (does not include the Orthopedic injections) at a participating provider.

Benefit Provided: Radiation Therapy

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Sleep Apnea

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Diagnostics and Therapeutic Procedure.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Sterilization Procedures

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Tubal Ligation and Vasectomy (Outpatient only)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medicaid State Plan: A. The recipient to be sterilized must not be declared mentally incompetent by a federal, State or Local court of Law. B . The recipient to be sterilized must be at least twenty one (21) years old at the time of obtaining informed consent to sterilization. C. The recipient to be sterilized must not be institutionalized in a corrective, penal, mental, or rehabilitation facility. D. The recipient to be sterilized must give informed consent, in accordance with the Medicaid approved informed consent to sterilization form, not less than thirty (30) days nor more than one hundred eighty (180) days prior to the sterilization. The physician performing the sterilization must sign and date the consent form after the sterilization has been performed.

Benefit Provided: Nuclear Medicine

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: End Stage Renal Disease/Hemodialysis

Source: Base Benchmark State Employees

Alternative Benefit Plan

Authorization: None
Provider Qualifications: Medicaid State Plan
Remove

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inhalation Therapy
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Congenital Anomaly Diseases Coverage
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit is likely not medically necessary for individuals in the New Adult Group.

Add

Alternative Benefit Plan

■ Essential Health Benefit 2: Emergency services

Collapse All ☐

Benefit Provided: Emergency Care

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: On/Off-Island emergency facility, physician services, laboratory, x-rays, ambulances services (ground transportation only), and emergency air transportation at a participating provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All ☐

Field	Value
Benefit Provided:	Hospitalization & Inpatient Benefits
Source:	Base Benchmark State Employees
Authorization:	Authorization required in excess of limitation
Provider Qualifications:	Medicaid State Plan
Amount Limit:	None
Duration Limit:	60 days
Scope Limit:	None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Semi-private room, intensive care, coronary care, surgery, elective surgery, physician's hospital services, acute admissions for mental health or chemical dependency conditions, and all other inpatient hospital services including laboratory, x-ray, operating room, anesthesia, and medication at a participating provider.

Field	Value
Benefit Provided:	Skilled Nursing Facility
Source:	Base Benchmark State Employees
Authorization:	None
Provider Qualifications:	Medicaid State Plan
Amount Limit:	None
Duration Limit:	60 days max per Fiscal Year
Scope Limit:	None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Field	Value
Benefit Provided:	Cardiac Surgery
Source:	Base Benchmark State Employees
Authorization:	Prior Authorization
Provider Qualifications:	Medicaid State Plan
Amount Limit:	None
Duration Limit:	None
Scope Limit:	Prior Authorization required for off-island services not available on Guam.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care

Collapse All

Benefit Provided: Maternity Care

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Labor and delivery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Prenatal Care

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Mental Health Care

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient psychiatric and psychological services to include counseling and medications.

Benefit Provided: Chemical Dependency

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Outpatient psychiatric and psychological services to include counseling and medications.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	No	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☐ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

30 day supply. Clinically appropriate drugs without alternative in the Drug Formulary list requires Prior Authorization and Justification.

Alternative Benefit Plan

■ Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided: Physical Therapy

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Occupational Therapy

Source: Base Benchmark State Employees

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 20 visits per Fiscal Year

Duration Limit: None

Scope Limit: Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. Prior Authorization and Justification are required for additional visits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Durable Medical Equipment (DME)

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: One (1) of each Type DME Every Five Years

Duration Limit: None

Scope Limit: Standard wheelchair, standard hospital bed, walker, crutches, and standard CPAP.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician Prescription is required and covers the lesser amount between purchase or rental of each type of medical equipment.

Remove

Benefit Provided: Oxygen and Accessories

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician Prescription is required.

Benefit Provided: Hearing Aids

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: $500 Every Three Years

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior Authorization and Justification are required for hearing aids above the $500.

Benefit Provided: Implants

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Limited to pacemakers, heart valves, stents, intraocular lenses, and orthopedic internal prosthetic devices

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All ☐

Benefit Provided: Blood & Blood Derivatives

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diagnostic Testing

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes diagnostic radiology and laboratory services. Prior authorization is required for CT Scan, MRI, MRA, and other type of non-invasive diagnostic imaging.

Add

Alternative Benefit Plan

■ Essential Health Benefit 9: Preventive and wellness services and chronic disease management

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Care Services

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B Recommendations and HRSA's Bright Futures.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Well-Women Preventive Care

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Annually

Scope Limit: In accordance with the guidelines supported by the Institute of Medicine (IOM).

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Wellness

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: $200 Annually

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Counseling and Monitoring of patient's condition under programs such as: A Mini-Newstart Program, Gestational Diabetes Program, Breathe-Free Stop Smoking Program in a participating wellness center. Prior Authorization and Justification are required for services/programs above the $200 annual limit.

Benefit Provided:

Immunizations/Vaccinations

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

In accordance with the guidelines established by the CDC Advisory Committee on Immunization Practices (ACIP).

Benefit Provided:

Fitness

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Gym memberships at a participating provider.

Add

Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐

Alternative Benefit Plan

☐ Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Annual Eye Exam

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Annual Eye Exams are not allowable essential health benefits.

Add

Alternative Benefit Plan

☐ Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

Attachment 3.1-C- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Assurances **ABP7**

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

Attachment 3.1-L- [X]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Service Delivery Systems **ABP8**

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☐ Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

All Medicaid beneficiaries on Guam receive their care through fee-for-service (FFS). Except for services that are otherwise specificed in Attachment 4.19-A, 4.19-B or 4.19-D of Guam's approved State Plan, Guam reimburses for FFS medical services primarily at or below the current Hawaii Medicare Fee Schedule.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

Attachment 3.1-C-

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	**ABP9**
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No
Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:	

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

Attachment 3.1-C- [ ]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. | Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

Attachment 3.1-C- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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V.20130917

ASSURANCE OF TRANSPORTATION

Transportation is furnished by vendors who are authorized by the Medicaid Program for reimbursement of transportation costs when the beneficiary has no other means of getting to and from covered medical services.

Emergency transportation service is covered in any emergency situation.

Described below are the methods used to assure necessary transportation of recipients to and from providers:

(1) For off-island emergency (See Attachment 3.1-A 23.a.)

(2) For on-island emergency, recipients may obtain the ambulance service through the Guam Fire Department.

(3) For on-island non-emergency, recipients must first use their own cars or seek assistance from friends or relatives before requesting transportation using the Guam Mass Transit system. Requesting an ambulance through the Guam Fire Department or medical transportation for medically necessary stretcher, wheelchair, and bed-confined transportation is available when medically necessary.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

JAN 2 1981

State Guam

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	**Family Planning Services** The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

State/Territory: Guam

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

NOT APPLICABLE

Revision: HCFA-PM-87-5 (BERC) OMB No.: 0938-0193
APRIL 1987

State/Territory: GUAM

Citation	
42 CFR 441.30 AT-78-90	3.1 (f) (1) Optometric Services Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist. /_/ Yes. /_/ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform. /x/ Not applicable. The conditions in the first sentence do not apply.
1903(i)(1) of the Act, P.L. 99-272 (Section 9507)	(2) Organ Transplant Procedures Organ transplant procedures are provided. /x/ No. /_/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Guam

Citation	
42 CFR 431.110(b) AT-78-90	3.1 (g) Participation by Indian Health Service Facilities Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.
1902(e)(9) of the Act, P.L. 99-509 (Section 9408)	(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/_/ 30 consecutive days;

/_/ ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/_/ Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Guam

Citation		
42 CFR 431.625(b) AT-78-90	3.2	Coordination of Medicaid with Medicare Part B

/xx/ The Medicaid agency makes the entire range of benefits under Part B of title XVIII available as part of the plan to certain eligible individuals under a buy-in agreement, through payment of the premium charges on behalf of such individuals, or by meeting all or part of the cost of the deductible, cost sharing or similar charges under Part B.

ATTACHMENT 3.2-A describes the method by which such benefits are made available.

The agency makes the same services available to recipients not covered by Medicare.

/ / Yes / / No

/ / The agency does not have such an agreement or arrangement to pay premiums, deductibles, cost sharing or similar changes under Part B.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Guam

Citation		
42 CFR 441.101, 42 CFR 431.620(c) and (d) AT-79-29	3.3	Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases. /_/ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met. /xx/ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: Guam

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

/_/ 1. Buy-in agreement with the Secretary of HHS. This agreement covers:

/_/ a. Money payment recipients under the State plan under title I or XVI of the Act.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System:

/_/ Are included

/_/ Are not included

/_/ b. Money payment recipients under all of the State plans under titles I, IV-A, X, XVI, and XVI of the Act.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System:

/_/ Are included

/_/ Are not included

/X/ c. All individuals eligible under this title XIX plan.

/_/ 2. A group payment arrangement entered into with the Social Security Administration. This arrangement covers the groups specified below:

/X/ 3. Payment of deductible and coinsurance costs. Such payments are made in behalf of the groups specified below:
Effective October 15, 1982, all individuals eligible under Guam's approved Title XIX Plan, provided the services charged are covered under the Guam Medicaid State Plan.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Guam

Citation		
42 CFR 441.252 AT-78-99	3.4	**Special Requirements Applicable to Sterilization Procedures** All requirements of 42 CFR Part 441, Subpart F are met.

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MARCH 1987

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State/Territory: Guam

1902(a)(10)(E) and 1905(p) of the Act, P.L. 99-509 (Section 9403)

3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries

/_/ (a) The Medicaid agency pays for all of the costs of the following Medicare cost sharing expenses for qualified Medicare beneficiaries described in section 1905(p) of the Act:

(1) Premiums under Medicare Part B and, if applicable, premiums for hospital insurance under Part A;

(2) Deductibles and coinsurance amounts under Medicare Part A and Part B; and

/_/ (3) Premiums for enrollment in an eligible HMO.

(b) The Medicaid agency uses the following methods to provide cost sharing specified under item 3.5(a) above:

/_/ Buy-in agreements with the Secretary of HHS;

/_/ Group premium payment arrangements entered into with the Social Security Administration;

/_/ Payment of deductibles and coinsurance costs;

/_/ Group premium payment arrangements entered into with eligible HMOs.

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State/Territory: Guam

1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)

3.6 Ambulatory Prenatal Care for Pregnant Women During Presumptive Eligibility Period

Ambulatory prenatal care for pregnant women is provided under the plan during a presumptive eligibility period if the care is furnished by a qualified provider in accordance with the requirements of section 1920 of the Act.

/_/ Yes. The requirements of section 1920 of the Act are met.

/X/ Not applicable. Medicaid is not provided to this group under the plan.

3.7 Unemployed Parent

For the purpose of determining whether a child is deprived on the basis of the unemployment of a parent the agency--

____ uses the standard for measuring unemployment which was in the AFDC state plan in effect on July 16, 1996.

__X__ uses the following more liberal standard to measure unemployment: A child will be considered deprived if family income is below the applicable income standard, regardless of the number of hours the parent/caretaker is employed.