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

OMB No.: 0938-0193

State/Territory: Guam

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation	
42 CFR 431.15 AT-79-29	4.1 Methods of Administration The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Guam

4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E. (42 CFR 431.202) (AT-79-29) (AT-80-34)

With respect to transfers and discharges from nursing facilities, the requirements of 1919(e)(3) are met. (1919(e)(3)

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

State/Territory: GUAM

Citation	
42 CFR 431.301 AT-79-29	4.3 Safeguarding Information on Applicants and Recipients Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

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

State/Territory: Guam

Citation	
42 CFR 431.800(c) 50 FR 21839 1903(u)(1)(D) of the Act, P.L. 99-509 (Section 9407)	4.4 **Medicaid Quality Control** (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P. (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j) and (k). /_/ Yes. /X/ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

* insert (j) "ink changes" per PM 87-14

per TN # 87-14

Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

State/Territory: GUAM

Citation	
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5 Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

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

State Guam

Citation		
42 CFR 431.16 AT-79-29	4.6	**Reports** The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

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

State Guam

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

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

JAN 29 1981

State ___Guam___

Citation		
42 CFR 431.18(b) AT-79-29	4.8	**Availability of Agency Program Manuals** Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

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

State Guam

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Revision: HCFA-PM-87-14 (BERC) OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Guam

Citation	
42 CFR 431.51 AT-78-90 46 FR 48524 48 FR 23212 1902(a)(23) of the Act P.L. 100-93 (sec. 8(f))	4.10 Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that any individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual-- (1) Under an exception allowed under 42 CFR 431.54, (2) Under a waiver approved under 42 CFR 431.55, or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act.

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

State Guam

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Department of Public Health and Social Services

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Public Laws of Guam

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

ATTACH 4.11 - A

Standards for Guam Memorial Hospital (being the only hospital) are set by the American Hospital Association. The hospital is fully accredited.

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

State Guam

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Department of PUblic Health and Social Services (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

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

State Guam

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

/_/ Yes, as listed below:

/_/ XX Not applicable. Similar services are not provided to other types of medical facilities.

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

State/Territory: Guam

Citation	4.13 Required Provider Agreement
42 CFR 431.107 AT-79-74 42 CFR Part 442, Subparts A & B	(a) All requirements of 42 CFR 431.107 and Part 442, Subparts A and B are met with respect to agreements between the Medicaid agency and each provider furnishing services under the plan.
1920 of the Act, P.L. 99-509 (Section 9407)	(b) All requirements of section 1920(b)(2) and ~~(c)~~ are met with respect to agreements between the Medicaid agency and each qualified provider furnishing ambulatory prenatal care to pregnant women during a presumptive eligibility period. /_/ Yes. /X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

MEDICAID STATE PLAN SUPPLEMENTAL - Attachment 4.13A

I. A Suspension or Termination of Provider from Participation:

1. Cause for Suspension or Termination:

a. Any violation of rule or regulation of this program by an individual, institution or organization, or any provider's practice which is deemed harmful to public health, safety and the welfare of recipients.

b. The conviction of a provider of a felony, or any offense involving moral turpitude.

c. Fraud against the program such as, but not limited to, the claiming and receiving of payment for services not provided, submittal of claim and acceptance of payment for services already paid, or deliberate preparation of a claim in a manner which causes higher payment than the amount of entitlement.

d. Requiring and receiving payment from a recipient to make up for the difference between the Department's applicable fee schedule or rate, and the provider's customary charges.

e. Action taken by the provider's professional group or organization, or court of law, disapproving the provider's methods of treatment or care as not being within the practice of his profession, or harmful to patient's health and safety.

2. Suspension or Termination Requirements:

a. Adequate substantiated evidence of a violation is obtained.

b. The provider is given full information and notice of the alleged violation and regarding the reason for investigation.

c. The provider is afforded adequate time and opportunity to express his views regarding the problem and to furnish information which may help to disprove the alleged violation.

d. Suspension may be permanent, but not less than one year.

75-13

Attachment 4.13 A

3. Determination to Suspend or Terminate:

Recommendation to suspend or terminate a vendor shall lay with the Medicaid Supervisor and Administrator of Social Services, with appropriate action being taken by the Director of Public Health and Social Services.

Revision: HCFA-PM-88- 10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

State/Territory: GUAM

Citation	4.14 Utilization Control
42 CFR 431.630 42 CFR 456.2 50 FR 15312	(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met: /X/ Directly.
1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	/_/ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO-- (1) Meets the requirements of §434.6(a); (2) Includes a monitoring and evaluation plan to ensure satisfactory performance; (3) Identifies the services and providers subject to PRO review; (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes. /_/ Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designated under 42 CFR Part 462.
1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	/_/ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: GUAM

OMB NO. 0938-0193

Citation		
42 CFR 456.2 50 FR 15312	4.14	(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/_/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/_/ All hospitals (other than mental hospitals).

/_/ Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/Territory: GUAM

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/_/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/_/ All mental hospitals.

/_/ Those specified in the waiver.

/_/ No waivers have been granted.

/X/ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: GUAM

OMB NO. 0938-0193

<u>Citation</u>
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/_/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/_/ All skilled nursing facilities.

/_/ Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: GUAM

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /_/(e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/_/ Facility-based review.

/_/ Direct review by personnel of the medical assistance unit of the State agency.

/_/ Personnel under contract to the medical assistance unit of the State agency.

/_/ Utilization and Quality Control Peer Review Organizations.

/_/ Another method as described in ATTACHMENT 4.14-A.

/_/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/X/ Not applicable. Intermediate care facility services are not provided under this plan.

87-4

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

OMB No.: 0938-0193

State/Territory: Guam

Citation		
1902(a)(30) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	/_/ 4.14 (f)	The Medicaid agency meets the requirements of section 1902(a)(30) of the Act for control of the utilization of services furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

/_/ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ A private accreditation body.

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

State Guam

Citation
42 CFR 456.2
AT-78-90

4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

/x/ Not applicable with respect to intermediate care facility services; such services are not provided under this plan.

/xx/ Not applicable with respect to services for individuals age 65 or over in institutions for mental diseases; such services are not provided under this plan.

/xx/ Not applicable with respect to inpatient psychiatric services for individuals under age 22; such services are not provided under this plan.

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

State Guam

Citation		
42 CFR 431.615(c) AT-78-90	4.16	Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615. ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

ATTACH 4.16 - A

1. The State agency will make cooperative arrangements with State health and State vocational rehabilitation agencies (including agencies which administer or supervise health or vocational rehabilitation services) directed toward maximum utilization of such services in the provision of medical assistance under the plan. Attached are descriptions of the cooperative arrangements.

2. The State agency will make cooperative arrangements with grantees under title V of the Social Security Act to provide for utilizing such grantee agencies in furnishing, to medical assistance recipients, care and services which are available under title V plans or projects and are included in the State plan for title XIX. Such arrangements will include, where requested by the title V grantee, provision for reimbursing the title V grantee for care or services furnished by or through such grantee to individuals eligible therefore under the title XIX plan, and will be in writing.

3. The arrangements with State health and State vocational rehabilitation agencies, and with title V grantees that request provision for reimbursement will include a description, as appropriate, of the items specified in 45 CFR 251.10(a) (3).

Revision: HCFA-AT-82-29 (BPP)
December 1982

State Guam

Citation
42 CFR 433.36(c)
AT-78-90
47 FR 43644

4.17 Liens and Recoveries

Liens are imposed against an individual's property.

/XX/ No.

/ / Yes.

(a) Liens are imposed against an individual's property before his or her death because of Medicaid claims paid or to be paid on behalf of that individual following a court judgement which determined that benefits were incorrectly paid for that individual.

/ / Item (a) is not applicable. No such lien is imposed.

/ / Item (a) applies only to an individual's real property;

/ / Item (a) applies only to an individual's personal property; or

/ / Item (a) applies to both an individual's real and personal property.

(b) Liens are placed against the real property of an individual before his or her death because of Medicaid claims paid or to be paid for that individual in accordance with 42 CFR 433.36(g)(1) and (g)(2).

/ / Item (b) is not applicable. No such lien is imposed.

Revision: HCFA-AT-82-29 (BPP)
December 1982

State Guam

Citation		
42 CFR 433.36(c) AT-78-90 47 FR 43644	4.17 (c)	Adjustments or recoveries for Medicaid claims correctly paid are imposed only in accordance with section 433.36(h).
	(d)	No money payments under another program are reduced as a means of recovering Medicaid claims incorrectly paid.
	(e)	ATTACHMENT 4.17-A —

(a) Specifies the process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the process meets the requirements of 42 CFR 433.36(d).

(b) Defines the terms specified in 42 CFR 433.36(e).

(c) Specifies the criteria by which a son or daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

☆ U.S. GOVERNMENT PRINTING OFFICE: 1982-361-858:72

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

State/Territory: Guam

Citation	
447.51 through 447.58	4.18 Cost Sharing and Similar Charges (a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act, P.L. 99-509 (Sec. 9403(g)(4))	(b) With respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

/_/ Age 19

/_/ Age 20

/_/ Age 21

Reasonable categories of individuals who are age 18 but under age 21 to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation	
447.51 - 58	4.18(b) (2) (Continued) (iii) All services furnished to pregnant women. /_/ Not applicable, Charges apply for services to pregnant women unrelated to the pregnancy.
	(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
	(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
	(vi) Family planning services and supplies furnished to individuals of childbearing age.
	(vii) Services furnished by a health maintenance organization in which the individual is enrolled.
1916 of the Act, P.L. 99-272, (Section 9505)	(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

ation 4.18(b) (Continued)
51 - 58

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/X/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

/_/ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation	
447.51 - 58	4.18(b) (3) (Continued)

(iii) ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/_/ Not applicable. There is no maximum.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation
447.51 - 58

4.18 (Continued)

(c) Individuals are covered as medically needy under the plan.

/xx/ No.

/ / Yes. With respect to them:

(1) An enrollment fee, premium or similar charge is imposed.

/ / Not applicable. No such charge is imposed.

/ / Yes. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation
447.51 - 58

4.18(c) (Continued)

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

/_/ Age 19

/_/ Age 20

/_/ Age 21

Reasonable categories of individuals who are age 18 but under age 21 to whom charges apply are listed below, if applicable:

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation	
447.51 - 58	4.18(c) (2) (Continued) (iii) All services furnished to pregnant women. /_/ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
	(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
	(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
	(vi) Family planning services and supplies furnished to individuals of childbearing age.
1916 of the Act, P.L. 99-272 (Section 9505)	(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation
447.51 - 58

4.18(c) (2) (Continued)

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

/_/ Not applicable. No such charges are imposed.

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

Reasonable categories of individuals who are 18 years of age but under 21 to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: GUAM

Citation 447.51-58

4.18(c) (3) (Continued)

(iii) ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

/_/ Not applicable. There is no maximum.

Medicaid Premiums and Cost Sharing

State Name: Guam

OMB Control Number: 0938-1148

Transmittal Number: GU - 1 4 - 0 2

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. **Yes**

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☒ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☐ The state includes an indicator in the Eligibility and Enrollment System
- ☐ The state includes an indicator in the Eligibility Verification System
- ☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☒ Other process

Description:

Medicaid Program will send a letter to providers informing them of the New Adult Group's co-payment for certain services and that they can charge clients for the co-payment as a condition of receiving the service or item. The state or Territory shall perform pre-payment manual review of claims to verify/check appropriate payment to providers.

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. **No**

Cost Sharing for Drugs

The state charges cost sharing for drugs. **Yes**

The state has established differential cost sharing for preferred and non-preferred drugs. **No**

Medicaid Premiums and Cost Sharing

■ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and 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.

V.20140114

Medicaid Premiums and Cost Sharing

State Name: Guam

OMB Control Number: 0938-1148

Transmittal Number: GU - 14 - 02

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals	G2a
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.	No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and 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.

V.20140113

Medicaid Premiums and Cost Sharing

State Name: Guam

OMB Control Number: 0938-1148

Transmittal Number: GU-14-02

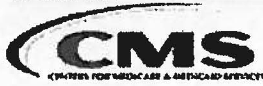
Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and 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.

V.20140116



Medicaid Premiums and Cost Sharing

State Name: Guam

Transmittal Number: GU-14-02

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional): New Adult Group

Eligibility Group(s) Included: Childless adult

Incomes Greater than 100% TO Incomes Less than or Equal to 133%

Service	Amount	Dollars or Percentage	Unit	Explanation
Diagnostic Laboratory	5.00	$	Visit	For visit that agency pays $50 and above
Diagnostic Radiology	5.00	$	Visit	For visit that agency pays $50 and above
Nuclear Medicine	5.00	$	Visit	For visit that agency pays $50 and above
Prescription Drugs	2.50	$	Prescription	For drug that agency pays $25 and above per prescription drug

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Medicaid Premiums and Cost Sharing

Remove Population

Add Population

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and 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.

V.20140107

Medicaid Premiums and Cost Sharing

State Name: Guam

OMB Control Number: 0938-1148

Transmittal Number: GU-14-02

Expiration date: 10/31/2014

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. — No

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. — No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).

■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.

■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.

■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.

■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

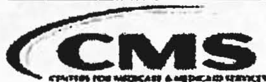
The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:

- ☐ The state accepts self-attestation
- ☐ The state runs periodic claims reviews
- ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
- ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients
- ☒ Other procedure

Description:

A statement will be included in both the member handbook and the provider manual that an Indian as defined in 42 CFR 447.51 who is either currently receiving services has ever received an item or service furnished by an Indian Health Service (HIS) facility or an Indian tribe, Tribal Organization, or Urban Indian Organization (ITU) or through a contract health services referral in any State and the other exemptions specified in 42 CFR 447.56(a) is exempt from all cost sharing.



Medicaid Premiums and Cost Sharing

Additional description of procedures used is provided below (optional):

[■] To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

[ ] The MMIS system flags recipients who are exempt

[ ] The Eligibility and Enrollment System flags recipients who are exempt

[ ] The Medicaid card indicates if beneficiary is exempt

[ ] The Eligibility Verification System notifies providers when a beneficiary is exempt

[ ] Other procedure

Additional description of procedures used is provided below (optional):

Since this cost sharing is targeted to the New Adult Group, none of the individuals who are exempt from cost sharing under the same statue or regulation would be subject to cost sharing. As mentioned above we will be enforcing the Indian exemption by providing information in member handbooks and provider manuals.

Payments to Providers

[✓] The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. | No

Aggregate Limits

[✓] Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

[■] The percentage of family income used for the aggregate limit is:

(●) 5%

( ) 4%

( ) 3%

( ) 2%

( ) 1%

( ) Other: [ ] %

[■] The state calculates family income for the purpose of the aggregate limit on the following basis:

( ) Quarterly

Medicaid Premiums and Cost Sharing

(•) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. | No

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

Guam Medicaid bases the aggregate limit for everyone on the 101% income guideline for a household size of one. Guam provided the following analysis to CMS showing that with the limited cost sharing being proposed it is very unlikely that anyone would reach the aggregate limit of 5% of the individual or family's income per month.

HH Size	100% Monthly	5%	110% Monthly	5%	120% Monthly	5%	133% Monthly	5%
1	$958	$48	$1054	$53	$1,149	$57	$1,274	$64
2	$1293	$65	$1422	$71	$1,551	$78	$1,719	$86

Total cost per month if patient utilizes all the above services with co-pay:

Services	Co-payment Amount
Laboratory- once	$5
Radiology- once	$5
Nuclear Medicine-once*	$5
Prescription - five	$12.50
Total Cost Per Month	$27.50

* This is a type of radiology service that is not frequently utilized. It is very unlikely that the individual would use this service more than once or twice in a year.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. | Yes

Describe the appeals process used:

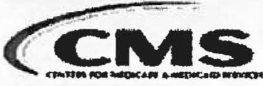
The Medicaid Program has a Fair Hearing Procedures. The client submits the Fair Hearing form to the Fair Hearing Coordinator(FHC). The FHC schedule a Fair Hearing Conference with the agency to discuss the appeal. If the client is not satisfied with the result of the Fair Hearing Conference, then the Fair Hearing is elevated to the Fair Hearing Officer for the final decision.

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Based on the client's/providers appeal, the program shall calculate the aggregate income of the client and calculate the correct cost share/co-payment and reimburse the client through direct payment. For providers, the program shall adjust and reprocess the corrected claim to reimburse the providers.

■ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Not applicable because Guam bases the 5% aggregate limit at 101% of the income guidelines for a household of one regardless of family size, which is the lowest amount for the affected eligibility group, there would not be a need for anyone to have their aggregate limit adjusted.



Medicaid Premiums and Cost Sharing

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).	No

PRA Disclosure Statement

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V.20140116

Reserved

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

State/Territory: Guam

Citation	4.19 Payment for Services
42 CFR 447.252 46 FR 44964 48 FR 56046 50 FR 23009 1902(e)(7) of the Act, P.L. 99-509 (Sec. 9401(d)) SECTION 1902(e)(7) OF THE ACT	(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and section 1902(e)(7) with respect to payment for inpatient hospital services. ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

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

State/Territory: GUAM

Citation		
42 CFR 447.201 42 CFR 447.302 AT-78-90 AT-80-34 1903(a)(1) and (n) and 1920 of the Act, P.L. 99-509 (Section 9403, 9406 and 9407) 52 FR 28648	4.19 (b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the requirements of 42 CFR Part 447, Subpart D, with respect to payment for all other types of services provided under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, skilled nursing and intermediate care facility services that are described in other attachments.

GUAM PAYMENT FOR INPATIENT HOSPITAL SERVICES

I. Payment Rates

1) Guam Hospitals

(a) Medicaid will pay all Guam inpatient hospital services that are covered by the Medicaid Program the lowest of the following:

i) hospital's current Medicare Interim Rate;
ii) 80% of hospital's current Medicare Interim Rate if the hospital's Medicare Interim Rate exceeds the lowest prevailing on-island hospital Medicare Interim Rate;
iii) negotiated rate of hospital's current Medicare Interim Rate.

2) Off-Island Hospitals

(a) For Hawaii hospitals, Medicaid will pay based on the individual hospital's Medicare Interim rate for the service, reimbursable on a claims basis.

(b) For California hospitals, Medicaid will pay based on the individual hospital's Medicare Interim rate for the service, reimbursable on a claims basis.

(c) All other hospitals, Medicaid will pay based on the individual hospital's Medicare Interim rate for the service, reimbursable on a claims basis.

(d) For services that cannot be provided by a provider that accepts payments under (a) through (c), Medicaid will pay based on the Charged Master w/discount of 45 to 55% or at negotiated rates that will not exceed the provider's customary charge.

(e) Out of Country hospitals, Medicaid will pay based on negotiated rates not to exceed 90% of Provider's Usual Customary Charges.

3) The Medicare Interim Rate is Medicare's annually computed interim payment rate, based on the hospital's latest available cost report, which estimates as closely as possible the Medicare actual reimbursable inpatient hospital cost for the service period.

4) Administrative Days. Reimbursement for patients receiving services at a Skilled Nursing Facility (SNF) level of care in an acute bed under conditions similar to those described in Section 1861 (v)(1)(G) of the Social Security Act will be at the same rate paid for SNF services provided to patients in GMH's SNF. The methodology and standards used to determine these rates are described under 4.19 Attachment D of this State Plan.

5) Medicaid shall not pay providers more than the billed charges.

REVISION:

II. Upper Payment Limits

The rates Guam Medicaid negotiates will not exceed either what Medicare would have paid for those Medicaid services or the cost of those Medicaid services under Medicare cost principles.

III. Appeals Procedures

Hospitals may appeal to address errors in rate setting and rate payments.

IV. Public Process

The State/Territory has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

V. Non-Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions
[42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903]

- Payment Adjustment for Provider-Preventable Conditions

  The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

- Health Care-Acquired Conditions (HCAC)

  Guam identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A of this State Plan.

  _X_ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

- Other Provider-Preventable Conditions (OPPC)

  Guam identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A of this State Plan.

  _X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

  ____ Additional Other Provider-Preventable Conditions identified below:

Guam performs utilization reviews on all on-island and off-island claims. The additional hospital inpatient days associated with the HCAC or OPPC will be identified and denied for per diem payments and any charges associated with the HCAC or OPPC will be denied for payments where the off-island hospital is reimbursed based on a percentage of charges.

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.

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

State/Territory: GUAM

Citation	
42 CFR 447.201 42 CFR 447.302 AT-78-90 AT-80-34 1903(a)(1) and (n) and 1920 of the Act, P.L. 99-509 (Section 9403, 9406 and 9407) 52 FR 28648	4.19 (b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the requirements of 42 CFR Part 447, Subpart D, with respect to payment for all other types of services provided under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, skilled nursing and intermediate care facility services that are described in other attachments.

Attachment 4.19-B

The Agency uses the following reimbursement principles in paying for each type of medical service:

A. Physician Services

1. Primary Care Physician Services/Evaluation and Management Services

Effective January 1, 2011, Medicaid will use the 100% Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com.

If the fee schedule is not available and not covered by Medicare, Medicaid will utilize the Current Medicare RBRVS Fee Schedule calculated based on Hawaii locality and Current Medicare Conversion Factor available at the Bureau of Health Care Financing Administration (BHCFA) office.

2. Anesthesia Services

Effective January 1, 2011, Medicaid will use the [2008 Crosswalk American Society of Anesthesiologist (ASA) Base Anesthesia Unit + Time Unit + ASA Physical Status Unit (any modifying factor/qualifying circumstance)] x Current Hawaii Medicare Fee Schedule Conversion Factor (CF) published at https://med.noridianmedicare.com. Time Unit is based on 15 minutes increments.

3. Surgery and All Other Physician Services

Effective January 1, 2011, Medicaid will use the 100% Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com.

If the fee schedule is not available and not covered by Medicare, Medicaid will utilize the Current Medicare RBRVS Fee Schedule calculated based on Hawaii locality and Current Medicare Conversion Factor available at the Bureau of Health Care Financing Administration (BHCFA) office.

Assistant Physician Surgeon will be paid at 15% of Surgeon's Fee.

B. Other Practitioner Services

Effective January 1, 2011, Medicaid will pay at 65% of Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com for Nurse Midwives and 85% of Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com for all Other Practitioners.

C. Clinic Services

Effective January 1, 2011, Medicaid will pay the same reimbursement and methodology used to pay physician services (see Item A).

D. Laboratory Services

Payment will be the lowest of the billed charges or the Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com.

E. Radiological Services

Effective January 1, 2011, Medicaid will use the 100% Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com.

If the fee schedule is not available and not covered by Medicare, Medicaid will utilize the Current Medicare RBRVS Fee Schedule calculated based on Hawaii locality and Current Medicare Conversion Factor available at the Bureau of Health Care Financing Administration (BHCFA) office.

F. Drugs

Medicaid implements the drug formulary which includes the name of drugs covered by Medicaid, the strength, the MAC and maximum and minimum allowable quantity effective July 1, 1991. The MAC is based on the lowest updated Average Wholesale price on the Red/Blue Book and/or Medispan, plus a reasonable dispensing fee of $4.40 which is 60% more than its previous years' dispensing fee of $2.75.

Note: The agency will review and update the drug formulary annually, in January.

If the pharmacist has in his inventory drugs with ingredient costs less than the MAC of acceptable quantity, he is required to charge Medicaid at the lower cost. (*MAC as used by Guam means the upper limit payable for any service under Medicaid.) In case of HHS/MAC drugs, Guam uses the rate set by the Secretary of HHS.

G. Eyeglasses

Medicaid will pay provider charges for corrective eyeglasses, not to exceed eighty dollars ($80.00) and bifocal eyeglasses not to exceed one hundred twenty eight dollars ($128.00) including lens and frame.

H. Dental Services

Effective January 1, 2011, Medicaid will use the 40% of 2001 American Dental Association Fee Schedule available at the BHCFA office.

I. Medical Supplies and Equipments

Medicaid pays based on Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com and not to exceed provider's acquisition cost.

J. Hearing Aids

Medicaid pays the provider's charges not to exceed provider's acquisition cost.

K. Hospital Ancillary Services

Medicaid will pay Guam hospital ancillary services including operating room, laboratory, x-ray, physical, occupational and inhalation therapy; renal dialysis; etc., the lowest of the following:

i) hospital's current Medicare Interim Rate;
ii) 90% of hospital's current Medicare Interim Rate if the hospital's Medicare Interim Rate exceeds the lowest prevailing on-island hospital Medicare Interim Rate;
iii) negotiated rate of hospital's current Medicare Interim Rate.

L. Hospital Physical and Occupational Therapy

Medicaid will pay outpatient hospital physical and occupational therapy services without limitation the lowest of the following:

i) hospital's current Medicare Interim Rate;
ii) 90% of hospital's current Medicare Interim Rate if the hospital's Medicare Interim Rate exceeds the lowest prevailing on-island hospital Medicare Interim Rate;
iii) negotiated rate of hospital's current Medicare Interim Rate.

This reimbursement will encompass both the professional and the facility component of all Physical and Occupational Therapy services.

M. Home Health Services

Medicaid pays Home Health services according to the CMS Federal Register National Per-Visit Rate (Federal Register Website).

N. Ambulatory Surgical Services

Effective January 1, 2011, Medicaid will pay according to the negotiated rates starting at Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com and not to exceed 70% of Provider's Usual Customary Charges.

O. Hospice Care

Effective January 1, 2011, Medicaid will pay according to the Annual Hospice Rates Established under Medicare published at https://med.noridianmedicare.com.

P. Medical Transportation Services

Effective January 1, 2011, Medicaid will pay medical transportation services on negotiated rates starting at Current Hawaii Medicare Fee Schedule published at https://med.noridianmedicare.com and not to exceed 70% of Provider's Usual Customary Charges.

Medicaid does not reimburse for non-emergency medical transportation expense on the usage of their car or transportation provided by friends, family or bus because Guam is 30 miles long and 4 miles to 12 miles wide, and the distance of travel and associated costs are minimal.

Q. Free-Standing Birthing Center Services

Effective January 1, 2011, Medicaid will pay according to the negotiated rates starting at the lowest Guam hospital Medicare Interim Rates and not to exceed 70% of Provider's Usual Customary Charges.

R. Outpatient Hemodialysis Services

Effective January 1, 2011, Medicaid will pay according to the Facility's Current Medicare Interim Rate.

S. Outpatient and Emergency Room Services

Medicaid will pay outpatient and emergency room services the lowest of the following:

i) hospital's current Medicare Interim Rate;
ii) 90% of hospital's current Medicare Interim Rate if the hospital's Medicare Interim Rate exceeds the lowest prevailing on-island hospital Medicare Interim Rate;
iii) negotiated rate of hospital's current Medicare Interim Rate.

T. Wellness and Fitness Services-Applicable to the Alternative Benefit Plan only

Medicaid will pay provider charges for Well ness services not to exceed two hundred dollars ($200.00) per Medicaid beneficiary annually, unless prior authorization is granted. Medicaid will pay providers for Fitness services not to exceed 90% of the monthly membership fees.

U. Mental Health Rehabilitative Services

Medicaid will pay provider for mental health rehabilitative services as follows:

Service Plan Development/Crisis Evaluation Plan-$24.80 first 15 minutes; $16.00 per next 15 minutes increment; maximum 3 hours.

Therapy and Medication Management - Medicaid will reimburse all therapy services, including individual therapy, group therapy and family counseling, at the Medicaid reimbursement rate for "Other Practitioner Services" as described in Attachment 4.19-B, page 1, Item B.

Care Coordination-$10.40 first 15 minutes; $8.00 per next 15 minutes increment; maximum 1.5 hours.

V. Hospital-Based Clinic Services

Medicaid will pay hospital-based clinic services the lowest of the following:

i) hospital's current Medicare Interim Rate;
ii) 90% of hospital's current Medicare Interim Rate if the hospital's Medicare Interim Rate exceeds the lowest prevailing on-island hospital Medicare Interim Rate;
iii) negotiated rate of hospital's current Medicare Interim Rate.

On-Island Providers will be reimbursed based on the methodologies described under (A) through (V). Off-Island Providers will also be reimbursed based on the methodologies described under (A) through (V), except for (K), (L), (S), (T), (U), and (V). Off-Island Hospital outpatient services, described in paragraphs (K), (L), (S) and (V) are reimbursed at the off-island hospital's Medicare interim rate. Paragraphs (T) and (U) are not applicable for off-island.

For Off-Island Providers that will not accept payments as described in the previous paragraph and the service is evident to save life or significantly alter an adverse prognosis or the prognosis for survival and recovery requires the immediate medical service, Medicaid will negotiate competitive rates starting at the above reimbursement rates, with consideration of current Hawaii Medicare Fee Schedule published at contracted provider's website, and not to exceed 70% of Provider's Usual Customary Charges.

Out of Country Providers will be reimbursed based on negotiated rate not to exceed the Current Hawaii Medicare Fee Schedule for service under (A) through (S) and (V) above. If the fee schedule is not available and not covered by Medicare, reimbursement will be based on negotiated rate not to exceed 100% of Contracted Out-of-Country Provider's Usual Customary Charges/Acquisition Cost.

Except as otherwise noted in the plan, territory-developed fee schedule rates are the same for both governmental and private providers and providers shall not be paid more than the billed charges, as outlined in items A to V above.

All providers are required to submit claims within one (1) year from the date of service except for Medicaid with Third Party Liability (TPL) which should be submitted within sixty (60) days from the receipt date of the TPL payments/statements.

Medicaid will pay the full amount of deductible, co-payment, and co-insurance for recipients who have Medicaid with TPL coverage provided the service charges are covered under the Guam Medicaid State Plan and not to exceed the Medicaid applicable reimbursement methodology outlined under (A) through (V) above.

Medicaid does not pay Non-Participating except in emergency cases, Medicaid will pay up to the Medicaid applicable reimbursement methodology outlined under (A) through (S), (U) and (V) above and Medicaid is the Payor of Last Resort.

Non-Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions [42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903]

- Payment Adjustment for Provider-Preventable Conditions
  The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider preventable conditions.

- Other Provider-Preventable Conditions (OPPC)
  Guam identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B of this State Plan.
  _X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

  ____ Additional Other Provider-Preventable Conditions identified below:

Any charges related to OPPC shall be denied.

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

State Guam

Citation		
42 CFR 447.40 AT-78-90	4.19 (c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

/_/ Yes. The State's policy is described in ATTACHMENT 4.19-C.

/X/ No.

Revision: HCFA-PM-87-9 (BERC) AUGUST 1987

OMB No.: 0938-0193

State/Territory: GUAM

Citation	4.19 (d)
42 CFR 447.252 47 FR 47964 48 FR 56046 42 CFR 447.280 47 FR 31518 52 FR 28141	/X/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/X/ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/X/ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/XX/ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Skilled Nursing Facility (SNF) Reimbursement Methodology

Guam Medicaid will reimburse for Skilled Nursing Facility services on a Medicare Prospective Payment System (PPS) Resource Utilization Group (RUG) rate. The payment rate must not exceed the provider's customary charges to the general public and the Medicare reimbursement standard.

Guam Medicaid will require the provider (hospital) to submit a copy of their current Medicare cost report.

Non-Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions
[42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903]

- Payment Adjustment for Provider-Preventable Conditions

  The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

- Other Provider-Preventable Conditions (OPPC)

  Guam identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-D of this State Plan.

  _X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

  ____ Additional Other Provider-Preventable Conditions identified below:

Guam performs utilization reviews on all on-island SNF claims; the additional skilled nursing facility days associated with the OPPC will be identified and denied for per diem payments.

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.

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

State Guam

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Attachment 4.19E

Definition of a Claim

A Claim is a statement for services rendered to Medicaid recipient for the same illness by one service provider.

State/Territory: Guam

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

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

State Guam

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19 (g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State Guam

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

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

State Guam

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19 (i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Citation		
42 CFR 447.201 42 CFR 447.205 AT-78-37 46 FR 58677	4.19 (j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(a)(1) of the Act, P.L. 99-509 (Sec. 9403(g)(2))	/_/ (k)	With respect to payments for Medicare cost sharing (as defined in section 1905(p)(3) of the Act) for qualified Medicare beneficiaries, the Medicaid agency meets the requirements of section 1903(a)(1) of the Act.
1902(n) of the Act, P.L. 99-509 (Sec. 9403(e))		The agency pays an amount for Medicare cost sharing and any other payment amount for an item or service under title XVIII of the Act that exceeds the amount otherwise payable under the plan for eligible individuals who are not qualified Medicare beneficiaries. /_/ Yes. The methods and standards used for the payment of these services are described in ATTACHMENT 4.19-B. /X/ Not applicable.
1920 of the Act, P.L. 99-509 (Section 9407)	/_/ (l)	The Medicaid agency meets the requirements of section 1920(d) of the Act with respect to payment for ambulatory prenatal care furnished to pregnant women during a presumptive eligibility period.
1903(v) of the Act, P.L. 99-509 (Section 9406)	(m)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act. ATTACHMENT 4.19-B describes the methods and standards used to determine payment of these services.

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: GUAM

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

~~X~~ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

X sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

1. All Medicaid private providers, Pediatricians, Family Practitioners and General Practitioners are supplied with free vaccines for administration to Medicaid eligible clients. These providers are paid by Medicaid for administering the vaccine aside from the regular clinic visit services.

2. All AFDC-EPSDT eligible clients are informed of available services including immunization through several venues:

During mass screening orientation;

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

State Guam

Citation		
42 CFR 447.25(b) AT-78-90	4.20	Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

/_/ Yes, for /_/ physicians' services

/_/ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

/XX/ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP) 10-81

State Guam

Citation

42 CFR 447.10(c)
AT-78-90
46 FR 42699

4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

State/Territory: GUAM

Citation	
433.137(a) 50 FR 46652	4.22 Third Party Liability (a) The Medicaid agency meets all requirements of 42 CFR 433.138 and 433.139.
433.138(f) 52 FR 5967	(b) ATTACHMENT 4.22-A -- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
433.138(g)(1)(ii) and (2)(ii) 52 FR 5967	(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
433.138(g)(3)(i) and (iii) 52 FR 5967	(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and
433.138(g)(4)(i) and (iii) 52 FR 5967	(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GUAM

Requirements for Third Party Liability -
Identifying Liable Resources

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

State/Territory: GUAM

Citation	
433.139(f)(2) and (3) 50 FR 46652	(c) ATTACHMENT 4.22-B specifies the threshold amount or other guideline used in determining whether to seek reimbursement from a liable third party; or describes the process by which the agency determines that seeking reimbursement would not be cost effective. It also specifies the dollar amount or time period the State uses to accumulate billings from a particular liable third party for this purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GUAM

**Requirements for Third Party Liability -
Payment of Claims**

If a Third Party Liability exists, Medicaid Providers are required to seek reimbursement (regardless of the dollar amount) from the liable third party first before charging Medicaid.

If the Agency identifies the Third Party Liability after a claim is paid, it will seek reimbursement from the third party within thirty (30) days after the end of the month it learned of the existence of the third party provided the amount exceeds $5.00.

Revision: HCFA-PM-86-3 (BERC)
MARCH 1986

State/Territory: GUAM

Citation	4.22 (continued)
42 CFR 433.151(a) 50 FR 46652	(c) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following: (Check as appropriate.) /X/ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met. /_/ Other appropriate State agency(s)-- ______ /_/ Other appropriate agency(s) of another State-- ______ /_/ Courts and law enforcement officials.
42 CFR 433.151(b) 50 FR 46652	(d) The Medicaid agency meets the requirements of 42 CFR 433.153 and 433.154 for making incentive payments and for distributing third party collections.

Revision: HCFA-AT-84-2 (BERC)
01-84

State GUAM

Citation		
42 CFR Part 434.4 48 FR 54013	4.23	Use of Contracts The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434. /_7 Not applicable. The State has no such contracts.

TN # 84-2
Supersedes
TN # 80-9

Approval Date 8-3-84 Effective Date 7-1-84

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Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: GUAM

Citation		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. _x_ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan. _X_ Not applicable to nursing facilities for the mentally retarded; such services are not provided under this plan.

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

State Guam

Citation		
42 CFR 431.702 AT-78-90	4.25	Program for Licensing Administrators of Nursing Homes The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

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

State Guam

4.26 [Reserved]

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

JAN 29 1981

State Guam

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	**Disclosure of Survey Information and Provider or Contractor Evaluation** The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Citation	
42 CFR 431.152 AT-79-18 52 FR 32544	4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities The Medicaid agency has established appeals procedures for skilled nursing and intermediate care facilities as specified in 42 CFR 431.153 and 431.154. /X/ Not applicable to intermediate care facilities; such services are not provided under this plan.

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

State Guam

Citation		
Sec. 1902(a) (4)(C) of the Act P.L. 95-559, sec. 14 AT-79-42	4.29	**Conflict of Interest Provisions** The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by Section 207 or 208 of title 18, United States Code.

State/Territory: Guam

Citation	
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals (a) All requirements of 42 CFR Part 1002, Subpart B are met. /_/ The agency, under the authority of State law, imposes broader sanctions.

State/Territory: Guam

Citation	
	(b) The Medicaid agency meets the requirements of--
1902(p) of the Act P.L. 100-93 (secs. 7)	(1) Section 1902(p) of the Act by excluding from participation--
	(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
	(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--
	(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
	(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

State/Territory: Guam

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by-- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Guam

Citation	
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8(f))	4.31 <u>Disclosure of Information by Providers and Fiscal Agents</u> The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967	4.32 <u>Income and Eligibility Verification System</u> (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (b) <u>ATTACHMENT 4.32-A</u> describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: GUAM

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The Guam Public Welfare Division requests information to verify Medicaid eligiblity and recipient income for each applicant as specified under provisions of 42CFR 435.948 (a) (2), (3) (4), & (6).

Provision 42 CFR 435.948 (a) (6) is met by Guam Welfare as follows:

Any additional income, resource, or eligibility information concerning Guam applicants and recipients is routinely requested and verified from agencies within Guam and other States administering the programs described in 42CFR 435.948 (a) (6).

☆U.S. GOVERNMENT PRINTING OFFICE: 1986 491 264 42132

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Guam

Citation	
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))	4.33 Medicaid Eligibility Cards for Homeless Individuals (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address. (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Guam

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

1. The Medicaid Card is mailed out to the mailing address indicated in the Public Assistance Recipient's application form submitted to the Department of Public Health and Social Services.

2. The Medicaid Card may be mailed to the address of relatives as indicated in the Public Assistance Recipient's application form submitted to the Department of Public Health and Social Services.

3. The Medicaid Card may be picked up at the Department of Public Health and Social Services as requested by the Public Assistance Recipient.

4. The Medicaid Card may be mailed to the Village Commissioner for homeless individuals where the Public Assistance Recipient may call.

Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

State/Territory: GUAM

Citation	
1137 of the Act P.L. 99-603 (sec. 121)	4.34 Systematic Alien Verification for Entitlements The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/_/ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/_/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/_/ Total waiver

/_/ Alternative system

/_/ Partial implementation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GUAM

Citation
1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GUAM**

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GUAM**

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 01, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

ATTACHMENT 4.42-A

Employee Education About False Claims Recoveries.

An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually. The Agency shall determine which individuals or organizations meet the definition of entity and notify the individual or organization in writing no later than November 15 each year.

For calendar year 2007, an entity that has met the $5,000,000 annual threshold shall be required to submit by July 31, 2007 the following: 1) A copy of the entity's policies and procedures which should include a brief description of the Federal law and any local laws on false claims and whistleblower protection, and 2) a copy of the employee handbook, if one exists, which contains the rights of the employees to be protected as whistleblowers and the procedures for preventing fraud, waste, and abuse. For subsequent years, entities that meet the $5,000,000 annual threshold by September 30 will be required to submit the above information by January 1 of the following year. The Agency will re-assess the entity's compliance on an ongoing basis by reviewing their policies and ensuring they are in conformity with the False Claims Act and the other provisions named in section 1902(a)(68).

The Agency will send reminder notices no later than December 15 of each year to the entity regarding the requirements of section 1902(a)(68) of the Act, P.L. 109-171 (section 6032). The provider's failure to meet the requirements could result in the forfeiture of all Medicaid payments during the period of noncompliance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GUAM

Citation	
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Guam

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

The Medicaid agency shall not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States. [Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)]

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	____The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. ✓ The State is seeking an exception to establishing such program for the following reasons: **Guam's Medicaid funds come in the form of an annual capped block grant, and because health care on the island is predominantly provided by the government, procuring a Recovery Audit Contractor is not a feasible option for Guam.**
Section 1902(a)(42)(B)(ii)(I) of the Act	____The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: ____The State will make payments to the RAC(s) only from amounts recovered.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	____The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments. The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): ____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. ____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	_____The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(III) of the Act	_____The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
	_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ___Guam_______

4.46 PROVIDER SCREENING AND ENROLLMENT

The Medicaid agency gives the following assurances:
[1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152]

PROVIDER SCREENING

__X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(3), 1902(a)(77) and 1902(kk) of the Act. (42 CFR 455 Subpart E)

ENROLLMENT AND SCREENING OF PROVIDERS (42 CFR 455.410)

__X_ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

__X__Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

VERIFICATION OF PROVIDER LICENSES (42 CFR 455.412)

__X__Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

REVALIDATION OF ENROLLMENT (42 CFR 455.414)

__X__Assures that providers will be revalidated regardless of provider type at least every 5 years.

TERMINATION OR DENIAL OF ENROLLMENT (42 CFR 455.416)

__X__Assures that the State Medicaid agency will comply with section 1902(a)(3) of the Act and with the requiremens outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ___Guam_______

REACTIVATION OF PROVIDER ENROLLMENT (42 CFR 455.420)

__X__Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

APPEAL RIGHTS (42 CFR 455.422)

__X__Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

SITE VISITS (42 CFR 455.432)

_X__Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderated" or 'high" risk categories will occur.

CRIMINAL BACKGROUND CHECKS (42 CFR 455.434)

_X__Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

FEDERAL DATABASE CHECKS (42 CFR 455.436)

_X__Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

NATIONAL PROVIDER IDENTIFIER (42 CFR 455.440)

_X_Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Guam

SCREENING LEVELS FOR MEDICAID PROVIDERS (42 CFR 455.450)

_X_ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

APPLICATION FEE (42 CFR 455.460)

_X_ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(i)(2)(C) of the Act and 42 CFR 455.460.

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS (42 CFR 455.470)

_X_ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

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 0938-1151. The time required to complete this information collection is estimated to average 15 minutes 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.