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 www.palmettogba.com/Medicare

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 www.palmettogba.com/Medicare. 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 www.palmettogba.com/Medicare.

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 www.palmettogba.com/Medicare for Nurse Midwives and 85% of Current Hawaii Medicare Fee Schedule published at www.palmettogba.com/Medicare 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 (Off-Island and On-Island)

Payment will be the lowest of the billed charges or the Current Hawaii Medicare Fee Schedule published at www.palmettogba.com/Medicare.

E. Radiological Services

Effective January 1, 2011, Medicaid will use the 100% Current Hawaii Medicare Fee Schedule published at www.palmettogba.com/Medicare.

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 www.palmettogba.com/Medicare 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 all Guam outpatient hospital ancillary services including operating room, laboratory, x-ray, physical, occupational and inhalation therapy; renal dialysis; etc., based on the lowest of the following:

i) The hospital's own Medicare interim rate in effect;
ii) A negotiated rate that does not to exceed 120% of the lowest Medicare interim rate for on-island hospitals;
iii) The hospital's billed charges.

The reimbursement methodology for Physical and Occupational Therapy services performed in the hospital are explained in item L below.

L. Physical and Occupational Therapy

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

i) The hospital's own Medicare interim rate in effect;
ii) A negotiated rate not to exceed 120% of the lowest Medicare interim rate for on-island hospitals, and
iii) The hospital's billed charges.

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 www.palmettogba.com/Medicare 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 www.cms.gov/center/hospice.asp.

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 www.palmettogba.com/Medicare 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) The hospital's own Medicare interim rate in effect;
ii) A negotiated rate not to exceed 120% of the lowest Medicare interim rate for on-island hospitals, and
iii) The hospital's billed charges.

T. Hospital-Based Clinic Services

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

i) The hospital's own Medicare interim rate in effect;
ii) A negotiated rate not to exceed 120% of the lowest Medicare interim rate for on-island hospitals, and
iii) The hospital's billed charges.

U. 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.

For services that cannot be provided by a provider that accepts payments under (A) through (T) 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 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 (T) 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.

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 (U) 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 (T) 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 4.19-8 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.