Gmail by Google

Speaker Won Pat <speaker@judiwonpat.com>

Messages and Communications

Speaker Won Pat <speaker@judiwonpat.com> Wed, Jan 21, 2015 at 9:48 AM
To: Guam Legislature Clerks Office <clerks@guamlegislature.org>

1/21/2015	1/21/2015	Guam State Clearing House	Ref: Department of Public Health & Social Services, Guam Medicaid State Plan Amendment- Mental Health Rehabilitative Services. SAI # 17001151002N	33-15-0084

——— Forwarded message ———
From: **TrinaJae Apatang** <trinajae.apatang@guam.gov>
Date: Wed, Jan 21, 2015 at 8:52 AM
Subject: NOTICE OF FEDERAL GRANT APPLICATION FOR DPHSS (022N)-REVISED
To: Speaker Won Pat <speaker@judiwonpat.com>

Buenas yan Hafa Adai! . Please see attached federal grant application for Department of Public Health & Social Services. This is a revision as the last email sent was addressing the 32nd Guam Legislature. I apologize for the mistake. Thank you!

V/R,
Trina

–

Trinajae M. Apatang
Grant Specialist · Guam State Clearinghouse
OFFICE OF THE LIEUTENANT GOVERNOR
P.O.Box 2950 *Hagåtña*, Guam 96932
W. (671) 475-9384
F. (671) 472-2007

Office of the Governor of Guam.
Ricardo J. Bordallo Governor's Complex, Adelup, Guam 96910
Tel: (671) 472-8931 • Fax: (671) 477-4826 • governor.guam.gov

Please consider the environment before printing this email.

33-15-0084
Office of the Speaker
Judith T. Won Pat, Ed.D
Date: 01/21/2015
Time: 9:55AM
Received By: CARL SANCHEZ MHA

–

Ufisinan I Etmås Ge'helo'Gi Liheslaturan Guåhan
Office of Speaker Judith T. Won Pat, Ed.D.
Kumiten Idukasion Tinakhelo', Kottura, Laibirihan Pupbleko siha yan Asunton Famalao'an
155 Hesler Place, Suite 201, Hagatna, Guam 96910
Tel: (671) 472-3586 Fax: (671) 472-3589
www.guamlegislature.com / speaker@judiwonpat.com

3 attachments

NOTICE- SPKR 002N.docx
381K

DPHSS State Plan 002N.pdf
1042K

FY2015 Medicaid Grant Award.pdf
588K

2015 JAN 21 AM 09:01

0084

GUAM STATE CLEARINGHOUSE
P.O. Box 2950 Hagåtna, Guam 96932
Tel: (671) 475-9380
Website: www.gsc.guam.gov
Email: clearinghouse@guam.gov

January 16, 2015

HONORABLE JUDITH T. WON PAT, Ed. D.
Speaker gi I Mina'Trentai Tres Na Liheslaturan Guåhan
155 Hesler Place
Hagåtña, Guåhan 96910

Ref: Department of Public Health & Social Services, Guam Medicaid State Plan Amendment-Mental Health Rehabilitative Services. SAI # 17001151002N

*Hafa Adai*Madam Speaker,

This letter is to respectfully notify you the Guam State Clearinghouse (GSC) has received a federal grant application from the Department of Public Health & Social Services (DPHSS). The GSC has accepted the application, assigned the State Application Identifier (SAI) 17001151002N and has initiated the process for an area wide review. An abstract of the project is provided below.

Grantor: Centers for Medicare and Medicaid Services
Grant Title/
Project Title: Medicaid Program
Details: Funds from this grant will be used in support of the continuation of the DPHSS's Mental Rehabilitative services. These services are to include individual and group therapies or interventions designed to provide a reduction of mental disability and improvement in community functioning consistent with the goals of resolving and/or ameliorating the individual's emotional and behavioral needs. This includes improving the capacity of the caregiver(s) to provide rehabilitative services to a person with mental, behavioral, or emotional disorder sufficient to meet diagnostic criteria. These services include assessment, service plan development, therapy, rehabilitation, and collateral contact. Funds will also be used towards administrative costs.

Start Date: 10/01/2014 **End Date:** 09/30/2015
Federal Grant: $1,023,506.00

GSC conducts area wide reviews and solicits comments through electronic communication and this notice is sent to you as a part of the review process. A digital copy of the grant proposal is attached for your perusal. Please submit any comments you may have pertaining to this proposal to Trinajae M. Apatang by **January 21, 2015**via email attrinajae.apatang@guam.gov.

Dangkolo Na Si Yu'os Ma'åse',

Kate G. Baltazar
Administrator
TMA
Cc: Fil

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

JAMES W. GILLAN
DIRECTOR

LEO G. CASIL
DEPUTY DIRECTOR

JAN 15 2015

MEMORANDUM

TO: Governor of Guam

FROM: Director, Department of Public Health and Social Services

SUBJECT: Guam Medicaid State Plan Amendment – Mental Health Rehabilitative Services

Submitted for your review and approval is the proposed Guam Medicaid State Plan Amendment for Mental Health Rehabilitative Services. The Guam Medicaid program will be providing mental health rehabilitative services coverage to the recipients. The amendment requires that the Medicaid agency comply with the requirements determined by the Secretary to be necessary for the Medicaid Program established under Title XIX of the Social Security Act.

Your immediate attention and approval is highly appreciated. Should there be any questions or comments, please call Ms. Teresa M. Bondoc, Bureau of Health Care Financing Administration (BHCFA) Administrator, at 735-7470 or Ms. Teresita Gumataotao, BHCFA Program Coordinator IV, at 735-7293.

Sincerely

JAMES W. GILLAN

123 CHALAN KARETA, MANGILAO, GUAM 96913-6304
www.dphss.guam.gov • Ph.: 1.671.735.7102 • Fax: 1.671.734.5910

GUAM STATE CLEARINGHOUSE

P.O. Box 2950 Hagåtna, Guam 96932
Tel: (671) 475-9380
Website: www.guamclearinghouse.com
Email: clearinghouse@guam.gov

EDWARD J.B. CALVO
I Maga'låhen Guahan

RAYMOND S. TENORIO
I Segundu Na Maga'låhen Guahan

Grant Project Application
Notice of Intent to Apply for Federal Assistance

GSC FORM REVISED 03/21/2012

SIGNATURE

GUAM STATE CLEARINGHOUSE

Guam State Clearinghouse Use Only	
Date Received:	01/15/2015 5:00
Received By:	
SAI Number:	1700115 1002 N

Type of Application ☐ New Grant* ☒ Continuing Grant** ☐ Supplemental Grant** ☐ Other*

A.) DUNS Number: 778904292 B.) Date: Jan 14, 2015

C.) Applicant/Department Name: Department of Public Health & Social Services

D.) Division: Division of Public Welfare

E.) Applicant Address: 123 Chalan Kareta; Mangilao, GU 96913-6304

F.) Applicant/Department Point of Contact Information

Contact Person Name: Teresa M. Bondoc Phone Number: 735-7470

E-mail Address: teresa.bondoc@dphss.guam.gov

G.) Due Date to Federal Agency: 1/16/15

H.) Federal Funds
- a.) Grant: $1,250,952.00
- b.) Other:

I.) Non-Federal, Matching Funds
- a.) Local: $1,023,506.00
- b.) In-Kind:
- c.) Other:

J.) TOTAL FUNDS: $2,274,458.00

K.) CFDA/Federal Program Name: Medicaid Program

L.) Federal Agency Name: Centers for Medicare and Medicaid Services 93.778

M.) Federal Agency Address: 90 7th St., Suite 5-300 (5W); San Francisco, CA 94103-6707

** Proceed to Question Section O.*
***Proceed to Section N - ONLY APPLICABLE TO CONTINUING AND SUPPLEMENTAL GRANTS.*

N.) For Continuing or Supplemental Grants, Please provide the following information:

a.) Initial Grant Period: 10/01/2014

b.) Guam State Clearinghouse SAI Number:

c.) Grant Year This Application Impacts: FY2015

O.) Has the Federal Funding Agency been notified? ☒ YES ☐ NO

P.) During which Fiscal Year will this program be implemented? FY2015

Q.) If the project requires local funding in addition to the federal funding requested, please specifically identify source and rationale:

General Fund-Matching Local Funds for Medicaid.

R.) This program is: ☒ Budgeted - Please identify legal budget authority PL32-181

☐ Non-Budgeted

S.) Will this program require the hiring of additional employees? Is YES, please provide the number of employees (both existing and new) and justification. ☐ YES - Esixting New ☒ NO

T.) List Departments and Agencies that would be affected directly or indirectly by this application: Guam Behavioral Health and Wellness Center

U.) Please provide a Project Summary with supporting documents if needed: Amendments-Title XIX of the Social Security Act: Mental Health Rehabilitative Services

V.) Please answer the following:

a.) Does this application require an Environmental Impact Study? ☐ YES ☒ NO

b.) Will this application conflict with any existing law? ☐ YES ☒ NO

c.) Is enabling legislation required? ☐ YES ☒ NO

d.) Will the program require a maintenance of effort? ☐ YES ☒ NO

e.) Are in-kind services allowed for this program? ☐ YES ☒ NO

f.) Does this program allow an indirect cost rate to be applied? ☐ YES ☒ NO

SUBMITTED AND APPROVED BY:

Printed Name, Position/Title of Authorized Representative: James W. Gillan, DPHSS Director

SIGNATURE

Date: 1.15.15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-01

2. STATE: Guam

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Title XIX of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $1,250,952.00
b. FFY 2016 $1,300,831.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 39-39a of 45 (Section 3 – Services: Mental Health Rehabilitative Services)

Page 4-5 of 5 (Section 4 – General Program Administration: Mental Health Rehabilitative Services)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Page 39 (Section 3 – Services: Mental Health Rehabilitative Services)

Page 4-5 of 5 (Section 4 – General Program Administration: Mental Health Rehabilitative Services)

10. SUBJECT OF AMENDMENT:
Mental Health Rehabilitative Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Eddie Baza Calvo

14. TITLE:
Governor of Guam

15. DATE SUBMITTED:

16. RETURN TO:
Department of Public Health & Social Services
Bureau of Health Care Financing Administration
123 Chalan Kareta
Mangilao, GU 96913-6304

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

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

13d. Mental Health Rehabilitative Services

Mental health rehabilitative services are individual and group therapies or interventions designed to provide a reduction of mental disability and improvement in community functioning consistent with the goals of resolving and/or ameliorating the individual's emotional and behavioral needs. This includes improving the capacity of the caregiver(s) to provide rehabilitative services to a person with mental, behavioral, or emotional disorder sufficient to meet diagnostic criteria. Mental health services may be provided face to face in an office, by telephone, or in the community to the individual or a significant support person. This service includes assessment, service plan development, therapy, rehabilitation, and collateral contact.

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

A. Provider Eligibility Requirements

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

2. Community Program Aide/Developmental Disability Aide qualifications:
    a. 18 years of age.
    b. High school diploma or equivalent.
    c. One year full-time experience, or equivalent, with persons with social, behavioral, or emotional disorders.
    d. Knowledge of mental health challenges and community resources.
    e. Knowledge and skills in use of Microsoft Office.
    f. CPR and First Aid certified.

14. Services for Ages 65 or older for Mental Diseases

Not provided.

15. Intermediate Care Facility

Not provided.

16. Inpatient Psychiatric Facility Services

Not provided.

17. Nurse-Midwife Services

Provided.

18. Hospice Care

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

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.
- Physicians' services performed by a physician (as defined in 42 CFR 410.20)
  except that the services of the hospice medical director of the physician of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.
- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training

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 the contracted provider's website 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 Guam Memorial Hospital Authority's (GMHA) Current 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 according to the Facility's Current Medicare Interim Rate.

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

Medicaid will pay provider charges for Wellness 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 not to exceed 80% of Guam Public Law 31-274 Systems of Care Children's Services Fee Schedule.

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

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 (S) and (U) 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Ma Theresa Arcangel
Health Services Administrator
Bureau of Health Care Financing
Dept. of Public Hlth/Soc. Svcs.
123 Chalan Kareta
Mangilao , GU 96913-6304

OCT - 1 2014

SEE FUNDING RESTRICTION ATTACHMENT

Dear Sir or Madam:

The grant awards listed below have been approved for federal funding for allowable Medicaid expenditures incurred by your State during the period 10/01/2014 - 09/30/2015 under Appropriation 75X0512 Centers for Medicare & Medicaid Services.

Medical Assistance Payments	**$14,209,000**
Administration Payments	**$1,911,000**
Total Grant Awards	**$16,120,000**

The above listed grant awards provide Federal funds for expenditures made in accordance with your State plan approved under Title XIX of the Social Security Act. Computation of the awards is shown on the enclosed statement.

With the acceptance of these awards, you agree to be responsible for limiting the drawing of Federal funds so as to minimize Federal cash on hand in accordance with policies established in Treasury Circular 1075 (Revised), and procedures established by the Department of Health and Human Services. You also agree to submit timely reports as required. Withdrawals of Federal funds are not to exceed the individual programmatic grant awards shown above. You also are required to provide for effective control over the accountability for all Federal funds as stated in Office of Management and Budget Circular No. 1075 (Revised). Failure to adhere to the above requirements may cause the unobligated portion of your letter-of-credit to be revoked. Part 92, Title 45, Code of Federal Regulations implements these circulars for this Department.

Any questions you may have in connection with the grant award should be referred to the appropriate Centers for Medicare & Medicaid Services regional office financial contact for your State.

Payment under this award will be made by the Department of Health and Human Services, Payment Management System administered by the Division of Payment Management (DPM), Program Support Center. Inquiries regarding payment should be directed to:

Director, Division of Payment Management
Post Office Box 6021
Rockville, Maryland 20852-0605

Telephone Number 1-877-614-5533

Please transmit a copy of this grant award document to the State official authorized to request funds from the Division of Payment Management.

Sincerely yours,

Deborah Abalos

Director,
Division of Financial Operations

Enclosures 5
FORM CMS-L151(7-90)

FUNDING RESTRICTIONS

THIS GRANT AWARD IS FOR ELIGIBLE PROGRAM COSTS FOR THE QUARTER BEGINNING OCTOBER 1, 2014 INCLUDING PRIOR QUARTER ADJUSTMENTS. FUNDING UNDER THIS GRANT AWARD MAY NOT BE DRAWN OR PAID UNTIL OCTOBER 1, 2014.

OCT - 1 2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATE	GUAM			
FISCAL YEAR	2015			
QUARTER	1ST [X]	2ND [ ]	3RD [ ]	4TH [ ]

COMPUTATION OF AMOUNTS FOR MEDICAL ASSISTANCE GRANTS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

	MEDICAL ASSISTANCE PAYMENTS	ADMINISTRATION PAYMENTS
1. ADJUSTMENTS FOR	$	$
ACTUAL FEDERAL SHARE OF EXPENDITURES		
ESTIMATED FEDERAL SHARE OF EXPENDITURES PREVIOUSLY FUNDED		
DIFFERENCE		
NET ADJUSTMENTS APPLICABLE TO PRIOR PERIODS		
COLLECTIONS		
OTHER		
TOTAL ADJUSTMENTS	0	0
2. ESTIMATED FEDERAL SHARE OF EXPENDITURES FOR QUARTER BEGINNING October 1, 2014	A. 14,209,000	A. 1,911,000
3. NET AMOUNT TO BE CERTIFIED	$ 14,209,000	$ 1,911,000

TOTAL AMOUNT TO BE CERTIFIED $ B. 16,120,000

DATE APPROVED: OCT - 1 2014

COMPUTATION PREPARED BY :

INTERNAL TRANSMITTAL NO. 1

COMPUTATION REVIEWED BY :

ACCOUNTING DATA

STATE **GUAM** QUARTER/FISCAL YEAR: **FIRST/2015**

☐ THIS AWARD IS FUNDED UNDER HHS SINGLE LETTER OF CREDIT NO. 75-08

CENTRAL REGISTRY SYSTEM
ENTITY IDENTIFICATION NUMBER (CRS/EIN) **198-001-8947-E6**

PROGRAM MAP/ADM SUBACCOUNT	FUNDS IDENTIFICATION NUMBER	COMMON ACCOUNTING NUMBER	DOCUMENT NUMBER	AMOUNT	
XIX-MAP15	75X0512	55993275	05-1505GQ5MAP	14,209,000	*
XIX-ADM15	75X0512	55993274	05-1505GQ5ADM	1,911,000	*
TOTAL AMOUNT TO BE CERTIFIED				16,120,000	

* CURRENT QUARTER FUNDING

OCT – 1 2014

FOOTNOTES

STATE: GUAM **QUARTER/FISCAL YEAR:** FIRST/2015

A. See Attachment 1.

B. The funding authorized by this grant award is paid subject to any further financial management review or audit.

Below please find the PMS subaccount information for FY 2015 and your new State specific document numbers that will be found on the accounting sheet for FY 2015. States should draw Medicaid funds for current year and prior year expenditures reported on FY 2015 expenditure reports using the XIX-MAP15 and XIX-ADM15 subaccounts.

PROGRAM	PMS SUBACCOUNTS	DOCUMENT NUMBER
MAP	XIX-MAP15	1505-GQ5MAP
ADM	XIX-ADM15	1505-GQ5ADM

OCT - 1 2014

FORM CMS-152 (10/14/93)Supporting Schedule
ATTACHMENT 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

CALCULATION OF INITIAL AWARD

STATE: **GUAM** QUARTER/FISCAL YEAR: **FIRST/2015**

	MEDICAL ASSISTANCE PAYMENTS	ADMINISTRATION PAYMENTS
Secretary's Estimate of Funding Need for the Quarter	$ 14,209,000	$ 1,911,000
Less:		
Third Party Liability/Assignment of Rights-Billing Offset	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
Part A (Buy-In) Premiums Attachment ____	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
Part B (Buy-In) Premiums Attachment ____	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
Phase-Down Premiums Attachment ____	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
Part A Interest Attachment ____	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
Part B Interest Attachment ____	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
Phase-Down Interest Attachment ____	XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
FUNDING ADJUSTMENT		
Adjusted funding for the quarter	$ 14,209,000	$ 1,911,000
Estimate previously funded for the quarter		
Net Amount of Funding	$ 14,209,000	$ 1,911,000

OCT - 1 2014