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Felix Perez Camacho
Governor

Kaleo Scott Moylan
Lieutenant Governor

Office of the People's Speaker
vicente (ben) c. pangelinan

SEP 30 2003

TIME: 4:13 ( )AM ( )PM
RECEIVED BY:

September 30, 2003

The Honorable Vicente C. Pangelinan
Speaker
I Mina'Bente Siete Na Liheslaturan Guahån
Twenty-Seventh Guam Legislature
155 Hesler Street
Hagåtña, Guam 96910

Dear Speaker Pangelinan:

Transmitted herewith is Bill No. 155 (COR), "AN ACT TO *REPEAL* AND *REENACT* ARTICLE 9 OF CHAPTER 2. DIVISION 1, PART 1 OF TITLE 10 OF THE GUAM CODE ANNOTATED RELATIVE TO THE MEDICALLY INDIGENT PROGRAM," which I have signed into law on September 30, 2003, as Public Law No. 27-30.

This Act is an important first step towards improving access and quality medical care for our indigent population. This measure and the planned expansion of the Department of Public Health and Social Services' northern and southern community health centers will go a long way towards addressing primary care and preventive health services with a goal of ensuring that everyone has a medical home.

I strongly urge the Guam Memorial Hospital, the Department of Public Health and Social Services, and other interested members of the community, to continue constructive dialogue and work closely with the Oversight Chair of the Committee on Health in the refinement and/or improvement of the administrative provisions put in place by this measure.

Sincerely yours,

KALEO S. MOYLAN
I Maga'låhi Para Pa'go
Acting Governor of Guam

Attachment: copy attached of signed bill

cc: The Honorable Tina Rose Muna-Barnes, Senator and Legislative Secretary

03

MINA'BENTE SIETE NA LIHESLATURAN GUÅHAN
2003 (FIRST) REGULAR SESSION

CERTIFICATION OF PASSAGE OF AN ACT TO *I MAGA'LAHEN GUAHÅN*

This is to certify that Substitute Bill No. 155 (COR) "**AN ACT TO *REPEAL* SECTION 32 OF PUBLIC LAW 26-35 AND TO *REPEAL* AND *REENACT* ARTICLE 9 OF CHAPTER 2, DIVISION 1, PART 1 OF TITLE 10 OF THE GUAM CODE ANNOTATED RELATIVE TO THE MEDICALLY INDIGENT PROGRAM,**" was on the 18th day of September, 2003, duly and regularly passed.

vicente (ben) c. pangelinan
SPEAKER

Attested:

LOU A. LEON GUERRERO
Senator and Acting Legislative Secretary

This Act was received by *I Maga'lahen Guåhan* this 19 day of SEPTEMBER, 2003, at 7:10 o'clock P.m.

Assistant Staff Officer
Maga'lahi's Office

APPROVED:

KALEO S. MOYLAN
I Maga'lahen Guåhan Para Pa'go
Governor of Guam, Acting

Date: **September 30, 2003**

Public Law No. **27-30**

I MINA'BENTE SIETE NA LIHESLATURAN GUAHAN
2003 (FIRST) Regular Session

Bill No. 155 (COR)
As substituted by the Sub-Committee
on Health, and further substituted
and *amended* on the floor.

Introduced by: L. A. Leon Guerrero
v. c. pangelinan
C. Fernandez
F. B. Aguon, Jr.
J. M.S. Brown
F. R. Cunliffe
Mark Forbes
L. F. Kasperbauer
R. Klitzkie
J. A. Lujan
T. R. Muña Barnes
J. M. Quinata
R. J. Respicio
Toni Sanford
Ray Tenorio

AN ACT TO *REPEAL* SECTION 32 OF PUBLIC LAW 26-35 AND TO *REPEAL* AND *REENACT* ARTICLE 9 OF CHAPTER 2, DIVISION 1, PART 1 OF TITLE 10 OF THE GUAM CODE ANNOTATED RELATIVE TO THE MEDICALLY INDIGENT PROGRAM.

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Section 32 of Public Law 26-35 is hereby *repealed* in its entirety.

Section 2. Article 9 of Chapter 2, Division 1, Part 1 of Title 10 of the Guam Code Annotated as enacted by Public Law 25-163 is hereby *repealed* and *reenacted* to read as follows:

"ARTICLE 9.

MEDICALLY INDIGENT PROGRAM

PROGRAM PARTICIPATION AND ELIGIBILITY STANDARDS

Section 2920. Severability.

Section 2901. Legislative Intent. *I Liheslaturan Guåhan* believes there is a moral and social obligation to increase access to quality health care for those individuals who lack sufficient financial resources to meet the costs of medical care. In the past several years, there have been attempts to make changes and revise the Medically Indigent Program ('MIP') to improve services and benefits, decrease costs and still provide the best health care possible while using scarce public resources.

As the government of Guam continues to experience economic difficulties to address many issues in the community, health remains to be the forefront in those discussions, especially for those individuals who cannot afford health insurance. It is paramount that *I Liheslaturan Guåhan* recognizes this when allocating health care resources.

It is therefore the intent of *I Liheslaturan Guåhan* to change the criteria for eligibility and benefit coverage to reflect budgetary constraints within the Medically Indigent Program without compromising the health care services provided by the government of Guam.

Section 2902. Medically Indigent Program. There is established the 'Guam Medically Indigent Program.' The Medically Indigent Program is established for the purpose of providing medical, dental and behavioral health assistance to the indigent people of Guam in a manner that ensures access to basic quality health care at an affordable cost. The Program shall be composed of the following:

(a) Defining eligibility for financial assistance, consistent with health care costs, consistent with Section 2905 of this Article; and as may be amended from time to time;

(b) Determining the scope of services covered by the Program along with a mechanism for updating the scope of services from time to time;

(c) Establishing Provider reimbursements and a care contribution or cost-sharing program for persons with the ability to pay for a portion of their health care costs, based upon family size, monthly income and resources as these terms are defined in this Article;

(d) Establishing procedures to verify the validity of need and eligibility of persons applying for assistance under this Program; *and*

(e) A plan to effectively implement policies and procedures for operations of this Program.

Section 2903. Definitions. In this Article, *unless* the context otherwise requires:

(a) *'Administrator'* means the administrator of the Guam Medically Indigent Program.

(b) *'Clean Claim'* means a claim, that may be processed without the need of additional information from the provider of service or from a third party but does not include any claim under investigation for fraud or abuse or claims under review for medical necessity. In no event may a claim be contested or denied for the lack

of information that has no factual impact upon the Health Plan Administrator's ability to adjudicate the claim.

(c) *'Department'* means the Department of Public Health and Social Services.

(d) *'Director'* means the Director of the Department of Public Health and Social Services.

(e) *'Eligible Person'* means any person who is:

(1) a resident of Guam and has been a resident of Guam for a period of *no less than* six (6) months; and who has been physically living on Guam within the last six (6) months of the year, *except* for temporary absences in the past year which cannot be reasonably construed as absences due to *bona fide* residency outside of Guam; who applies for and qualifies for assistance under this Article; who is unable to pay the cost of the necessary medical care; *and* who also:

(2) is *not* eligible for Medicaid or Medicare coverage and has exhausted all benefits under Title XVIII or XIX of the Social Security Act; or the State Children's Health Insurance Program under Title XXI of the Balanced Budget Act as of 1997; *or*

(i) does *not* have medical insurance coverage nor the financial ability to pay for medical insurance coverage or for medical services as determined by the cost-sharing Program developed by the Administrator based upon the criteria established in this Article; *or*

(ii) who has medical insurance coverage, but such coverage is inadequate to cover the cost of medically required treatment and is otherwise qualified for the Program as a result of inadequate income or other resources;

(3) is a child in foster care, age eighteen (18) years and below, for whom public agencies are assuming financial responsibility in whole or in part; *or*

(4) is eligible for temporary emergency medical or other special care as provided in Section 2905.3.

(f) *'Federal Poverty Guideline'* means the poverty guidelines updated annually in the *Federal Register* by the U.S. Department of Health and Human Services under authority of §673(2) of the Omnibus Budget Reconciliation Act of 1981.

(g) 'Guam MIP Income Guidelines' means the Federal poverty guidelines adjusted for the higher cost of living on Guam relative to the national standard.

(h) *'Medical Necessity'* or *'Medically Necessary'* must be determined on an individual basis and must consider available research findings, health care practice guidelines and standards issued by professionals, recognized organizations or government agencies. *'Medical Necessity'* or *'Medically Necessary'* means the treatment must be certain to save lives or significantly alter an adverse prognosis:

(1) in accordance with generally accepted standards of medical practice; *and*

(2) clinically appropriate in terms of type, frequency, extent, site and duration.

(i) *'Member'* means an eligible person who enrolls in the Program.

(j) *'Non-Provider'* means a person who provides hospital, medical, dental or behavioral health care, but does *not* have a contract or subcontract with the Program.

(k) *'Practitioner'* means a person licensed pursuant to Chapter 12 of Division 1, Part 1 of Title 10 of the Guam Code Annotated.

(l) *'Prepaid capitated'* means a mode of payment by which a health care Provider directly delivers health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member notwithstanding:

(1) the actual number of members who receive care from the Provider; *or*

(2) the amount of health care services provided to any member.

(m) *'Primary Care Physician'* means a physician who is a family practitioner, general practitioner, pediatrician, general internist, obstetrician, psychiatrist or gynecologist.

(n) *'Primary Care Practitioner'* means a nurse practitioner licensed pursuant to Article 3 of Chapter 12, Division 1, Part 1 of Title 10 of the Guam Code Annotated, or a physician's assistant licensed pursuant to Article 16 of Chapter 12, Division 1, Part 1 of Title 10 of the Guam Code Annotated. Nothing in this Act shall expand the

scope of practice for nurse practitioners or for physician assistants as defined in Chapter 12 of Division 1, Part 1 of Title 10 of the Guam Code Annotated.

(o) *'Provider'* means any person who contracts with the Program for the provision of hospitalization, medical, dental or behavioral health care to members according to the provisions of this Chapter, or any subcontractor of such Provider delivering services pursuant to this Article.

(p) *'Program'* means the Guam Medically Indigent Program established by this Article.

Section 2904. Establishment of the Bureau of Health Care Financing Administration.

(a) There is established within the Department of Public Health and Social Services, within the Division of Public Welfare, a Program unit entitled the 'Bureau of Health Care Financing Administration,' which shall administer the Guam Medicaid Program and the Guam Medically Indigent Program, *subject to* the requirements and exceptions of this Article.

(b) The Administrator has full operational responsibility for the Program, *subject to* supervision by the Chief Human Services Administrator of the Division of Public Welfare with such duties that may include any or all of the following:

(1) Defining eligibility for financial assistance with health care costs, consistent with Section 2905 of this Article;

(2) Development of implementation and operation plans for the Program, which include reasonable access to hospitalization, medical, dental and behavioral health care services for members, as provided by this Article.

(3) Contract administration, certification and oversight of Providers.

(4) Provision of technical assistance services to Providers and potential Providers.

(5) Development of a complete system of accounts and controls for the Program, including provisions designed to ensure that covered health services provided through the Program are *not* used unnecessarily or unreasonably, including, but *not* limited to, inpatient mental health services provided in a hospital. The Administrator shall regularly compare the scope, utilization rates, utilization control methods and unit prices of major health care services provided on Guam in comparison with Program health care services to identify any unnecessary or unreasonable utilization within the Program. The Administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the Program in order to reduce unnecessary or unreasonable utilization.

(6) Establishment of peer review and utilization review functions for all Providers.

(7) Assistance in the formation of medical, dental and behavioral health care consortiums to provide covered health and medical services under the Program.

(8) Development and management of a Provider payment system.

(9) Establishment and management of a comprehensive system for assuring the quality of care delivered by the Program.

(10) Establishment and management of a system to prevent fraud by members, eligible persons and Providers of the Program.

(11) Development of a health education and information program.

(12) Development and management of a participant enrollment system.

(13) Establishment of a system to implement medical child support requirements, as required by Federal and local law. The Administrator may enter into an intergovernmental agreement with the Department of Law to implement the provisions of this Subsection.

(14) *Except* for reinsurance obtained by Providers, the Administrator shall coordinate benefits provided under this Article to an eligible person who also is covered by workers' compensation, disability insurance, a health care services organization, an accountable health plan, or any other health or

medical or disability insurance plan, including coverage made available to eligible persons or who receives payments for accident-related injuries, so that any costs for hospitalization, medical, dental or behavioral health care paid by the Program are recovered from any other available third-party payers. The Administrator may require that Providers and Non-Providers are responsible for the coordination of benefits for services provided under this Article. Requirements for coordination of benefits by Non-Providers under this Section shall be limited to coordination with standard health insurance and disability insurance policies, and similar programs for health coverage. The Program shall act as a payer of last resort for eligible persons as defined by this Article, *unless* specifically prohibited by Federal or local law. The Administrator may require eligible persons to assign to the system rights to all types of medical benefits, to which the person is entitled, including, but *not* limited to, first-party medical benefits under automobile insurance policies. The government of Guam has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this Subsection are controlling over the provisions of any insurance policy, which provides benefits to an eligible person *if* the policy is inconsistent with the provisions of this Subsection.

(15) The Administrator shall require as a condition of a contract with any Provider that all records relating to contract

compliance are available for inspection by the Administrator or the Director and that such records be maintained by the Provider for five (5) years. The Administrator shall also require that a Provider make such records available on request of the Secretary of the United States Department of Health and Human Services, or its successor agency.

(16) The Administrator shall establish procedures for:

(i) the transition of patients between system Providers and Non-Providers; *and*

(ii) the referral of members and persons who have been determined eligible to hospitals and other medical facilities, which have contracts to care for such persons.

(17) The Administrator shall set forth procedures and standards for use by the Program in requesting long-term care for members or persons determined eligible.

(18) As a condition of the contract with any Provider, the Administrator shall require such contract terms as are necessary, in the judgment of the Administrator, to ensure adequate performance and compliance with all applicable local and Federal laws by the Provider of the provisions of each contract executed pursuant to this Article. Contract provisions required by the Administrator may include, but are *not* limited to, the maintenance of deposits, performance bonds, financial reserves or other financial security. The Administrator may

waive requirements for the posting of bonds or security for Providers which have posted other security, equal to or greater than that required by the system, with a local agency for the performance of health service contracts *if* funds would be available from such security for the Program upon default by the Provider. The Administrator may also establish procedures, which provide for the withholding or forfeiture of payments to be made to a Provider by the Program for the failure of the Provider to comply with a provision of the Provider's contract with the Program or with the provisions of adopted rules.

(19) *If* the Administrator determines that it is more cost effective for an eligible person to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the Program may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under the Program. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under Section 2903 (e) through Section 2905.

(20) *If* the Administrator determines that it is more cost effective to provide for the medical management of a Program participant's health care needs with the provision of services that may fall outside the defined Program benefits, such treatment may be pursued; *provided,* that there will be a significant beneficial outcome to the patient's health status and

the total cost of this alternate treatment regime does *not* exceed a total cost of Seventy-five Thousand Dollars ($75,000.00). Treatment outside the defined Program benefits, must take place at teaching hospitals or be sanctioned by the Federal, Drug Administration as an experimental drug or procedural practice.

(c) The Director, in consultation with the Administrator, shall promulgate, *subject to* the Administrative Adjudication Law, a process for the periodic updating and revision of Program Benefits based upon an annual review of Program enrollment, utilization and claims payment and operating expenses.

(d) The Director, in consultation with the Administrator, shall establish Guam MIP Income guidelines and annually review and adjust pursuant to the Administrative Adjudication Law.

(e) *Subject to* the Administrative Adjudication Law, the Sunshine Reform Act of 1999 and the Health Insurance Portability and Accountability Act (HIPAA) which affects all health insurance entities regarding the type of Protected Health Information (PHI) that they are allowed to disclose and to whom they are to disclose it to, the Director, in consultation with the Administrator, shall prescribe by rules and regulations the types of information that are confidential, and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Such rules shall be designed to provide for the exchange of necessary information among Providers, the

Administrator and the Department for purposes of eligibility determination or coordination of eligible medical care under this Article.

PROGRAM PARTICIPATION AND ELIGIBILITY STANDARDS

Section 2905. Program Participation and Eligibility Standards.

(a) General Eligibility Criteria. To be eligible for Program coverage, an applicant for the Medically Indigent Program must be a resident of Guam as defined by Section 2903(e) of this Article and as further defined by this Section. In addition, an applicant shall also meet the additional standards for eligibility according to the following three (3) criteria: General Eligibility Standards, Income Limitations, and Resource Limitations as established in this Section, Section 2905.4, and Section 2905.5.

(b) Effective Date of Coverage. *Except* as specifically required by Federal law, Section 2905.3 or by Section 2914 of this Article, the Program is only responsible for providing medical coverage effective the first day of the month of application provided that that person has been determined eligible for the program.

(c) Applications. Applications for the Medically Indigent Program shall be completed by the applicant, or by someone authorized to act on the applicant's behalf. Upon receipt of an application, the program shall investigate and prepare a complete record of the circumstances of the applicant and provide the applicant with a written response as to the person's eligibility under the Program.

(d) Application Requirements. Each applicant shall be required to file an affirmation setting forth such facts about their qualifications for eligibility, annual income and other resources as may be required by the Program. Such statements shall be on forms prescribed by the Program, and may be accepted as evidence of the facts stated, but shall *not* be interpreted to preclude a full and complete investigation by the Program.

(e) System for Quality Reviews (QR). The Administrator shall establish a system for QR of a sufficient sample size of applications to assure the validity of all applications.

(f) False Declarations as to Eligibility; Liability for Repayment; Penalty. Any individual receiving assistance under this Article for which they were *not* eligible on the basis of false declarations as to their eligibility, or on behalf of any other person receiving assistance under this Article for which such other person or persons were *not* eligible, shall be liable for repayment of all benefits received and shall be guilty of a misdemeanor or felony depending on the amount paid in that person's behalf for which the person was *not* eligible, as specified in the Criminal and Correctional Code, Title 9 of the Guam Code Annotated.

Section 2905.1. General Eligibility Standards.

(a) An applicant must be a person who is, or would be legally obligated to pay for medical services rendered to such person, but through indigence or other financial circumstances, is unable to pay for such services, *and*

(1) is *not* eligible for Medicare, Medicaid coverage under Title XVIII or XIX of the Social Security Act or the State Children's Health Insurance Program under Title XXI of the Balanced Budget Act of 1997; *or*

(2) has neither private medical insurance coverage nor the financial ability to pay for medical insurance coverage, or for necessary medical services as determined by the Program; *or*

(3) has Medicare, Medicaid or private medical insurance coverage, but such coverage is inadequate to cover the cost of medically required treatment and such person is otherwise qualified for the Program as a result of inadequate income or resources.

Section 2905.2. Program Residency Requirements.

(a) The Administrator shall establish rules and regulations for use in determining whether an applicant is a resident of Guam or is eligible for temporarily assisted care, as provided in this Article. The rules shall require that an applicant shall be eligible for Program benefits *only if* the applicant is a resident of Guam and has been a resident on Guam for a period of *no less than* six (6) months, and has physically resided on Guam for a period of *not less than* six (6) months, *except* for temporary absences in the past year which cannot be reasonably construed as absences due to *bona fide* residency outside of Guam.

(b) In order for an applicant to prove residency, the requirements of Subsections (a) and (b) of this Section must be met:

(1) an applicant shall produce at least one (1) of the following in their name in addition to a Guam rent, mortgage receipt, or utility bill in order to establish beyond a reasonable doubt proof of residency of *no less than* six (6) months:

(i) a current Guam motor vehicle driver's license;

(ii) a current Guam motor vehicle registration;

(iii) a document showing that the applicant is or was employed on Guam, and *if* currently unemployed, an applicant shall provide a document showing that the applicant has registered with a public or private employment service on Guam;

(iv) evidence that the applicant has enrolled the applicant's children in a school on Guam;

(v) evidence that the applicant is receiving public assistance on Guam; *or*

(vi) evidence of registration to vote on Guam.

(2) The applicant signs an affidavit attesting that all of the following apply to the applicant:

(i) the applicant does *not* own or lease a residence outside of Guam;

(ii) the applicant does *not* own or lease a motor vehicle registered outside of Guam;

(iii) the applicant is *not* receiving public assistance outside of Guam; *and*

(iv) the applicant is actively seeking employment on Guam, *if* the applicant is able to work and is *not* employed.

(3) Applicants who refuse to cooperate in the eligibility determination process pursuant to this Subsection are *not* eligible. Refusal to cooperate shall be construed to mean that the applicant is unwilling to obtain documentation required for eligibility determination. The Program shall maintain its own applicant file copies of the application submitted to the Program in accordance with this Subsection.

(c) An applicant denied eligibility by a program eligibility worker may appeal the determination through the established fair hearing process.

Section 2905.3. Emergency Medical, Tuberculosis.

(a) Persons who would be otherwise eligible as provided by this Article, *except* for their failure to meet the residency requirements prescribed in Section 2905.2, who are ineligible for Title XIX services, are eligible to receive temporary emergency services on Guam that are determined by the Administrator as necessary to treat an emergency medical condition.

(b) No residency requirement shall be imposed for persons with tuberculosis. Persons with tuberculosis or leprosy shall be required only to meet income and resource eligibility standards.

(c) Each person desiring to be classified as eligible pursuant to this Section shall apply for certification pursuant to rules

established by the Administrator. The Administrator shall make the final determination regarding eligibility. On determination that the person is eligible for emergency care, the Administrator shall issue certification of limited eligibility to the applicant and shall provide notification to Program Providers.

(d) All persons who are applying for eligibility pursuant to this Section shall submit the application with copies of verification documents to the Administrator, which shall determine the applicant's eligibility. *If* the person is hospitalized at the time of the application, the Administrator may certify the person as eligible pursuant to this Section pending a final determination of eligibility.

Section 2905.4. Income Eligibility Standards. The Administrator shall set standards for determining monthly income for purposes of eligibility, which shall consider the individual's average pattern of income and earnings, *subject to* subsequent adjustment *if* actual experience deviates substantially from the amount determined by such method.

(a) Income Limitations. The Guam MIP Income Guidelines shall be used to determine income eligibility for the Medically Indigent Program. In the calculation of income, payments for medical insurance or Medicare premiums shall be excluded. *Prior to* the promulgation of the Guam MIP Income Guidelines, Federal Poverty Guidelines shall be used.

(b) Program Participant's Liability Based on Partial Coverage. *If* an applicant applying for assistance under the Medically Indigent Program has gross income which exceeds the gross income

limit of the applicant's category as described above, and exceeds that limit by an amount *not greater than* Three Hundred Dollars ($300.00), the applicant may still be eligible for partial coverage as provided in this Section.

(c) Liability Guide.

The following is a table of the percentage of a client's liability (per visit, hospital, admission, encounter) for each range of available income per month above the income guideline:

Available Income Per Month Above Income Guide	Percentage Liability Guide (Client's Liability)
$1 - $50	7%
$52- $100	15%
$101 - $150	22%
$151 - $200	30%
$201 - $250	37%
$251 - $300	45%

Section 2905.5. Resource Eligibility Standards.

(a) Resources. For the purposes of this Article, the term *'resources'* shall include all real or personal property, or any combination of both, held by household members. *If* the holdings are in the form of real property, the value shall be the assessed value determined under the most recent Guam property tax assessment *less* the unpaid amount of any encumbrance of record. *If* the holdings consist of money on deposit, the value shall be the actual amount thereof. *If* the holdings are in any other form of personal property or

investment, *except* life insurance, the value shall be the conversion value as of the date of application.

The value of property holdings shall be determined as of the date of application and, *if* the household member is found eligible, this determination shall establish the amount of such holdings.

(b) Disposition. The providing of assistance under this Article shall *not* impose any limitation or restriction upon the individual's right to sell, exchange or change the form of property holdings, nor shall the care provided constitute any encumbrance on the holdings. *However*, any transfer of the holdings, by gift or without adequate or reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance. Such act shall disqualify the seller for assistance under this Article for future claims for a period determined under standards established by the Administrator. In no event shall the period of ineligibility be for less than the period of time that the capital value of the transferred property would have supplied the person's income or resource needs from the time of the transfer in excess of allowable income or resource limitations.

(c) Resource Limitation. Household's total resources shall not exceed Two Thousand Dollars ($2,000.00).

(1) Resources, personal and real properties are counted toward the resource reserve limit, for all persons included in the assistance unit. Property of the caretaker, natural, legally liable, or adoptive parents, with whom the children are living, are also

included in the assistance unit's property reserve. Properties are evaluated at market value less encumbrances. The following are considered real property: land, houses, mobile homes, and immovable property attached to the land; personal property is all assets other than real property.

(2) Client who is a 'Representative Payee' or 'Legal Guardian' or managing someone else's funds. These funds are not included in the client's personal property reserve when they are kept in an account separate and apart from the client's monies and can be identified as being received and designated for someone other than the client.

(d) Assets. In determining the liquid resources of a household applying for the Program, the following shall be included as liquid assets, *unless* otherwise exempted in this Article:

(1) cash on hand;

(2) check or savings account amount;

(3) stocks or bonds; *and*

(4) shares in credit union wages from employment, including lump sum payments, time certificates, other investments or cash holdings.

(e) Cash Resources for Medical Treatment Exempted.

Cash resources that will be used for medical treatment-related expenditures are exempted in determining liquid resources.

(f) Vehicles. The entire value of one (1) licensed vehicle shall be excluded for one (1) parent households and two (2) vehicles shall be

excluded for two (2) parent households. All other vehicles shall individually be evaluated at Fair Market Value (FMV) and that portion of the value which exceeds the current Food Stamp Program vehicle disregard shall be attributed in full toward the household's resource limit, regardless of any encumbrances on the vehicles. Vehicles for individuals with disabilities which are customized with a lift to accommodate those individuals with wheelchairs for the purpose of transporting those individuals shall be exempted on a case-by-case basis.

(1) Verifications. Client's statement regarding the number of vehicles owned, ownership status and availability is acceptable. To obtain a vehicle's market value, the possible sources of verification include, but are not limited to:

(i) Kelly Blue Book (Wholesale Value);

(ii) Copy of Bill of Sale;

(iii) Estimate from Auto Dealer; *or*

(iv) Cars not in the Kelly Blue Book, ES assessments.

(g) Real Property. Real property is excluded in determining the resources of the household when it is their primary home, including the surrounding land which is not separated from the home by intervening property owned by others. Public rights of way, such as roads which run through the surrounding property and separate it from the home will not affect the property exemption. Households that currently do not own a home, but own or are buying a land on

which they intend to build or are building a permanent home, shall receive an exclusion for the value of the land and, if it is partially completed for the home.

(1) Verifications:

(i) Signed and Dated statement from a licensed real estate broker;

(ii) Tax Listings;

(iii) Copy of the Mortgage Papers; *and*

(iv) Copy of the Deed of Gift.

The agency shall exclude from 'resources' consideration the necessary non-liquid income producing property but not real property as defined under the following criteria: Stocks, inventory, tools, equipment and other non-liquid income-producing property which are usual customary for a given trade, profession or business.

Section 2905.6. Supplemental Coverage; Limitation. Any supplemental coverage provided pursuant to this Article is *limited to* those items or services for which coverage is *not* otherwise provided by any other insurer, Program or basis of entitlement. Supplemental coverage may include amounts due for co-insurance, deductibles and costs of services which are eligible benefits of the Program for which other coverage or benefit entitlement may *not* have been available at the time the medical service was rendered. Any supplemental coverage to be provided is *subject to* the benefit coverage and all limitations of the Medically Indigent Program. When appropriate, the supplemental coverage assistance may be obtained via the Catastrophic Illness Assistance Program.

Section 2905.7. **Applicability to All Applicants.** All applicants for the Medically Indigent Program shall meet the eligibility requirements set forth in Section 2905 of this Article. This shall include, but *not* be limited to, individuals requiring services for tuberculosis, leprosy, lytico, bodig, end stage renal disease or insulin for diabetes.

(a) **Cost Sharing Program.** Applicants applying for assistance under the Program who are individuals requiring services for tuberculosis, leprosy, lytico, bodig, end stage renal disease or insulin for diabetes, and who have a gross income which *exceeds* by an amount *not greater than* One Thousand Dollars ($1,000.00) of the gross monthly income limit of its category, shall be eligible for partial coverage as set out below:

The following is a table of percentage of an applicant's cost sharing portion for each range of available income per month above the income guidelines:

Available Income Per month (Above Income Guideline)	Percentage of Cost Sharing (Participant's Share)
$1 - $167	7%
$168 - $335	15%
$336 - $502	22%
$503 - $670	30%
$671 - $837	37%
$838 - $1,000	45%

Section 2905.8. **Uncovered Medical Procedure.** In situations where a person's health insurance will *not* be able to cover a particular condition or

procedure, and the condition or procedure is within the scope of services covered by the Program, the person may apply for assistance. *If* found eligible, only the uncovered procedure will be covered by the Program.

Section 2905.9. Discontinuance of Insurance. *If* otherwise insured, any household member at the time of application must maintain the member's insurance. Any household member who is discontinued from insurance coverage for reasons beyond that person's control may be eligible for Program coverage *if* eligibility criteria are met. A one (1) year penalty shall be imposed for applicants that knowingly violate this requirement.

Section 2905.10. Potential Medicaid Clients. Potential Program applicants that may qualify for Medicaid benefits must apply for assistance to the appropriate Medicaid categorical program and exhaust all eligible benefits before they can be eligible for coverage under the Medically Indigent Program.

Section 2905.11. Last Resort for Medical Services. The Medically Indigent Program is intended to be the last resort for the provision of medical services for those persons who cannot pay for medical services. Therefore, a person with medical insurance must refer claims to that person's insurance company *first*, before the bills can be submitted to the Medically Indigent Program. Those services provided by Federal or other Guam Programs shall be utilized first, in order that the Medically Indigent Program is the payor of *last resort*.

Section 2905.12. Treatment of Eighteen Year Old Applicants. An individual who has attained the age of eighteen (18) years and who is *not* a dependent for tax purposes of another household may apply to the

Medically Indigent Program. An individual who is between the ages of eighteen (18) and twenty-three (23) years who is still attending high school or college and living at home may be included under that person's parents, or household member's application to the Medically Indigent Program and the family's income.

Section 2905.13. Emancipated Adult. A minor may apply for Program eligibility as a legally declared emancipated adult; *provided,* that an affidavit is submitted by the minor indicating that the minor is living a life as an adult apart from the minor's parents, and is *'self-sufficient.'*

Section 2905.14. Eligibility Certification Periods. Once qualified as eligible, persons may participate in the Program for periods that run from six (6) months to one (1) year, *subject to* the restrictions established herein. Households with *at least* one (1) member between the ages of seventeen (17) and fifty-four (54) years shall be given a certification for a period of six (6) months. A household with all members who are fifty-five (55) years old or older, or with *at least* one (1) member with a permanent disability affirmed by a Provider, shall be given certification for a period of one (1) year. Shorter periods of certification may be established *if* deemed necessary by the Administrator.

Section 2905.15. Special Provisions for Children in Child Protective Services. All children in the legal custody of Child Protective Services shall be eligible to receive health care benefits as provided in Section 2907 through Section 2915 of this Article, if either parent is not covered by a health insurance plan or does not qualify for the Medically Indigent Program.

ADMINISTRATIVE PROVISIONS

Section 2906. Administrative Provisions.

(a) The Administrator may:

(1) prescribe uniform forms to be used by all Providers and shall prescribe and furnish uniform forms and procedures, including methods of identification of members, to be used for determining and reporting eligibility of members; *and*

(2) enter into an interagency agreement with the Department to determine the eligibility of all persons defined pursuant to this Article, and ensure that the eligibility process is coordinated with other assistance Programs.

(b) *No less than* sixty (60) days prior to the implementation of a policy or a change to an existing policy relating to reimbursement, the Administrator shall provide notice to interested parties.

(c) The Administrator is authorized to apply for any Federal funds available for the support of Programs to investigate and prosecute violations arising from the administration and operation of the Program. Available local funds appropriated for the administration and operation of the Program may be used as matching funds to secure Federal funds pursuant to this Subsection.

(d) Determination of Head of Household.

(1) In a single-member household the person shall be the head of household.

(2) In a household where there is only one (1) parent, that parent shall be the head of household.

(3) In a household where both the male and female parents have earned income, the parent with the higher income shall be the head of household.

(e) Document Verification; Birth Certificates and Social Security Card.

(1) A birth certificate and social security card are required for each member of the household applying for assistance.

(2) Birth certificates may be substituted by a passport, baptismal certificate, an Alien Registration Receipt Card (green card) or a government of Guam Identification Card, *if* birth certificates are *not* available.

(3) In the absence of a Social Security Card, a receipt of the application for Social Security Card should be sufficient; *however*, the member shall provide the Program with a photocopy of the Social Security Card *after* its receipt. For verification, a written statement or other documents from the Social Security Administration, or a Guam driver's license or Guam ID if the social security number is indicated on it shall be accepted.

(f) Alien Registration Receipt Card. The Alien Registration Receipt Card will be required for all resident alien applicants.

(g) Income.

(1) Last two (2) month's check stubs and current month's check stub shall be provided as part of income verification.

(2) An employment verification from the employer must be obtained showing the average hours worked and hourly rate the employee has earned for the last three (3) months.

(3) Self-employed individuals, other than those farming and fishing, with income over One Hundred Dollars ($100.00) a month must provide the latest gross receipts, tax receipts and the latest 1040 Forms. *If* no 1040 Forms can be provided, an affidavit indicating expenses for the same month shall be furnished. For fishermen or farmers, a notarized statement of income will be required and proof of being exempted from filing the gross receipts tax must be obtained from the Department of Revenue and Taxation and submitted to the Medically Indigent Program. Those others with income *less than* One Hundred Dollars ($100.00) a month will be required also to submit a notarized statement of earnings.

(h) Vehicle and Property. An affidavit shall be provided indicating that the applicant meets the eligibility restrictions on ownership of vehicles and real property as provided in Section 2905.5 (f) and (g).

(i) Cash Resources. Photocopies of passbooks and bank statements are required *if* an applicant indicates amounts of cash resources in the application form.

(j) Permanent Resident Alien. Aliens who are applying for assistance shall provide information and required documentation concerning the sponsor's income and resources as a condition for eligibility. In determining the eligibility for all qualified aliens, the income and resources of any person who executed an affidavit of support pursuant to the Immigration and Nationality Act on behalf of the qualified alien and the income and resources of the spouse, *if any*, of the sponsoring individual shall be counted at the time of application and for the re-determination of eligibility for the duration of the attribution period, as specified in Federal law. *If* a resident alien's sponsor did *not* execute an affidavit of support pursuant to the Immigration and Nationality Act on behalf of the qualified alien, then the income and resources of a sponsor(s) and the sponsor's spouse, *if* living together, shall be treated as unearned income and resources.

(k) Issuance of Program Card. An identification card will be issued identifying all eligible family members. Each household will be assigned a unique number. Cards will indicate the period of Medically Indigent Program coverage, other medical insurance coverage, applicable liability rates, and selected primary physicians and specialist(s).

(l) Denials. Applicants will be denied when:

(1) ineligibility is established;

(2) an applicant fails to provide necessary information to determine eligibility; *or*

(3) the Program loses contact with the applicant *before* eligibility is determined.

(m) Reporting Requirements. All MIP Program Participants shall report within ten (10) days to the Medically Indigent Program any changes in their households, such as the following:

(1) moved to another house;

(2) someone moved into the household;

(3) someone moved out of the household;

(4) someone in the household has given birth;

(5) someone in the household terminated from employment;

(6) someone in the household received a raise in wage or salary;

(7) someone in the household obtained a job;

(8) someone in the household reached the age of nineteen (19) or sixty-five (65) years old;

(9) someone in the household becomes permanently disabled; *or*

(10) someone in the household has expired.

(n) Penalty for Failure to Report Changes. The above list is *not* inclusive. Therefore, all changes shall be reported. Failure to report changes within ten (10) calendar days, a change or changes in household circumstances which should have resulted in ineligibility,

making false or misleading statements or withholding information at the time of application which should have resulted in ineligibility, the head of household and spouse (if any) shall be suspended from the Program participation for:

(1) Three (3) months, for the first occasion;

(2) Six (6) months, for the second and subsequent occasions.

The individual(s) must be notified in writing once it is determined that he/she is to be penalized. The period of suspension shall be no later than the second month which follows the date the individual(s) receive the written notice of the suspension. The period of suspension must continue uninterrupted until completed regardless of the eligibility of the suspended individual's household. This penalty is in addition to the recoupment of improper payments made to the service provider.

(o) Termination of Assistance. In addition to any other penalties imposed elsewhere in this Article for fraud or false declarations with an intention to obtain improper access to Program services, the following shall constitute grounds for the termination of assistance:

(1) false declarations in seeking Program eligibility; *or*

(2) failure to report changes in household status as required by this Article.

AMOUNT, DURATION AND SCOPE OF SERVICES

Section 2907. Scope of Services. The Medically Indigent Program will provide the following medical, dental and mental health services when medically necessary, and *subject to* the stated benefit limitations and exclusions.

Section 2907.1. In-Patient Services.

(a) The Medically Indigent Program shall cover *only* the following medically necessary in-patient services:

(1) maximum of sixty (60) days inpatient hospitalization per illness. If confinement is medically necessary after the sixty (60) days, prior authorization is required from MIP;

(2) semi-private room and board, or private room when medically necessary;

(3) coronary and intensive care;

(4) neonatal intensive care, intermediate nursery care and wellborn nursery care;

(5) surgery and anesthesia;

(6) operating room, delivery room and licensed birthing center services;

(7) diagnostic laboratory services;

(8) diagnostic radiology, ultrasound and mammography screening services;

(9) renal dialysis treatment;

(10) physician services;

(11) emergency room services;

(12) acute physical and occupational therapy when prescribed by physician and provided by a qualified licensed and registered therapist, *subject to* limitations stated below;

(13) respiratory therapy;

(14) prescribed drugs in accordance with the established MIP formulary;

(15) podiatry services;

(16) care in an intermediate care facility; *and*

(17) ambulance services.

(b) In-Patient Services *Not* Covered. The Medically Indigent Program shall *not* cover the following in-patient services:

(1) elective cosmetic surgery, *except* as provided for in the Women's Health Act;

(2) custodial care, domiciliary care, private duty nursing or rest cures, *except* as provided for in hospices;

(3) personal comfort or convenience items;

(4) any diagnostic service requiring prior authorization which has *not* been obtained or has been denied;

(5) any specialized elective surgical service requiring prior authorization, which has *not* been obtained or has been denied; *or*

(6) non-emergency use of the Emergency Room.

(c) Limitations and Exclusions. All in-patient services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2907.2. Out-Patient Services.

(a) The following out-patient medical services shall be covered when medically necessary:

(1) Physician Evaluation and Management Services;

(2) Laboratory Diagnostic Services;

(3) Diagnostic Radiology, Ultrasound and Mammography Screening Services;

(i) CT Scan or MRI services must be authorized by the MIP Program *prior to* the rendering of services;

(4) Prescription Drugs;

(5) Ambulatory Surgical Services;

(6) Renal Dialysis;

(7) Physical and Occupational Therapy;

(8) Respiratory Therapy;

(9) Emergency Room Services. The use of the Guam Memorial Hospital Emergency Room shall be limited to urgent and life threatening situations as diagnosed by the emergency physician and a Five Dollar ($5.00) co-payment is required.

(10) Services *Not* Covered. The following out-patient medical services shall *not* be covered:

(a) Non-emergency use of the Emergency Room of the hospital shall *not* be covered. Non-emergency use of the Emergency Room for the purposes of this exclusion shall be defined as the use of the Emergency Room for non-urgent or non-life threatening medical problems. All

Program recipients seeking care at the hospital Emergency Room for purposes other than the treatment of urgent or life-threatening medical problems shall be fully responsible for the cost of all care and services rendered.

(b) Over-the-counter drugs *not* listed in the established MIP Formulary.

(c) Limitations and Exclusions. All out-patient services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2907.3. Physician Services.

(a) Coverage shall include:

(1) physician evaluation and management services on an in-patient and out-patient basis;

(2) consultation services; *and*

(3) specialty services.

(b) Physician Services *Not* Covered. The following services will *not* be covered:

(1) elective cosmetic surgery, except as provided for in the Women's Health Act; *or*

(2) any services or items requiring prior authorizations, which have *not* been obtained or have been denied by the Medically Indigent Program.

(c) Limitations and Exclusions. All physician services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2907.4. Skilled Nursing and Intermediate Care Services.

(a) Skilled nursing and intermediate care shall be covered. The Program shall provide skilled nursing care coverage for one hundred eighty (180) days per year for recipients.

(b) Services *Not* Covered. The following services are *not* covered under skilled nursing facilities and intermediate care facility services:

(1) personal comfort items; *and*

(2) private duty nursing services.

(c) Limitations and Exclusions: All skilled nursing and intermediate care services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

DENTAL SERVICES

Section 2908. Dental Services.

(a) Emergency dental services (restoration, extraction and root canal treatment) which are necessary to alleviate severe pain and annual routine treatment (dental exams and cleaning) are covered for all persons age seventeen (17) and above. MIP clients are responsible for twenty percent (20%) of the cost of each treatment.

(b) Dental Services *Not* Covered. The following shall *not* be covered as dental benefits under the provisions of the Medically Indigent Program:

(1) cosmetic or cosmetic related treatments;

(2) treatments initiated while *not* on existing plan;

(3) services or treatments *not* in accordance with accepted dental therapeutics;

(4) any services or procedure *not* listed in American Dental Association's procedure codes;

(5) any treatment or service related to temporomandibular joint dysfunction syndrome ('TMJ/TMD') or disease;

(6) posterior composites;

(7) broken appointment fees;

(8) dental implants and implant prosthesis; *and*

(9) ordontics or orthodontic-related treatments.

(c) Limitations and Exclusions. All dental services are also *subject to* the stated Program benefit limitations and exclusions outlined in Section 2912 through Section 2913 as applicable.

SERVICES REQUIRING *PRIOR* AUTHORIZATION

Section 2909. Services Requiring *Prior* Authorization. The Administrator shall issue *prior* authorization for elective or specialized surgical procedures, off Guam care and certain other services as follows:

(a) *prior* authorization must be obtained *prior to* rendering of hospital services, *except* in emergency situations; *and*

(b) all services requiring *prior* authorization from the Medically Indigent Program must be prescribed by a physician as medically necessary.

Section 2909.1. ***Prior*** **Authorization for Admission for Elective Surgery.** *Prior* authorization is required for patients to be admitted to the hospital *prior to* the date of surgery. A justification by the attending physician must be submitted to the Program.

Section 2909.2. Physical Therapy and Occupational Therapy. Medically Indigent Program recipients in need of the above services must submit to the Medically Indigent Program a copy of the attending physician's treatment plan, which includes the patient's name, diagnosis, type of frequency and the suggested regime. An authorization for the continued coverage of the services will be issued by the Program upon completion of review of the treatment plan and progress reports.

Section 2909.3. CT Scan or MRI Diagnostic Services. Before an authorization for coverage is issued, a justification for the need of the service by the attending physician must be submitted to the Program.

OFF GUAM MEDICAL CARE

Section 2910. Off Guam Medical Care and Services.

(a) Prior Authorization is required before any MIP Program recipient may receive care and services at an off Guam treatment facility.

(b) Failure to obtain an authorization *prior to* the rendering of care and services will result in the denial of assistance from the Program.

(c) Off Guam medical care and services are to be provided in accordance with the Program benefits outlined in Section 2907.

(d) Off Guam medical care and services are provided to MIP Program recipients in accordance with the following:

(1) Eligibility. Program standards are in effect with regard to income, resource and residency requirements for off Guam care.

(2) An applicant must *not* have voluntarily discontinued the applicant's insurance coverage within six (6) months *prior to* application to the Medically Indigent Program.

(3) Those with insurance must continue with their insurance coverage.

(e) Medical Review. All off Guam referrals will be reviewed by the Administrator *after* the applicant is found eligible and all necessary documents have been submitted. Referrals will be reviewed to determine that the treatment is medically necessary, significant beneficial outcomes affecting the patient's quality of life is expected and the care is *not* available on Guam. The Administrator shall consult with the attending physician and any other specialists as may be required.

(f) Coverage. The Program shall cover off Guam care and services *subject to* all benefit limitations and exclusions *if* the off Guam medically necessary care or treatment is provided at a contracted facility or a non-contracted facility, *if* care is *not* available at a contracted facility when referral criteria are met and care or treatment is *not* available on Guam.

(g) Air Transportation. Round trip air transportation will be provided to an eligible Program patient when all other criteria for off Guam care have been met. One (1) parent, or guardian, *if* the parent is unable to accompany the child, will be covered *if* the patient is a minor, seventeen (17) years of age or below. Air transportation and *per diem* will also be provided for one (1) medical escort (registered nurse or physician). If more than one (1) escort is required, client shall cover the cost for additional escorts.

(h) Supplemental Assistance for Off Guam Care Upon Exhaustion of Insurance Benefits. A patient may be covered under an existing insurance Program and may be eligible to apply to the Medically Indigent Program for supplemental assistance upon exhaustion of benefits, and *subject to* all benefit limitations and exclusions.

(i) Off Guam services *not* covered:

(1) elective cosmetic surgery;

(2) experimental treatments;

(3) fertility procedures, sterilizations, abortions;

(4) off Guam living expenses;

(5) organ transplants;

(6) other services covered by local or Federal government; *and*

(7) off Guam emergency medical services.

(j) Limitations and Exclusions. All off island services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

MENTAL HEALTH SERVICES

Section 2911. Mental Health Services.

(a) The Medically Indigent Program will provide the following mental health benefits to Program recipients:

(1) maximum of thirty (30) days inpatient hospitalization per illness,

(2) out-patient facility/day treatment;

(3) maintenance counseling;

(4) chemical dependency services shall be provided *subject to* the following limitations:

(i) outpatient services limited to Ten Thousand Dollars ($10,000.00) per year;

(5) psychological and neuropsychological testing which has been determined to be medically necessary to determine a diagnosis, to establish a baseline level of functioning, and/or to assist in determining a treatment regime which is expected to result in an improvement of the patient's functional abilities and/or quality of life;

(6) mental illness coverage for patients diagnosed with mental retardation and mental illness to address mental illness concerns; *and*

(7) only generic drug benefits provided;

(b) Limitations and Exclusions. All mental health benefits are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

LIMITATIONS

Section 2912. MIP Program Benefit Limitations.

The benefits provided for under the Medically Indigent Program shall be *subject to* the following annual limitations, *unless* otherwise specified:

(a) There will be a ten percent (10%) co-insurance for the following services:

1. Radiation Therapy;
2. Cardiac Related Services;
3. Orthopedic Services and Appliances,
4. Radiology.

(b) Renal Dialysis. Limited coverage to first twelve (12) months and payment of Medicare Part B Premiums and co-insurance. Prior to the expiration of the twelve (12) month limited coverage period, the Administrator shall facilitate the application of each Program recipient for Medicare coverage of renal dialysis.

(c) Physical Therapy. Therapy must be to restore a bodily function that once existed or has been lost or damaged due to disease or accidental injury. Coverage is *only* to the extent that it restores function to the status of function *prior to* the disease or accidental injury. Therapy must result in

significant and demonstrable improvement in patient ability to function independently, limited to treatment by a physical therapist. The first twenty (20) visits shall be covered. Fifty percent (50%) co insurance is required thereafter.

(d) Off Guam Medical Care. Off Guam medical care shall be a maximum of One Hundred Seventy-Five Thousand Dollars ($175,000.00) per year, including airfare and escort fees.

(e) Blood and Blood Products. Blood and blood products shall be a maximum of Fifty Thousand Dollars ($50,000.00). This limitation shall *not* apply to any person with hemophilia or any hemophilia-related condition requiring the administration of blood and blood products.

(f) Hospice Care. Hospice care shall be limited to the comparable Medicare payment rate per day maximum of with a maximum of one hundred eighty (180) days. This benefit shall only be eligible for services using Medicare criteria rendered on Guam.

(g) Eye Exam. Eye exam shall be limited to Fifty Dollars ($50.00) per visit.

(h) Corrective Lenses. Corrective lenses shall be limited to One Hundred Dollars ($100.00).

(i) Hearing Aids. Hearing aids as are medically necessary shall be covered; *provided,* that all available community resources for such hearing aids have been

exhausted. Benefit is limited to a maximum of Five Hundred Dollars ($500.00) per hearing aid.

(j) Physical Examination. There shall be a Five Dollar ($5.00) co-payment for each physical exam related service per year.

(k) Well Child Care. Well Child Care shall be limited to six (6) visits per year up to age two (2), excluding visits for immunizations.

(l) Pharmaceutical Prescriptions. Pharmaceutical prescriptions shall be limited to a maximum of thirty (30) days supply at one (1) time, with the exception of birth control pills dispensed with a ninety (90) day supply.

(m) Occupational Therapy. Coverage limited to medically necessary services where an expectation exists that the therapy will result in significant practical improvement in the individual's level of functioning within a reasonable period of time. Coverage is excluded *if* related solely to specific employment opportunities, work skills or work settings. The first twenty (20) visits shall be covered *up to* the maximum provided herein. Additional treatments *subject to* re-certification for continuing treatment after initial twenty (20) visits *subject to* medical review of further significant practical improvement to be attained.

(n) Acupuncture Care. Acupuncture care shall be limited to ten (10) visits per contract period, maximum of Fifty Dollars ($50.00) per visit.

(o) Chiropractic Care. Chiropractic care shall be limited to ten (10) visits per contract period, maximum of Twenty-Five Dollars ($25.00) per visit.

Section 2912.1. Optometrist Services. Optometrist services are covered for an eye refractive examination *not to exceed* one (1) examination every year. This benefit is limited to Fifty Dollars ($50.00).

Lenses are limited to lenses that are medically necessary, *not to exceed* one (1) set every two (2) years; *provided,* that all available community resources for such lenses are exhausted. Benefit is limited to One Hundred Dollars ($100.00).

Section 2912.2. Audiological Exam. Audiological exams that are medically necessary will be covered. Benefit is limited to One Hundred Dollars ($100.00) per visit.

Section 2912.3. Hearing Aids. Hearing aids as are medically necessary shall be covered; *provided,* that all available community resources for such hearing aids have been exhausted. Benefit is limited to a maximum of Five Hundred Dollars ($500.00) per hearing aid.

Section 2912.4. Orthopedic Conditions and Prosthetic Appliances. Chronic orthopedic conditions along with internal or external prostheses are covered to a benefit maximum of Fifty Thousand Dollars ($50,000.00) per year.

Section 2912.5. Voluntary Sterilization Services. Voluntary sterilization services with physician counseling for those eighteen (18) years and above are covered.

Section 2912.6. Home Health Services.

(a) The following home health services shall be covered by MIP for one hundred (100) days per year when medically necessary and ordered by a licensed physician:

(1) home health visits by licensed practitioner or home health aide;

(2) prescribed medical supplies *not* otherwise available over the counter; *and*

(3) intermittent equipment and appliances provided on a part-time or intermittent basis by a licensed home health agency within a recipient's residence.

(4) Standard Wheelchairs;

(5) Walkers;

(6) Crutches;

(7) Standard Hospital Beds;

(8) Bedside Rails;

(9) Bedpans;

(10) Oxygen Related Equipment.

(b) Home Health Services *Not* Covered. The following home health agency services shall *not* be covered:

(1) private duty nursing, domiciliary care or rest cures; *and*

(2) unskilled services.

(c) Limitations and Exclusions. All home health services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2912.7. Prescription Drug Coverage.

(a) The following drug prescriptions shall be covered:

(1) Out-patients prescribed drugs are provided in accordance with the Drug Formulary.

(2) Medically Indigent Program clients will have to pay a Two Dollars and Fifty Cents ($2.50) co-payment charge per prescription filled and shall be limited to generic brand items. Those with cost sharing liabilities shall pay the required co-payment charge plus their cost sharing liability.

(3) Pharmaceutical prescriptions, with the exception of birth control prescriptions, dispensed for ninety (90) days are limited to a thirty (30) day supply at one (1) time.

(b) Prescription Drug Services *Not* Covered. The following prescription drug benefits shall *not* be covered under the Medically Indigent Program:

(1) drugs *not* listed in the established formulary and requested with justification for consideration;

(2) over-the-counter drugs *not* listed in the established MIP formulary; *and*

(3) experimental drugs, *unless* approved by the Administrator.

(c) Limitations and Exclusions. All prescription drug benefits are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2912.8. Physical Therapy.

(a) Physical therapy when medically necessary is covered; *provided,* that the therapy must be to restore a bodily function that once existed, or has been lost or damaged due to disease or accidental injury. Coverage is *only* to the extent that it restores function to the status of function *prior to* the disease or accidental injury.

(1) Therapy must result in significant and demonstrable improvements in the patient's ability to function independently.

(2) Benefit is limited to treatments by a physical therapist.

(3) The first twenty (20) visits are covered in full.

(4) A fifty percent (50%) co-insurance is required for all subsequent treatments meeting the criteria set forth in subsection (a) above.

(b) Services *Not* Covered. The following are *not* covered under the physical therapy benefit:

(1) services determined *not* to result in significant and demonstrable improvements in the patient's ability to function independently.

(c) Limitations and Exclusions. All physical therapy services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2912.9. Occupational Therapy.

(a) Occupational therapy when medically necessary is covered; *provided,* that the therapy must be to restore a bodily function that once existed, or has been lost or damaged due to disease or accidental injury. Coverage is *only* to the extent that it restores function to the status of function *prior to* the disease or accidental injury.

(1) Therapy must result in significant and demonstrable improvements in the patient's ability to function independently.

(2) Benefit is limited to treatments by a occupational therapist.

(3) The first twenty (20) visits are covered in full.

(4) A fifty percent (50%) co-insurance is required for all subsequent treatments meeting the criteria set forth in subsection (a) above.

(b) Services *Not* Covered. The following are *not* covered under the occupational therapy benefit:

(1) services determined *not* to result in significant and demonstrable improvements in the patient's ability to function independently.

(c) Limitations and Exclusions. All occupational therapy services are *subject to* the stated benefit limitations and exclusions outlined in Section 2912 through Section 2913.

Section 2912.10. Services Provided by Public Health. The Medically Indigent Program shall *not* reimburse Public Health for services provided by Public Health Programs.

EXCLUSIONS

Section 2913. Exclusions. The Medically Indigent Program does *not* cover the following services:

(a) voluntary abortions, abortions and interrupted pregnancy that are *not* medically necessary;

(b) elective cosmetic surgery, *except* as provided for in the Women's Health Act;

(c) custodial care, domiciliary care, private duty nursing services or rest cures, *except* as provided for in hospices;

(d) personal comfort or convenience items;

(e) any service *not* medically necessary for the diagnosis or treatment of a disease, injury or condition;

(f) non-emergency use of Emergency Room;

(g) over-the-counter drugs *not* listed in the Drug Formulary;

(h) drugs *not* listed in the Drug Formulary, *unless* otherwise provided in this Act;

(i) experimental drugs, experimental and palliative treatments or procedures, *unless* approved by the Administrator;

(j) fertility procedures, reversal of sterilization and services related to artificial conception;

(k) treatment, services and supplies related to sexual dysfunction;

(l) trans-sexual surgery and related services;

(m) motorized limbs;

(n) services for any incarcerated person;

(o) care or services furnished by immediate relatives or members of the patient's household, *unless* rendered as a duly licensed medical practitioner employed by a health care Provider;

(p) health cares services, which are provided and reimbursed by other local or Federal programs, MIP is the payer of last resort;

(q) speech and language therapy;

(r) tissue and organ transplants, and any other related hospital, surgical drug, radiology, laboratory or other medical services before, during and after transplant;

(s) treatment and services for artificial weight reduction, including gastric bypass stapling or reversal, or liposuction;

(t) treatment by any method for temporomandibular joint disorders, including, but *not* limited to, crowning, wiring or repositioning of teeth;

(u) treatment for injuries sustained in the commission of an illegal or criminal act, including driving under the influence;

(v) any work-related injury, *subject to* compensation pursuant to the Workers Compensation Law;

(w) care for military service connected disabilities to which the patient is legally entitled to government benefits or care;

(x) orthopedic footwear, *unless* attached to an artificial foot or *unless* attached as a permanent part of a leg brace; *and*

(y) benefits and services *not* specifically listed as covered.

RESPONSIBILITIES

Section 2914. Member Use of Primary Care Physicians. Effective May 1, 2004, all MIP members shall seek primary care services at the Southern or Northern Medical Clinics within the Department of Public Health and Social Services. If the services cannot be provided by the primary care physician at any one of the clinics described above, an appropriate referral shall be made by the primary care physician from the list of Participating Providers upon being determined eligible for the Medically Indigent Program. The Program shall *only* provide reimbursement for any health or medical services or costs of related services provided by or under referral from any primary care physician, or primary care practitioner participating in the Program.

Section 2914.1. Change In Primary Care Physician. A change in primary physician may be approved upon the member's written request to the Medically Indigent Program. This change will take effect on the first day of the following month. *If* the selected primary care physician is *not* available, the member may see another physician who has signed an agreement with the Medically Indigent Program, but must obtain a statement that the member's primary physician was *not* available on a certain date and time.

Section 2914.2. Hospital to Inform Member of Coverage of Emergency Room Services. On behalf of the Program, as the collector of co-insurance, deductibles and premiums, all hospital Providers shall advise the MIP member, or eligible person, that *if* the visit to the Emergency Room is *not* for an emergency condition, as determined by the hospital, the member or eligible person shall be charged the required co-payment, and may be liable for services resulting from the non-emergency use of the Emergency Room. *If* a person who has been determined eligible, but who has *not* yet enrolled in the system receives emergency services, the Administrator shall provide by rule for the enrollment of the person on a priority basis. *If* a person requires Program-covered services on or after the date the person is determined eligible for the Program, but before the date of enrollment, the person is entitled to receive such services in accordance with rules adopted by the Administrator, and the administration shall pay for such services.

APPEALS AND GRIEVANCE PROCESS

Section 2915. Appeals and Grievance Process.

(a) The Director, in consultation with the Administrator, shall establish, *subject to* the Administrative Adjudication Law and the provisions of this Article, a grievance and appeal procedure to cover grievances arising pursuant to this Article. The grievance and appeal procedure shall include time limits for filing appeals or grievances, and shall establish procedures to conduct fair hearings to be used by Providers, Non-Providers, eligible persons, persons applying to be Providers or persons denied eligibility. A grievance

for the denial of a claim for reimbursement for services, or for denial of eligibility, may contest the validity of any adverse action, decision, policy implementation, or rule that related to or resulted in the full or partial denial of the claim. The grievance and appeal procedure shall contain provisions related to the notice to be provided to aggrieved parties, including notification of final decisions, complaint processes and internal appeals mechanisms. Any grievance and appeal procedure *not* specified pursuant to this Subsection, but identified pursuant to this Subsection, shall be handled in the same manner. Other provisions for processing grievances shall include:

(1) the client has a right to have another person of that client's own choosing to assist with that client's case; *and*

(2) *if* the client chooses to go through a hearing, an opportunity will be granted for a hearing conducted by an impartial hearing officer.

(3) Notification of Time and Place of Hearing. The time, date and place of the hearing shall be arranged to provide the claimant and all other parties involved *at least* ten (10) working days of advance written notice. Notice shall:

(i) inform claimant of the time, date and place of the hearing;

(ii) advise the claimant or representative of the name, address and phone number of the person to notify in the event it is *not* possible for the claimant to attend the scheduled hearing;

(iii) specify that the agency will dismiss the hearing request *if* the claimant or the claimant's representative fails to appear for the hearing without good cause;

(iv) explain that the claimant or the claimant's representative may examine the case file *prior to* the hearing; *and*

(v) advise the claimant of the possible availability of legal services from the Public Defender Service Corporation.

(4) Hearing Officer. A hearing shall be conducted by an attorney or an arbitrator who does *not* have any personal stake or involvement in the case; and was *not* directly involved in the initial determination of the action which is being contested. Responsibilities of the hearing officer shall include:

(i) administer required oaths or affirmations;

(ii) insure all relevant issues are considered;

(iii) request, receive and make part of record all evidence determined necessary to decide the issues being raised; *and*

(iv) regulate the conduct and course of the hearing, consistent with due process to insure an orderly hearing.

(5) Hearing Decisions. The claimant shall be notified in writing of the decision and the reasons for the decision.

(6) After a hearing decision, which upholds the agency action, the claimant shall be notified of the right to pursue judicial review of the decision.

(b) A grievance or appeal shall be filed in writing and received by the Administrator *no later than* sixty (60) days after the date of the adverse action, decision or policy implementation being grieved. *If* a grievance or appeal is *not* filed within the time required by this Section, the initial decision shall be considered the final decision.

(c) The Hearing Officer shall render a decision on each grievance *no later than* ninety (90) days from the date the Administrator receives the request for a hearing, *unless* the hearing is postponed or rescheduled at the request of all of the parties, or the hearing officer orders a further extension. *If* a person is dissatisfied with a final decision on a grievance properly submitted and heard under the provisions of this Article, the person may file for judicial review under the provisions of the Administrative Adjudication Law.

(d) Notice of Change in Benefits. Notice of a denial or discontinuance shall be made in writing to the client ten (10) days in advance, and state the reason and effective date.

REIMBURSEMENT

Section 2916. Medically Indigent Program Reimbursement Fee Schedules for Providers.

(a) Reimbursements to Providers and Non-Providers shall be in amounts *not to exceed* the following:

(1) for in-patient hospital services, the Program shall reimburse services in accordance with the annual Medicare *per diem* rates set for the hospital's in-patient services;

(2) for out-patient hospital services, the Program shall reimburse a hospital by applying the annual Medicare hospital specific out-patient cost-to-charge ratio to the covered charges;

(3) for skilled nursing services, the Program shall reimburse at fifty percent (50%) of the annual Medicare per diem rates set for the hospital's in-patient services;

(4) for intermediate care services, the Program shall reimburse services at sixty percent (60%) of reimbursement rate established in Section 2916(a)(3) for skilled nursing;

(5) for professional fees and home health services, the Program shall reimburse services at one hundred percent (100%) of the Medicare Participating Provider fee schedule rate adjusted in accordance with the Hawaii or Guam conversion factor as applicable; *and*

(6) for dental fees, the National Dental Advisory Schedule shall be used to reimburse services.

(b) The Administrator of the Medically Indigent Program shall have discretionary authority to establish Provider and Non-Provider reimbursement rates for services which are *not* specifically addressed herein, but which are consistent with the Program services provided by Section 2901 through Section 2915 of this Article. Said schedules will be developed in conjunction with the Administrator's

duties to secure the necessary Provider and Non-Provider relationships to ensure the availability of adequate medical care and assistance to all Program recipients.

(1) The Program shall *not* pay claims for Program-covered services that are initially submitted *more than* twelve (12) months after the date of the service as clean claims, *except* for claims submitted for services to members involving the coordination of benefits amongst multiple payers.

(2) Payments shall be made on clean claims in accordance with the reimbursement rates set forth in this Section.

(c) *'Clean claims'* as defined by this Article and as further defined herein shall mean:

(1) For a Hospital Bill. A hospital bill is considered received for purposes of this Subsection upon initial receipt of the legible claim form by the administration *if* the claim includes the following error-free documentation in legible form:

(i) an admission face sheet;

(ii) an itemized statement;

(iii) an admission history and physical;

(iv) a discharge summary or an interim summary *if* the claim is split;

(v) an emergency record, *if* admission was through the Emergency Room;

(vi) operative reports, *if* applicable;

(vii) a labor and delivery room report, *if* applicable;

(viii) utilization review report.

(2) For Medical Service Claims. For medical service claims, a claim that is submitted on a HCFA 1500 reflecting CPT and HCPCS codes for services and supplies. Services requiring *prior* authorization shall have a copy of the approved authorization form attached. Specialist services shall have the appropriate referral form attached.

(3) For Dental Claims. For dental claims, a claim that is submitted on the ADA claim form reflecting proper codes for services.

(4) For Behavioral Health Forms. For behavioral health forms, a claim submitted on a HCFA 1500 reflecting CPT codes for behavioral health services.

(d) Payment received by a Provider or Non-Provider from the Program is considered payment by the Program of the Program's liability for the member's bill. A Provider may collect any unpaid portion of its bill from other third party payers or the member in the event of non-covered services. A Provider or Non-provider shall *not*:

(1) charge, submit a claim to, demand or otherwise collect payment from a member or person who has been determined eligible, *unless* specifically authorized by this Article or rules adopted pursuant to this Article; *or*

(2) refer or report a member who has been determined eligible to a collection agency or credit reporting agency for the failure of the member to pay charges for Program covered care or services, *unless* specifically authorized by this Article or rules adopted pursuant to this Article.

(e) The Administrator may conduct post-payment review of all claims paid by the Program and may recoup any monies erroneously paid. The Administrator shall adopt rules that specify procedures for conducting post-payment review. The Program Administrator shall review all prepaid captivated payments and may conduct a post-payment review of all claims paid by the Program, and may recoup monies that are erroneously paid.

(1) Any Provider receiving reimbursements under this Article for which they were *not* entitled on the basis of false claims filed on behalf of any person receiving assistance under this Article shall be liable for repayment, and shall be guilty of a misdemeanor or felony, depending on the amount paid for which the person was *not* entitled, as specified in the Criminal and Correctional Code of Guam, Title 9 of the Guam Code Annotated.

(f) Claims for Program-covered services which are determined valid by the Administrator pursuant to Section 2907 through Section 2912.10, and the Program's grievance and appeal procedure, shall be paid from the funds established by this Section.

(g) For purposes of this Section, *'Program-covered services'* exclude administrative charges for operating expenses.

(h) All payments for services established by this Article shall be accounted for by the Administrator by the fiscal year in which the claims were paid, regardless of the fiscal year in which the payments were incurred.

(i) Notwithstanding any other law to the contrary, government-owned Providers are subject to all claims processing and payment requirements or limitations of this Article, which are applicable to non-government Providers.

(j) Notwithstanding any law to the contrary, the Director or Administrator may receive confidential adoption information for the purposes of identifying adoption-related third party payers in order to recover the total costs for prenatal care and the delivery of the child, including capitation reinsurance and any fee-for-service costs incurred by the Program on behalf of an eligible person who the Administrator has reason to believe had an arrangement to have the eligible person's newborn adopted. *Except* for the sole purpose of identifying adoption-related third party payers, the Administrator shall *not* further disclose any information obtained pursuant to this Subsection, and shall develop and implement safeguards to protect the confidentiality of this information, including limiting access to the information to only those Program personnel whose official duties require it. At no time shall the Director or Administrator release to the adoptive parents' or birth parents' insurance carrier personally

identifying information regarding the other party. A person who knowingly violates the requirements of this Subsection pertaining to confidentiality is guilty of a Class 6 felony.

QUALITY OF CARE

Section 2917. Quality of Care.

(a) The Administrator, *subject to* the Administrative Adjudication Law, shall develop by rule and regulation a standard for Providers to use in monitoring the quality of health care received by members. Each Provider shall adopt and use such standard.

(b) The Administrator shall periodically determine whether each Provider has properly adopted and implemented the quality of health care monitoring standard. *If* the Administrator determines that a Provider has *not* done so, the Administrator shall undertake additional special efforts to monitor and assess the quality of health care provided by that Provider for as long as the Administrator deems necessary. The Administrator shall determine the cost incurred in undertaking such special efforts and shall deduct that amount each month from any payment owed to that Provider for as long as the special efforts continue.

CATASTROPHIC ILLNESS PROGRAM

Section 2918. Catastrophic Illness Program. The Department shall continue to administer the Catastrophic Illness Program, as established by Public Law Number 18-8, as further amended by Public Law Numbers 18-31 and 23-76, and as further regulated by the rules and regulations

previously adopted by the Department pursuant to the public laws that originally established this Program. The Department may also adopt additional rules in accordance with the Administrative Adjudication Law to administer the Catastrophic Illness Program. The Program shall provide for care of victims of catastrophic illnesses, whether such care is provided on Guam or at off Guam medical facilities. The Catastrophic Illness Assistance Program ('CIAP') maximum coverage per individual is established at One Hundred Seventy-five Thousand Dollars ($175,000.00)."

Section 2919. Effective Date. This shall become effective upon enactment of this Act.

Section 2920. Severability. *If* any provision of this Law or its application to any person or circumstance is found to be invalid or contrary to law, such invalidity shall *not* affect other provisions or applications of this Law which can be given effect without the invalid provisions or application, and to this end the provisions of this Law are severable.