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State/Territory Name: Guam

State Plan Amendment (SPA) #: 14-001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JUN 04 2014

Theresa Archangel
Division of Public Welfare
Bureau of Health Care Financing
PO Box 2816
Hagatna, GU 96932

Dear Ms. Archangel:

Enclosed for your records is an approved copy of Guam's Alternative Benefit Plan (ABP) State Plan Amendment (SPA) GU-14-001. This ABP, which was submitted on March 6, 2014, meets all federal statutory and regulatory requirements for establishing an ABP.

This ABP SPA is approved effective January 1, 2014. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 3.1-C:
    - ABP 1, page 1
    - ABP 2a, pages 1-4
    - ABP 2c, pages 1-4
    - ABP 3, pages 1-2
    - ABP 4, page 1
    - ABP 5, pages 1-26
    - ABP 7, pages 1-2
    - ABP 8, page 1
    - ABP 9, pages 1
    - ABP 10, page 1
    - ABP 11, page 1

If you have any questions, please contact Peter Banks at (415) 744-3782 or Peter.Banks@cms.hhs.gov.

Sincerely,

[redacted]

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:
Guam
Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.
14-01

Proposed Effective Date
01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation
Title XIX of the Social Security Act, Section 1937

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 476850.00
Second Year	2015	$ 635800.00

Subject of Amendment
Medicaid Alternative Benefit Plan for the New Adult Group

Governor's Office Review
- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**
  Describe:
- **No reply received within 45 days of submittal**
- **Other, as specified**
  Describe:

Signature of State Agency Official
Submitted By:
Teresita Gumataotao
Last Revision Date:
Jun 2, 2014
Submit Date:
Mar 6, 2014

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- [X]

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations **ABP1**

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

Alternative Benefit Plan Population Name: New Adult Group

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

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

Geographic Area

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

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

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- [X]

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act ABP2a

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

No

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

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

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

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

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

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

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

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

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

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

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

☒ Letter

☐ Email

☒ Other

Describe:

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

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

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

An attachment is submitted.

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

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

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

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

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

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

Alternative Benefit Plan

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

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

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

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

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

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

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

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

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

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

☐ In the eligibility system.

☒ In the hard copy of the case record.

☐ Other

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

☐ Copy of correspondence sent to the individual.

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

Alternative Benefit Plan

☐ Other

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

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

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

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- [X]

OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants ABP2c

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

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

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

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

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

Describe:

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

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

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

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

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

[ ] Self-identification

[ ] Other

Alternative Benefit Plan

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

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

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

☐ Review of claims data

☐ Self-identification

☒ Review at the time of eligibility redetermination

☐ Provider identification

☐ Change in eligibility group

☒ Other

Describe:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- X

OMB Expiration date: 10/31/2014

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

Select one of the following:

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

Name of benefit package: New Adult Benefit Plan

Selection of the Section 1937 Coverage Option

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

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

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

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

Plan name: GovGuam SelectCare 1500

Selection of Base Benchmark Plan

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

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

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

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

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

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- [X]

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing	ABP4

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

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

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

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

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

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

Attachment 3.1-C- [ ]

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

GovGuam SelectCare 1500

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

GovGuam SelectCare 1500

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All

Benefit Provided: Acupuncture

Source: Base Benchmark State Employees — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 Visits Per Fiscal Year

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Aids Treatment

Source: Base Benchmark State Employees — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Approved FDA Treatment and Drugs only.

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

Benefit Provided: Airfare Benefit

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

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

Remove

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

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

Benefit Provided: Allergy Testing/Treatment

Source:

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: $500 Annually

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Ambulatory Surgi-Center Care

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Breast Reconstructive Surgery

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Remove

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

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

Benefit Provided: Cataract Surgery

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Outpatient only, including conventional lens

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

Benefit Provided: Chemotherapy

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Chiropractic Care

Source: Base Benchmark State Employees

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
30 visits per Fiscal Year

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Elective Surgery

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Non-emergency Outpatient Surgeries.

Benefit Provided:
Orthopedic conditions

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes Internal and External Prosthesis.

Alternative Benefit Plan

Benefit Provided: Physician Care & Services

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Radiation Therapy

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Sleep Apnea

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Diagnostics and Therapeutic Procedure.

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

Remove

Benefit Provided: Sterilization Procedures

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Tubal Ligation and Vasectomy (Outpatient only)

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

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

Benefit Provided: Nuclear Medicine

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: End Stage Renal Disease/Hemodialysis

Source: Base Benchmark State Employees

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Inhalation Therapy

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Congenital Anomaly Diseases Coverage

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit is likely not medically necessary for individuals in the New Adult Group.

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services — Collapse All

Benefit Provided: Emergency Care

Source: Base Benchmark State Employees — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided: Hospitalization & Inpatient Benefits
Source: Base Benchmark State Employees
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: 60 days

Scope Limit: None

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

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

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: 60 days max per Fiscal Year

Scope Limit: None

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

Benefit Provided: Cardiac Surgery
Source: Base Benchmark State Employees

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: Prior Authorization required for off-island services not available on Guam.

Alternative Benefit Plan

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

Remove

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care — Collapse All

Benefit Provided: Maternity Care

Source: Base Benchmark State Employees — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Labor and delivery.

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

Benefit Provided: Prenatal Care

Source: Base Benchmark State Employees — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided: Mental Health Care

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Outpatient psychiatric and psychological services to include counseling and medications.

Benefit Provided: Chemical Dependency

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

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

Add

Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

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

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: Physical Therapy
Source: Base Benchmark State Employees — Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Occupational Therapy
Source: Base Benchmark State Employees — Remove
Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: 20 visits per Fiscal Year
Duration Limit: None
Scope Limit: Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. Prior Authorization and Justification are required for additional visits.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Durable Medical Equipment (DME)
Source: Base Benchmark State Employees
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: One (1) of each Type DME Every Five Years
Duration Limit: None
Scope Limit: Standard wheelchair, standard hospital bed, walker, crutches, and standard CPAP.

Alternative Benefit Plan

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

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

Remove

Benefit Provided: Oxygen and Accessories

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Physician Prescription is required.

Benefit Provided: Hearing Aids

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: $500 Every Three Years

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Implants

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

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

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services — Collapse All

Benefit Provided: Blood & Blood Derivatives
Source: Base Benchmark State Employees — Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

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

Benefit Provided: Diagnostic Testing
Source: Base Benchmark State Employees — Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

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

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

Add

Alternative Benefit Plan

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

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

Benefit Provided: Preventive Care Services

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

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

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

Benefit Provided: Well-Women Preventive Care

Source: Base Benchmark State Employees

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Annually

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

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

Benefit Provided: Wellness

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: $200 Annually

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

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

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

Benefit Provided:

Immunizations/Vaccinations

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Fitness

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Gym memberships at a participating provider.

Add

Alternative Benefit Plan

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☐ Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Annual Eye Exam

Source:

Base Benchmark

Remove

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

Annual Eye Exams are not allowable essential health benefits.

Add

Alternative Benefit Plan

☐ Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Alternative Benefit Plan

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

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

Benefits Assurances **ABP7**

EPSDT Assurances

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

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

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

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

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

◉ Through an Alternative Benefit Plan.

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

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

Prescription Drug Coverage Assurances

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

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

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

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

Other Benefit Assurances

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

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

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

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
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Attachment 3.1-L- [X]

Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☐ Other service delivery system.

Fee-For-Service Options

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

◉ Traditional state-managed fee-for-service

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

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

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

Additional Information: Fee-For-Service (Optional)

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

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

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐

OMB Expiration date: 10/31/2014

General Assurances	ABP10

Economy and Efficiency of Plans

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

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

Compliance with the Law

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

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

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

PRA Disclosure Statement

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐

OMB Expiration date: 10/31/2014

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

PRA Disclosure Statement

V.20130917