I Mina'trentai Singko Na Liheslaturan Guåhan
BILL STATUS

BILL NO.	SPONSOR	TITLE	DATE INTRODUCED	DATE REFERRED	CMTE REFERRED	PUBLIC HEARING DATE	DATE COMMITTEE REPORT FILED	FISCAL NOTES	NOTES
303-35 (COR)	Louise B. Muña	AN ACT TO *ADD* A NEW § 3707 TO ARTICLE 7, CHAPTER 3, TITLE 10, GUAM CODE ANNOTATED RELATIVE TO CREATING *THE GUAM MEDICAID STATE PLAN ADVISORY COUNCIL.*	2/24/20 9:30 a.m.						

I MINA'TRENTAI SINGKO NA LIHESLATURAN GUÅHAN
2020 (SECOND) Regular Session

Bill No. 303-35(COR)

Introduced by: Louise B. Muña LBM

AN ACT TO *ADD* A NEW § 3707 TO ARTICLE 7, CHAPTER 3, TITLE 10, GUAM CODE ANNOTATED RELATIVE TO CREATING *THE GUAM MEDICAID STATE PLAN ADVISORY COUNCIL*.

2020 FEB 24 AM 9:30

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Findings and Intent. *I Liheslaturan Guåhan* finds that the *Medicaid and CHIP Payment and Access Commission* describes the Medicaid State Plan process as follows:

> "Federal Medicaid law sets broad requirements for the program and mandates coverage of some populations and benefits, while leaving many optional. States, then, make the many operational and policy decisions that determine who is eligible for enrollment, which services are covered, and how payments are set.
>
> Each state specifies the nature and scope of its Medicaid program through the state plan. This comprehensive document must be approved by the Centers for Medicare & Medicaid Services (CMS), operating under authority delegated by the Secretary of the U.S. Department of Health and Human Services (HHS), in order for the state to access federal Medicaid funds. The state plan can be amended as needed to reflect changes in state policy and federal law and regulation.
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> **State plan format and structure**
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> The state plan is a formal, written agreement between a state and the federal government, submitted by the single state agency (42 CFR 431.10) and approved by CMS, describing how that state administers its Medicaid program. The state plan:

- provides assurances that a state will abide by federal rules in order to claim federal matching funds;
- indicates which optional groups, services, or programs the state has chosen to cover or implement; and
- describes the state-specific standards to determine eligibility, methodologies for providers to be reimbursed, and processes to administer the program.

The state plan document is organized into seven sections:

- Section 1 – Single State Agency Organization
- Section 2 – Coverage and Eligibility
- Section 3 – Services: General Provisions
- Section 4 – General Program Administration
- Section 5 – Personnel Administration
- Section 6 – Financial Administration
- Section 7 – General Provisions

Within each section are preprint pages, with each page generally referencing a specific federal provision or group of related provisions. If the provision is a mandatory requirement of all state Medicaid programs, state submission of the page is considered to be agreement and assurance of compliance. If the provision is optional, the state can indicate on the page whether the state elects to implement that provision or can leave it blank, indicating that the state does not choose to implement the provision, or indicate whether the provision is not applicable to that state.

States also include attachments and supplements to describe state-specific payment methods, the amount, duration, and scope of coverage for certain services, eligibility processes and standards, methods of administration, and mechanisms to assure compliance. Including these attachments, state plans may be hundreds of pages long.

While every provision in the state plan preprint is related to a specific federal statute or regulation, the converse is not true—not all federal rules regarding the Medicaid program are memorialized in the state plan. The first page of the state plan requires the state to acknowledge that, as a condition for the receipt of federal funds under Title XIX of the Social Security Act, the single state agency must agree to administer the program in accordance with the requirements of titles XI and XIX and all applicable federal regulations. The state plan does not include specific pages related to many rules regarding administration of the program; state assurance of compliance with these provisions is provided through submission of the first state plan page. CMS uses a number of mechanisms in addition to the state plan, such as state systems advance planning documents, to record how states implement federal Medicaid requirements.

State plan amendment process

As federal requirements and state policies change over time, updates are made via state plan amendments (SPAs). States can choose to submit SPAs to make changes to their programs; for example, to change a provider payment methodology or discontinue coverage of an optional service. If new federal Medicaid statutes, rules, or court decisions are made, CMS must develop a new state plan amendment template and send it to the states, which must complete it and submit it for review. Through this process, CMS can determine whether the plan continues to meet federal requirements and authorize federal expenditures for new eligibility groups or services, if applicable.

When a state proposes an amendment to its state plan, it sends CMS the revised page(s) with an official transmittal form (Form CMS-179). SPAs are generally submitted on paper forms, although CMS is not in the process of implementing a system for electronic submission, as described in Chapter 4 of MACPAC's June 2014 report.

Once a SPA is submitted, CMS has 90 days to make a decision, otherwise the proposed change automatically goes into effect. However, the federal government can "stop the clock" by writing to request additional information. Once the state

submits the required information, a new 90-day clock begins; however, CMS may stop the clock only once per SPA (§§1116 and 1915(f)(2), 42 CFR 430.16). SPA approvals are not contingent on meeting any budgetary target, but states are required to indicate on the transmittal form the expected federal financial impact.

Once approved, copies of each state plan page, including the approval date and effective date, are retained by the state and CMS. Changes can take effect retroactively to the first day of the quarter in which the state submitted the amendment. While the operations of state Medicaid programs are subject to review, changes made by SPAs are not generally subject to periodic renewal (42 CFR 430.32). That is, once approved, a SPA does not expire, but a state can change it through a subsequent SPA.

Generally, the only federal public notice requirements for SPAs apply when states plan significant changes in payment methods and standards (42 CFR 447.205), although states may have their own public notice requirements. Transmittals and SPA approvals are posted to the CMS website.

State Children's Health Insurance Program (CHIP) state plans

States must also submit a CHIP state plan to obtain federal CHIP funds. The CHIP state plan application is similar to the Medicaid preprint but references federal CHIP rules and is organized into major sections that parallel Title XXI of the Act. The CHIP state plan amendment process is the same as the Medicaid state plan amendment process.

Waivers of state plan provisions

States seeking additional flexibility can apply to the Secretary of HHS for formal waivers of certain statutory requirements. For example, states can request waivers of provisions requiring service comparability, statewideness, and freedom of choice in order to offer an alternative benefit plan to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers, or to extend coverage to groups beyond those defined in Medicaid law.

> In exchange for the flexibility offered by waivers, states must meet budgetary criteria and provide regular reports and evaluations to CMS to show that the requirements of the waiver are being met, which are not requirements placed on state plans. Also, unlike most SPAs, waivers require lengthy applications and must be renewed periodically. A state can operate significant portions of its program under waiver authority but must maintain a complete and up-to-date state plan in order to access federal funds."

I Liheslatura further finds that up until Fiscal Year 2020, Medicaid funding has not been sufficient to adequately cover the federal mandates associated with the *Patient Protection and Affordable Care Act* so little or no money was available for locally created healthcare initiatives. The enactment of PL 116-94, however, (the *Further Consolidated Appropriations Act, 2020*) significantly increased the amount of federal Medicaid funding while reducing the percentage match for local funds for the next several years. As such, Guam may have sufficient funding to pay for additional services and initiatives provided that they are approved by the *Centers for Medicare & Medicaid Services (CMS).*

Prior to the increased funding provided by PL 116-94, Medicaid reimbursement rates were so low that healthcare providers where often faced with a take-it-or-leave scenario where such rates were below providers' cost and they were forced to make up the shortfall by charging other patients higher rates.

It is the intent of *I Liheslatura* to allow Guam's healthcare providers the opportunity to observe the Medicaid State Plan creation process and make recommendations.

Section 2. A new § 3707 is added to Article 7, Chapter 3 of 10GCA.

"§ 3707. The Guam Medicaid State Plan Advisory Council.

(a) The Guam Medicaid State Plan Advisory Council (The Council) consists of the following officials or their designees"

(1) The Director of Public Health and Social Services;

(2) The Chairperson of the Board of Medical Examiners;

(3) The Chairperson of the Board of Examiners for Dentistry;

(4) The Chairperson of the Board of Examiners for Pharmacy;

(5) The Chairperson of the Board of Allied Health Examiners;

(6) The Administrator of the Guam Memorial Hospital Authority, and

(7) The Director of Public Health and Social Services shall appoint the following additional members:

A. A member employed by a large clinic or healthcare facility that is defined as having $5,000,000 (Five Million Dollars) or more in annual revenues.

B. A member employed by a small clinic or healthcare facility that is defined as having less than $5,000,000 (Five Million Dollars) in annual revenues.

C. A member employed by a private hospital on Guam.

(b) The powers and authority of the Council shall include, individually or collectively, the following:

(1) To propose recommendations to the Guam State Medicare Plan agency for inclusion in the Guam State Medicare Plan;

(2) To solicit recommendations from local healthcare providers, supplies and equipment vendors and other professionals for inclusion in the Guam State Medicare Plan;

(3) To propose recommendations to *I Maga'låhi/I Maga'håga* and *I Liheslatura* for amendments to the Guam State Medicare Plan or the Guam State Medicare Plan planning process; and

(4) To attend any or all Guam State Medicare Plan meetings and work sessions."