EDDIE BAZA CALVO
Governor

RAY TENORIO
Lieutenant Governor

Office of the Governor of Guam

February 6, 2012

31-11-1324
Office of the Speaker
Judith T. Won Pat, Ed. D.
Date 2/7/12
Time 4:19pm
Received by

Honorable Judith T. Won Pat, Ed.D.
Speaker
I Mina'trentai Unu Na Liheslaturan Guåhan
155 Hesler Street
Hagåtña, Guam 96910

Dear Speaker Won Pat:

Transmitted herewith is Bill No. 292-31 (LS) "**AN ACT TO *AMEND* §3812 OF ARTICLE 8, CHAPTER 3, AND §2912.10 OF ARTICLE 9, CHAPTER 2, ALL OF TITLE 10, GUAM CODE ANNOTATED, RELATIVE TO AUTHORIZING THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICAL INDIGENT PROGRAM PATIENTS**", which I signed into law on February 3, 2012 as **Public Law 31-176**.

Senseramente,

EDDIE BAZA CALVO

Attachment: copy of Bill

Ricardo J. Bordallo Governor's Complex • Adelup, Guam 96910
Tel: (671) 472-8931/6 • Fax: (671) 477-4826 • www.governor.guam.gov

1324

I MINA'TRENTAI UNU NA LIHESLATURAN GUÅHAN
2012 (SECOND) Regular Session

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

This is to certify that **Bill No. 292-31 (LS), "AN ACT TO *AMEND* §3812 OF ARTICLE 8, CHAPTER 3, AND §2912.10 OF ARTICLE 9, CHAPTER 2, ALL OF TITLE 10, GUAM CODE ANNOTATED, RELATIVE TO AUTHORIZING THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS",** was on the 20th day of January, 2012, duly and regularly passed.

Judith T. Won Pat, Ed.D.
Speaker

Attested:

Tina Rose Muña Barnes
Legislative Secretary

This Act was received by *I Maga'lahen Guåhan* this 23rd day of Jan, 2012, at 12:45 o'clock P.M.

Assistant Staff Officer
Maga'lahi's Office

APPROVED:

EDWARD J.B. CALVO
I Maga'lahen Guåhan

Date: FEB 03 2012

Public Law No. 31-176

I MINA'TRENTAI UNU NA LIHESLATURAN GUÅHAN
2011 (FIRST) Regular Session

Bill No. 292-31 (LS)
As amended on the Floor.

Introduced by:

Dennis G. Rodriguez, Jr.
T. C. Ada
V. Anthony Ada
F. F. Blas, Jr.
B. J.F. Cruz
Chris M. Dueñas
Judith P. Guthertz, DPA
Sam Mabini, Ph.D.
T. R. Muña Barnes
Adolpho B. Palacios, Sr.
v. c. pangelinan
R. J. Respicio
M. Silva Taijeron
Aline A.Yamashita, Ph.D.
Judith T. Won Pat, Ed.D.

AN ACT TO *AMEND* §3812 OF ARTICLE 8, CHAPTER 3, AND §2912.10 OF ARTICLE 9, CHAPTER 2, ALL OF TITLE 10, GUAM CODE ANNOTATED, RELATIVE TO AUTHORIZING THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS.

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Findings and Intent. *I Liheslaturan Guåhan* finds that the Northern and Southern Regional Community Health Centers (CHC)

of the Department of Public Health & Social Services (DPHSS) Bureau of Primary Care are unable to seek compensation for services rendered to patients under the Medically Indigent Program (MIP). The DPHSS Community Health Centers are grantees under the Health Recourses and Services Administration, U.S. Department of Health & Human Services.

This is due to a policy interpretation that since the MIP Reform Act provides in 10GCA, Chapter 2, Article 9, §2912.10, that, "[t]he Medically Indigent Program shall not reimburse Public Health for services provided by Public Health Programs." In effect, all services provided by the Department of Public Health for MIP patients are free (i.e., no reimbursements can be made for services), and, the CHC cannot submit a claim to the MIP program for the reimbursement of the cost of services rendered. This situation is resulting in a continually diminishing balance in the Community Health Center Revolving Fund, and is contrary to the Federal statutory provisions applicable to the CHC's grant award.

I Liheslaturan Guåhan recognizes that the Northern and Southern Regional Community Health Centers are Federally Qualified Health Centers (FQHCs) that are mandated to collect revenues from third party payers (i.e., private insurance indemnities), Medicare, Medicaid, Medically Indigent Program (MIP), and self-pay patients so that the revenues or program income monies generated are to be used exclusively for the operation of the Guam Community Health Centers. And to that end, 10GCA, Article 8, Chapter 3, §3811, provides for the establishment of the Community Health Centers Revolving Fund. Subsection (d) provides that, *"Deposits – All monies deposited in the Fund shall be applied to the expenses of the community center allowable by Federal regulations and guidelines as the non-*

Federal share of project costs in accordance with the Department's grant from the U.S. Department of Health & Human Services."

Further, *I Liheslaturan Guåhan* takes due note of the grant compliance requirements of the Health Resources & Services Administration, U.S. Department of Health &Human Services, as provided pursuant to §330(k)(3)(F) & (G) of the U.S. Public Health Services Act, that grantee health centers have: *Billings and Collections: Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.*

It is the intent of *I Liheslaturan Guåhan* that the conflicting provisions of §2912.10 of Article 9 – Medically Indigent Program – Chapter 2, Title 10, Guam Code Annotated, relative to services provided by Public Health, be reconciled with §3812 of Article 8, Chapter 3, Title 10, Guam Code Annotated, relative to DPHSS Regional Community Health Centers fee schedules, so as to allow the CHCs as a Federally Qualified Health Center grantee to conform and comply with the Federal statutory provisions and regulations applicable to its programs.

Section 2. §3812 of Article 8, Chapter 3 of Title 10, Guam Code Annotated, is hereby *amended* to read:

"**§ 3812. Fee Schedule.**

(a) The Department is hereby authorized to implement a fee schedule. The provision of this Act *shall* be repealed upon subsequent submission and approval of the fee schedule through the Administrative Adjudication Law. The fee schedule must give discounts accordingly to the Federal Income Poverty Guideline.

(b) Individuals or families whose income falls below the federal poverty guidelines *shall* apply for subsidized medical services through the Medically Indigent Program or other medically subsidized program.

(1) The Program *shall* submit a billing claim to the Guam Medically Indigent Program Administrator for the necessary amount to recover the cost of services rendered to the Medically Indigent Program patients at the fee schedule rates established for reimbursement pursuant to applicable law, rules and regulations.

(A) Notwithstanding any other provision of law, rule or regulation, for the purposes of billing and collections, the Community Regional Health Centers Program *shall* be deemed apart and separate from the Department, and the Guam Medically Indigent Program *shall* promptly remit payment to the Program as reimbursement for services rendered to MIP patients, for deposit into the Community Health Center Revolving Fund."

Section 3. §2912.10 of Article 9, Chapter 2 of Title 10, Guam Code Annotated, is hereby *amended* to read:

"**§ 2912.10. Services Provided by Public Health.** With the exception of the Regional Community Health Centers of the Department of Public Health & Social Services (DPHSS), the Medically Indigent Program *shall not* reimburse other DPHSS programs for services provided or rendered. It is further provided, that services provided or rendered by the DPHSS Regional Community Health Centers, for patients participating in the Medically Indigent Program for medical, laboratory, and pharmacy services for which a fee is charged, *shall* be eligible for reimbursement by

the Medically Indigent Program and deposited into the Community Health Center Revolving Fund, at the fee schedule rates established pursuant to applicable law, rules and regulations."

Section 4. Severability. *If* any of the provisions of this Act or the application thereof to any person or circumstance are held invalid, such invalidity *shall not* affect any other provision or application of this Act, which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

6

I MINA' TRENTAI UNU NA LIHESLATURAN GUÅHAN

2012 (SECOND) Regular Session

Date: 1/20/12

VOTING SHEET

Bill No. 292-31(COR)
Resolution No. _____
Question: _____

NAME	YEAS	NAYS	NOT VOTING/ ABSTAINED	OUT DURING ROLL CALL	ABSENT
ADA, Thomas C.	✓				
ADA, V. Anthony	✓				
BLAS, Frank F., Jr.	✓				
CRUZ, Benjamin J. F.	✓				
DUENAS, Christopher M.	✓				
GUTHERTZ, Judith Paulette	✓				
MABINI, Sam	✓				
MUNA-BARNES, Tina Rose	✓				
PALACIOS, Adolpho Borja, Sr.	✓				
PANGELINAN, vicente (ben) cabrera					EA
RESPICIO, Rory J.	✓				
RODRIGUEZ, Dennis G., Jr.	✓				
SILVA TAIJERON, Mana	✓				
WON PAT, Judith T.	✓				
YAMASHITA, Aline A.	✓				
TOTAL	14	0	0	0	1

CERTIFIED TRUE AND CORRECT:

Clerk of the Legislature

*3 Passes = No vote
EA = Excused Absence

Ufisinan Todu Guam
SENATOR DENNIS G. RODRIGUEZ, Jr.
I Mina'trentai Unu Na Liheslaturan Guåhan
CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

October 20, 2011

Honorable Judith T. Won Pat, Ed.D.
Speaker
I Mina'Trentai Unu Na Liheslaturan Guåhan
155 Hesler Place
Hagåtña, Guam 96910

RECEIVED
OCT 20 2011
BY: [illegible]
TIME: 4:15

VIA: The Honorable Rory J. Respicio Rory J. Respicio
Chairperson, Committee on Rules

RE: Committee Report – Bill No. 292-31(LS)

Dear Speaker Won Pat:

Transmitted herewith, for your consideration, is the **Committee Report** on **BILL NO. 292-31(LS)- An act to authorize the Community Health Centers of the Department of Public health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated;** Sponsored by myself, and referred to the Committee on Health & Human Services, Economic Development, Senior Citizens and Election Reform. Bill No. 292-31(LS) was publicly heard on September 15, 2011.

Committee votes are as follows:

07 **TO PASS**
0 **NOT TO PASS**
0 **ABSTAIN**
02 **TO REPORT OUT ONLY**
0 **TO PLACE IN INACTIVE FILE**

Senseramente,

Senator Dennis G. Rodriguez, Jr.
Chairman

Attachments

176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638 Email: senatordrodriguez@gmail.com

Ufisinan Todu Guam
SENATOR DENNIS G. RODRIGUEZ, Jr.
I Mina'trentai Unu Na Liheslaturan Guåhan
CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

COMMITTEE REPORT
ON

BILL NO. 292-31(LS)
Sponsored by:
Senator Dennis G. Rodriguez, Jr.

An act to authorize the Community Health Centers of the Department of Public health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated

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Telephone: 671.649.8638 Email: senatordrodriguez@gmail.com

Ufisinan Todu Guam

SENATOR DENNIS G. RODRIGUEZ, Jr.

Trentai Unu Na Liheslaturan Guåhan

AN, COMMITTEE ON HEALTH & HUMAN SERVICES,
DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

date

October 24, 2011

MEMORANDUM

To: **ALL MEMBERS**
Committee on Health & Human Services, Economic Development, Senior Citizens and Election Reform.

From: **Senator Dennis G. Rodriguez, Jr.**
Committee Chairperson

Subject: **Committee Report on Bill no. 292-31(LS).**

Transmitted herewith, for your consideration, is the **Committee Report** on **BILL NO. 292-31(LS)- An act to authorize the Community Health Centers of the Department of Public health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated;** Sponsored by Senator Dennis G. Rodriguez, Jr..

This report includes the following:

- Committee Voting Sheet
- Committee Report Narrative/Digest
- Copy of Bill No. 292-31 (LS)
- Public Hearing Sign-in Sheet
- Copies of Submitted Testimony and Supporting Documents
- Copy of COR Referral of Bill No. 292-31(LS)
- Notices of Public Hearing (1st and 2nd)
- Copy of the Public Hearing Agenda
- Related News Articles (Public hearing publication of public notice)

Please take the appropriate action on the attached voting sheet. Your attention to this matter is greatly appreciated. Should you have any questions or concerns, please do not hesitate to contact me.

Si Yu'os Ma'åse'!

Attachments

176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638 Email: senatordrodriguez@gmail.com

Ufisinan Todu Guam

SENATOR DENNIS G. RODRIGUEZ, Jr.

I Mina'trentai Unu Na Liheslaturan Guåhan

CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

COMMITTEE VOTING SHEET

BILL NO. 292-31(LS)- An act to authorize the Community Health Centers of the Department of Public health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated

	SIGNATURE	TO PASS	NOT TO PASS	ABSTAIN	REPORT OUT ONLY	PLACE IN INACTIVE FILE
DENNIS G. RODRIGUEZ, Jr. Chairman		9/28/11				
ADOLPHO B. PALACIOS, Sr. Vice Chairman		10/24/11				
JUDITH T. WON PAT, Ed.D. Speaker						
BENJAMIN J. F. CRUZ Vice-Speaker		10/24/11				
TINA ROSE MUÑA BARNES Legislative Secretary						
THOMAS C. ADA		10/24/11				
VICENTE C. PANGELINAN						
RORY J. RESPICIO						
JUDITH P. GUTHERTZ, DPA						
FRANK F. BLAS, Jr.					10/24/11	
V. ANTHONY ADA						
ALINE A. YAMASHITA, Ph.D.					10/24/11	
SAM MABINI, Ph.D.						
MANA SILVA TAIJERON		10/24/11				
CHRISTOPHER M. DUENAS		10/24/11				

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Telephone: 671.649.8638 Email: senatordrodriguez@gmail.com

Ufisinan Todu Guam

SENATOR DENNIS G. RODRIGUEZ, Jr.

I Mina'trentai Unu Na Liheslaturan Guåhan

CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

COMMITTEE REPORT DIGEST

Bill No. 292-31(LS)

I. OVERVIEW: The Committee on Health & Human Services, Economic Development, Senior Citizens and Election Reform conducted a public hearing on September 15, 2011. The hearing convened at 8:30AM in I Liheslatura's Public Hearing Room. Among the items on the agenda was the consideration of **BILL NO. 292-31(LS)- An act to authorize the Community Health Centers of the Department of Public health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated;** Sponsored by Senator Dennis G. Rodriguez, Jr..

Public Notice Requirements

Notices were disseminated via hand-delivery/fax and/or email to all senators and all main media broadcasting outlets on September 08, 2011 (5-day notice), and again on September 13, 2011 (48-hour notice).

Senators Present

Senator Dennis G. Rodriguez, Jr.	Chairman
Senator Adolpho B. Palacios, Sr.	Vice-Chairman
Senator Benjamin J. F. Cruz	Committee Member
Senator V. Anthony Ada	Committee Member

The public hearing on agenda item Bill No. 292-31(LS) was called to order at 8:33AM.

II. SUMMARY OF TESTIMONY & DISCUSSION.

Chairman Dennis G. Rodriguez, Jr., convened the Public Hearing on Bill 292-31(LS). **As the author of Bill 292-31 (LS), Senator Rodriguez explained the intent of the bill.**

Chairman Rodriguez: Short introduction of bill.

Jim Gillian: Read written testimony in SUPPORT of Bill 292.

Linda Unpingco-DeNorcey: Read written testimony in SUPPORT of Bill 292.

There being no other testimony, or comments by Senators, Chairman Rodriguez declared the bill as having been heard, and concluded the public hearing on Bill No. 292-31(LS). The committee would continue to accept written testimony for a period of ten (10) days subsequent to the public hearing.

Fiscal Note: Requested on August 26, 2011 (attached) and pending receipt.

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Telephone: 671.649.8638 Email: senatordrodriguez@gmail.com

Ufisinan Todu Guam

SENATOR DENNIS G. RODRIGUEZ, Jr.

I Mina'trentai Unu Na Liheslaturan Guåhan

CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

III. FINDINGS AND RECOMMENDATIONS

The Committee on Health & Human Services, Economic Development, Senior Citizens and Election Reform, hereby **reports out Bill No. 292-31(LS),** with the recommendation to TO ~~PASS~~ REPORT OUT ONLY. BR.

176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638 Email: senatordrodriguez@gmail.com

MINA' TRENTAI UNU NA LIHESLATURAN GUAHAN
2011 (FIRST) Regular

Bill No. 292-31(LS)

Introduced by: **D.G. RODRIGUEZ, JR.**

AN ACT TO AUTHORIZE THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS, BY AMENDING §3812 OF ARTICLE 8, CHAPTER 3, AND BY AMENDING §2912.10 OF ARTICLE 9, CHAPTER 2, OF TITLE 10, GUAM CODE ANNOTATED.

2011 AUG 25 AM 9:04

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Findings and Intent: *I Liheslaturan Guåhan* finds that the Northern and Southern Regional Community Health Centers (CHC) of the Department of Public Health & Social Services Bureau of Primary Care are unable to seek compensation for services rendered to patients under the Medically Indigent Program. The DPHSS community health centers are grantees under the Health Recourses and Services Administration, US Department of Health & Human Services.

This is due to a policy interpretation that since the MIP Reform Act provides in 10GCA, Chapter 2, Article 9, §2912.10, that, "[t]he Medically Indigent Program shall not reimburse Public Health for services provided by Public Health Programs." In effect, *all* services provided by the Department of Public Health for MIP patients are free (i.e., no reimbursements can be made for services), and, the CHC can not submit a claim to the MIP program for the reimbursement of the cost

of services rendered. This situation is resulting in a continually diminishing balance in the Community Health Center Revolving Fund, and is contrary to the Federal statutory provisions applicable to the CHC's grant award.

I Liheslaturan Guåhan recognizes that the Northern and Southern Regional Community Health Centers are Federally Qualified Health Centers (FQHC's) that are mandated to collect revenues from third party payers (i.e., private insurance indemnities), Medicare, Medicaid, Medically Indigent Program (MIP), and self-pay patients so that the revenues or program income monies generated are to be used exclusively for the operation of the Guam Community Health Centers. And, to that end, 10GCA, Article 8, Chapter 3, §3811, provides for the establishment of the Community Health Centers Revolving Fund. Subsection (d) provides that, *"Deposits – All monies deposited in the Fund shall be applied to the expenses of the community center allowable by Federal regulations and guidelines as the non-Federal share of project costs in accordance with the Department's grant from the U.S. Department of Health & Human Services."*

Further, *I Liheslaturan Guåhan* takes due note of the grant compliance requirements of the Health Resources & Services Administration, US Department of Health &Human Services, as provided pursuant to §330(k)(3)(F) & (G) of the U.S. Public Health Services Act, that *grantee health centers* have: *Billings and Collections: Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.*

It is the *intent* of *I Liheslaturan Guåhan* that the conflicting provisions of §2912.10 of Article 9 – Medically Indigent Program – Chapter 2, Title 10, Guam Code Annotated, relative to services provided by Public Health, be reconciled with

§3812 of Article 8, Chapter 3, Title 10, Guam Code Annotated, relative to DPHSS Regional Community Health Centers fee schedules, so as to allow the CHC's as a Federally Qualified Health Center grantee to conform and comply with the Federal statutory provisions and regulations applicable to its programs.

Section 2. §3812 of Article 8, Chapter 3, Title 10, Guam Code Annotated, is hereby amended, to read:

"§ 3812. Fee Schedule.

(a) The Department is hereby authorized to implement a fee schedule. The provision of this Act shall be repealed upon subsequent submission and approval of the fee schedule through the Administrative Adjudication Law. The fee schedule must give discounts accordingly to the Federal Income Poverty Guideline.

(b) Individuals or families whose income falls below the Federal poverty guidelines shall apply for subsidized medical services through the Medically Indigent Program or other medically subsidized program.

(1) The Program ***shall*** submit a billing claim to the Guam Medically Indigent Program Administrator for the necessary amount to recover the cost of services rendered to the Medically Indigent Program patients at the fee schedule rates established for reimbursement pursuant to applicable law, rules and regulations.

(A) Notwithstanding any other provision of law, rule or regulation, for the purposes of billing and collections, the Community Regional Health Centers Program *shall* be deemed apart and separate from the Department, and the Guam Medically Indigent Program *shall* promptly remit payment to the Program as reimbursement for services

rendered to MIP patients, for deposit into the Community Health Center Revolving Fund."

Section 3. §2912.10 of Article 9 – Medically Indigent Program – Chapter 2, Title 10, Guam Code Annotated, is hereby amended, to read:

"§ 2912.10. Services Provided by Public Health. Generally, [~~T~~] the Medically Indigent Program shall not reimburse Public Health for services provided by Public Health Programs, **provided, however,** services provided or rendered by the Regional Community Health Centers of the Department of Public Health for medical, dental, laboratory, x-ray, pharmacy, and/or any other health related services, etcetera, ***shall*** be reimbursed at the fee schedule rates established pursuant to applicable law, rules and regulations."

Section 4. Severability. If any of the provisions of this Act or the application thereof to any person or circumstance are held invalid, such invalidity shall not affect any other provision or application of this Act, which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

Section 5. Effective Date. This Act shall become immediately effective upon enactment.

SENATOR DENNIS G. RODRIGUEZ, Jr., Chairman

COMMITTEE ON HEALTH & HUMAN SERVICES, ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

Mina'trentai Unu Na Liheslaturan Guåhan • 31st Guam Legislature

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PUBLIC HEARING DATE / TIME: Thursday, September 15, 2011 1:30pm

AGENDA ITEM: Bill No. 292-31 (LS) - An act to authorize the Community Health Centers of the Department of Public health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated. By: Sen. DG Rodriguez, Jr.

PRINT NAME	SIGNATURE	AGENCY or ORGANIZATION	ORAL TESTIMONY	WRITTEN TESTIMONY	IN FAVOR	OPPOSE	CONTACT NUMBERS
James Gilliam		DPHSS		✓	✓		
Melissa Savares		GCHC Bd	✓		✓		632-5203
LINDA VNPINGCO-DEN		DPHSS	✓	✓	✓		635-4422
SONYA NAPUTI-SAVARES		GCHC	N/A	N/A	X		477-9000
None follows							

BILL NO: 292-31 (COR) Page 1 of 1

EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

JAMES W. GILLAN
DIRECTOR

LEO G. CASIL
DEPUTY DIRECTOR

September 15, 2011

Honorable Dennis G. Rodriguez, Jr.
Chairman, Committee on Health and Human
Services, Senior Citizens, Economic
Development and Election Reform

Re: Bill No.292-31, AN ACT TO AUTHORIZE THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES TO OBTAIN REIBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS….. (Senator Rodriguez)

Dear Mr. Chairman:

Thank you for allowing me to present testimony on the above bill. These amendments will allow the Community Health Centers to collect much needed revenue.

We believe that the original law's intent was not to exempt MIP from paying for services for their clients. The intent, rather was to exempt those services traditionally provided free of charge under discrete Public Health Programs.

Passage of this bill will allow the Community Health Centers to recoup some of their charges as required by their Federal Charter. This will allow the Centers to continue to provide services with out fear operating with insufficient funds.

James W. Gillan

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

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

EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

JAMES W. GILLAN
DIRECTOR

LEO G. CASIL
DEPUTY DIRECTOR

WRITTEN TESTIMONY IN FAVOR OF Bill No.292-31

My name is Linda Unpingco-DeNorcey and I am the Executive Director of the Northern and Southern Region Community Health Centers. As you know, the mission of the Guam Community Health Centers is to increase access to primary health care and preventive services and to reduce health disparities among the medically underserved population.

The Northern and Southern Region Community Health Centers are Federally Qualified Health Centers (FQHCs) that are mandated to collect revenues from third party payers (i.e., private insurance indemnities), Medicare, Medicaid, Medically Indigent Program (MIP), and self-pay patients so that the revenues or program income monies generated are to be used exclusively for the operation of the Guam Community Health Centers.

According to the federal health center program requirements as stipulated in Section 330(k) (3) (F) and (G) of the Public Health Service Act: "Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement." "Health centers must bill Medicare, Medicaid, Child Health Insurance Program (CHIP), and other applicable public or private third party payors." (see attachment). Thus, the Guam Community Health Centers must bill the Medically Indigent Program (MIP) as this is a public third party payor.

This federal mandate is duly recognized by the Guam legislators through several public laws such as Public Law 24-248: "The Community Health Center Act of 1998" and Public Law 30-108. Public Law 24-248 Section 3811 Community Health Center Revolving Fund stipulates: "there is hereby established a Community Health Center Revolving Fund to be maintained and administered by the Director of the Department. All monies collected by the Department for medical services rendered at the community health centers shall be deposited into the Fund and applied to the expenses of the community centers allowable by Federal regulations and guidelines as the non-Federal share of the project costs in accordance with the Department's grant from the U.S. Department of Health and Human Services."

Currently, the MIP Reform Law states that all services provided by the Department of Public Health for MIP patients are free (i.e., no reimbursements can be made for services). Although there may be several different interpretations of this statement, (one may interpret it as federal programs managed at Central Public Health in Mangilao-not

inclusive of the CHCs, yet another may interpret it to include CHCs), the interpretation made by the Guam Medically Indigent Program Office is that it includes the CHCs since they are under the Department of Public Health and Social Services. Their interpretation has resulted in the CHCs' inability to collect revenues for medical, laboratory, and pharmacy services rendered by the CHCs. If the CHCs were to ignore the federal program mandate of billing public third party payers (e.g., MIP), the inability to bill for services simply is not consistent with sound business practice! It costs money to operate the CHCs in terms of paying personnel cost, health professional contractual services, and medical, laboratory, and pharmaceutical supplies. Like in any business, if reimbursements or payments are not received to cover overhead costs, the business simply would go bankrupt and close its doors of operation! If the CHCs continue providing MIP patients with free services, it most certainly would adversely affect the centers' financial sustenance and viability, which ultimately would result in the CHCs no longer extending services to MIP patients since the demand for services exceeds available resources and continually serving MIP patients would jeopardize the center's financial viability. Therefore, the CHCs have the right to turn MIP patients away.

HRSA's **Policy Information Notice 2007-09 (Page 5)** states: "Section 330 (e) grantees and FQHC Look-Alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay. Centers are also free to extend services to those residing outside the service area. However, **HRSA recognizes that health centers must operate in a manner consistent with sound business practices. As such, health centers are not expected to extend services to additional patients residing inside or outside of the service area if (1) the demand for services exceeds available resources, and/or (2) doing so would jeopardize the center's financial stability**." (see PIN 2007-09 attachment).

In view of the above, I fully support Bill No. 292-31 for the MIP Reform Law to be amended so that the Community Health Centers can obtain reimbursements from MIP for medical, laboratory, and pharmacy services in order to be in compliance with HRSA's Federal program requirements. By doing so, the CHCs would be able to garnish patient revenues so that sufficient resources can be made available to uphold the demand for health care services as well as maintain the CHCs' financial stability. Otherwise, the CHCs would have no other alternative, but to avert MIP patients from receiving primary health care and ancillary services. Doing this would further strain Guam's health care system since only a handful of providers accept this indigent population who are most in need and least able to find care.

MPH

LINDA UNPINGCO-DENORCEY, M.P.H.

U.S. Department of Health and Human Services
HRSA BPHC Bureau of Primary Health Care
Health Resources and Services Administration

POLICY INFORMATION NOTICE

Policy Information Notice 2007-09

DOCUMENT NAME: Service Area Overlap: Policy and Process

DATE: MAR 1 2 2007

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices

This Policy Information Notice (PIN) describes the Health Resources and Services Administration's policies and processes for health center service area overlap. As the number of health center and Federally Qualified Health Center (FQHC) Look-Alike sites grows, so does the potential that service areas will overlap. Consequently, there are an increasing number of service area overlap-related issues emerging that involve federally funded health centers, FQHC Look-Alikes, and/or current applicants for Federal health center funding.

Please contact Shannon Dunne Faltens at 301-594-4060 for any questions regarding this PIN.

James Macrae
Associate Administrator

I. Purpose

The purpose of this PIN is to (1) define what constitutes "service area overlap" in the context of the Health Center and Federally Qualified Health Center (FQHC) Look-Alike Programs administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care; (2) state HRSA's policies with respect to service area overlap; and (3) describe HRSA's process for determining whether to approve a pending application and/or change in scope request in a service area overlap situation.

II. Background

As the number of health center sites (including federally funded sites and FQHC Look-Alike sites) grows, so does the potential that service areas will overlap. In some places, such as areas with large and diverse underserved populations and significant unmet need, it may be appropriate and beneficial to both the community and the health centers involved to share all or part of the same service area. In other communities, however, service area overlap may undermine the stability of one or more of the health centers involved in serving the area. Moreover, HRSA has a responsibility to ensure that limited Federal grant dollars are used efficiently and effectively to provide access to as many underserved people as possible, and, in some instances, supporting multiple sites within the same service area may compromise this principle.

While overlapping service areas may not necessarily raise concerns, there are an increasing number of service area overlap-related issues that require analysis and resolution before HRSA may move forward in making a final decision on a health center's funding application, request for change in scope of project, or application for designation as a FQHC Look-Alike. This PIN describes and clarifies HRSA's policies and processes for resolving these issues, with the goal of improving the likelihood of early identification and timely resolution of service area overlap situations.

III. Definitions

A. Federally Funded Health Centers

For purposes of this guidance, the term "federally funded health centers" or "grantee health centers" includes all health centers funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, specifically:

- Community Health Center (CHC) Programs, funded under section 330(e);
- Migrant Health Center (MHC) Programs, funded under section 330(g);

- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

B. FQHC Look-Alike

FQHC Look-Alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive the FQHC Look-Alike designation and the benefits of that designation, FQHC Look-Alikes must meet the same statutory, regulatory, and policy requirements as grantee health centers. Applicants for FQHC Look-Alike designation must meet the following requirements:

- be a public or a private nonprofit entity;
- serve, in whole or in part, a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP);
- meet the same statutory, regulatory, and policy requirements as grantees supported under section 330 of the PHS Act; and
- comply with section 1905(l)(2)(B) of the Social Security Act which states that an FQHC Look-Alike entity may not be owned, controlled, or operated by another entity.

When appropriate, this PI N will specifically reference FQHC Look-Alikes to emphasize the applicability of the PIN to these entities.

C. Health Centers

As used in this PIN, the term "health centers" includes both federally funded health centers and FQHC Look-Alikes.

D. Service Area

A service area, which is one element of a health center's scope of project, is comprised of several factors. Although, in general, the service area is the area in which the majority of the health center's patients reside, health centers may use other geographic or demographic characteristics to describe their service area.

1. .Overview and Statutory Requirements

The concept of a "service" or "catchment" area has been part of the Health Center Program since its beginning. The Health Center Program's authorizing statute requires that each grantee periodically review its catchment area to:

i. ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;[1]
ii. ensure that the boundaries of such area conform, to the extent

[1] Primary health services of the center must also be provided "in a manner which assures continuity." (PHS Act section 330(k)(3)(A).)

practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

iii. ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

Public Health Service Act sec. 330(k)(3)(J)

Health centers receiving grants under section 330(e) of the PHS Act are statutorily obligated to make services available to all residents of the service area, to the extent that they are able, using available resources. Grantees receiving funding only under section 330(g), (h), and/or (i) of the PHS Act, which are targeted respectively to migrant and seasonal, homeless, or public housing populations (i.e., the grantee receives no section 330(e) funds), are not subject to the requirement to serve all residents of the service area (see section F. below).

2. Assessing and Identifying Service Areas

Each health center should periodically assess its declared service area to ensure that the description adequately reflects the health center's current activities. Routine patient origin analysis (for example, using the zip codes of the patient records on file) will help to ensure that the reported service area is accurate and can help determine updated service area boundaries by indicating the areas from which the health center draws the majority of its patients. While health centers may be called upon to serve patients from outside their service area, the service area should include, at a minimum, the area from which the vast majority of patients reside.

The service area should, to the extent practicable, be identifiable by county and by census tracts within county. Describing service areas by census tracts is typically necessary to enable analysis of service area demographics. Service areas may also be described by other political or geographic subdivisions (e.g., county, township, zip codes as appropriate). The service area must be federally designated as a MUA in full or in part or contain a federally designated MUP.

Starting with calendar year (CY) 2005 Uniform Data System (UDS) data, grantees now annually report information on the aggregate geographic area in which its patients reside. This will enable HRSA to better identify overall health center service areas.

3. Service Area Establishment and Expansion

Applicants for funding under section 330 of the PHS Act initially document their service area in the New Access Point (NAP) or Service Area

Competition (SAC) funding application. The funded NAP or SAC application is the basis for determining a grantee's initial service area. Similarly, FQHC Look-Alikes initially document their service area in the designation application. Once established, health centers should incorporate periodic service area assessments into the annual grant application (competing or non-competing) or FQHC Look-Alike annual re-certification application.

A grantee or FQHC Look-Alike that wishes to expand its service area by opening a new site may submit a change in scope request at any time. For grantees, they must demonstrate that this expansion will not require additional grant funds. Grantees may also expand their service area through a funded NAP application which requests additional grant support to add a new service delivery location to the approved scope of project. (See PIN 2002-07, "Scope of Project Policy," for information on change in scope requests.)

E. Health Center Service Site

For purposes of determining which sites are included within a health center's scope of project, a service site is any place where a health center, either directly or through a subrecipient[2] or contract arrangement, provides required primary health services and/or approved additional services to a defined service area or population. Service sites are defined as locations where all of the following conditions are met:[3]

- health center encounters are generated by documenting in the medical record face-to-face contacts between patients and providers;
- providers exercise independent judgment in the provision of services to the patient;
- services are provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location; and
- services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month).[4] However, there is no minimum number of hours per week that services must be available at an individual site/location.

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[2] For purposes of Medicaid and Medicare FQHC reimbursement, a subrecipient is an organization that: (1) receives funding from a section 330 grant through a contract with the recipient of such a grant and (2) is compliant with all of the requirements of section 330 of the PHS Act (see §1861(aa)(4) and §1905(l)(2)(B) of the Social Security Act).

[3] Service sites are a critical component of a health center's scope of project. Other programs, (e.g., FTCA, 340B, and FQHC) have their own standards to determine eligibility for the benefits available through these programs. Each of these programs has a specific application process and a comprehensive set of requirements, of which service site is only one. In other words, identification as a service site within a scope of project is necessary, but not sufficient to ensure participation in the other programs. To participate, all of the requirements of the other programs must be met and coordination with these programs is required.

[4] Again, note the statutory requirement in section 330(k)(3) of the PHS Act that "primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity." In addition, note the regulatory requirement for community and migrant health center grantees that such centers "must be operated in a manner calculated to . . .

Administrative offices or locations that do not provide direct health care services are not service sites.

F. Target Population

The target population is the population to be served by the health center. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service area.

Section 330(e) grantees and FQHC Look-Alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay. Centers are also free to extend services to those residing outside the service area. However, HRSA recognizes that health centers must operate in a manner consistent with sound business practices. As such, health centers are not expected to extend services to additional patients residing inside or outside of the service area if (1) the demand for services exceeds available resources, and/or (2) doing so would jeopardize the center's financial stability. However, grantee health centers and FQHC Look-Alikes should address the acute care needs of all who present for service, regardless of residence.

Some health center programs receive funding to target special populations: specifically, migrant and seasonal farmworkers and their families, persons who are homeless, and residents of public housing. Health centers receiving such funding (i.e., grants under section 330(g), (h), or (i) of the PHS Act) are not subject to the requirement to serve all residents of the service area; however, they should make services available to all members of the special population targeted, and, as stated above, address the acute care needs of all who present for service.

G. Health Center Patient

For purposes of the HRSA UDS reporting, a patient is an individual who has at least one clinical encounter at one of the health center's service sites in a given calendar year. For purposes of serving on a health center's governing board, a consumer board member should utilize the health center as his/her principle source of care and, at a minimum, should have used the health center's services within the last 2 years (see HRSA PIN 98-23, section III(B)(2)).[5]

H. Unmet Need

In communities with high levels of unmet need among the underserved population(s), service area overlap may be appropriate and provide critical additional access. This is particularly true in areas with high numbers of underserved people and limited providers serving this population or in areas with specific sub-groups of the population who may need special approaches to ensure

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maximize . . . effective utilization of services." (See 42 CFR 51c.303(m) and 42 CFR 56.603(k).)

[5] Health centers receiving funding only under section 330(g), (h), and/or (i) of the PHS Act (i.e., the center receives no section 330(e) funds) may apply for a waiver of this and other governing board requirements.

access (e.g., non-English speaking groups, people who are homeless, or newly arrived immigrants/refugees). In order to determine whether overlapping service areas could benefit the community without threatening the stability of existing health centers, some assessment of the degree and type of unmet need in the service area is necessary. The process for assessing unmet need in situations of service area overlap is explained further, below.

I. Collaboration

In order to maximize limited resources and access to care for their patients, health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made "and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center" (PHS Act section 330(k)(3)(B)). As stated in section V. of this PIN, "HRSA Policy," the goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, existing or potential service area overlaps.

IV. Identifying Service Area Overlap

HRSA examines issues of overlap in the context of the service area definition in section III of this PIN. As stated above, service areas are primarily defined by patient origin and identified by census tracts or other political or geographic subdivisions (e.g., zip codes). Issues of service area overlap are raised primarily in five types of situations, listed below:

1. an existing grantee health center, new entity, or FQHC Look-Alike applies for NAP or other funding to serve an area which includes all or part of the service area of another existing grantee health center;
2. an existing grantee health center or FQHC Look-Alike requests a "Change in Scope" to open a new health center service site to serve all or part of the service area of another health center, or to provide new services to all or part of the service area of another health center;
3. an existing grantee health center, non-grantee health center, or FQHC Look-Alike applies for NAP funding, other section 330 funding, or requests a Change in Scope at the same time as another grantee health center, non-grantee health center, or FQHC Look-Alike proposes to serve an area which, at the time of the application, is not served by either organization;
4. an existing grantee health center or FQHC Look-Alike relocates an existing clinic to an area served by another health center; or

5. an organization applies for FQHC Look-Alike status to serve an area or population already served by an existing grantee health center.

Potential overlaps are typically identified through a number of sources (e.g., HRSA staff reviews, health center grantees, applicants, FQHC Look-Alikes, and/or Primary Care Associations (PCAs)). All applications for grant funding, FQHC Look-Alike designation/recertification, and changes in scope are examined for potential service area overlap. Applications that present possible service area overlaps are flagged for additional review, if necessary.

V. HRSA Policy

HRSA's foremost concern is to utilize its limited Federal grant dollars to provide access to high quality primary care services to as many underserved people as possible, as efficiently as possible. As such, grant dollars should be targeted to entities in areas of high need that demonstrate that the Federal investment will be efficiently and effectively applied to those needs.

To achieve this, HRSA will be guided by the following overarching principles listed below when assessing individual situations of service area overlap:

1. Meeting the health care needs of the community and target population is paramount in decisions related to service area overlap;
2. Federal grant dollars should be distributed in such a way as to minimize the potential for unnecessary duplication and/or overlap in services, sites, or programs;
3. HRSA recognizes the advantage of using existing resources with proven capabilities to maintain effective and efficient delivery of health care within communities;
4. When a newly identified group of underserved people within a community already served by a health center is proposed to be served by a new site (e.g., homeless people within the service area), this potentially unmet need in the community will be considered when reviewed for service area overlap. If the health care needs of the relevant medically underserved population group within a service area are not being met, geographic service area boundaries will not serve as a barrier to the approval of the application, even where the service area does in fact overlap with that of an existing grantee health center or FQHC Look-Alike;
5. HRSA encourages openness and collaboration among providers.[6] The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall needs of the area's underserved population; and
6. HRSA has a responsibility to ensure the efficient distribution of Federal resources. Therefore, when the potential exists for patients to be drawn from an existing health center to a new organization or proposed site, HRSA will consider the financial impact on the existing health center. In doing so, HRSA

[6] See also section III.H., above.

may examine the past performance of the existing health center and its historical and current ability to meet the needs of the community.

VI. Process for Resolving Potential Service Area Overlap

HRSA's approach to resolving potential situations of service area overlap is based on: 1) early identification of potential overlap; 2) utilization of standard data to define service area and unmet need whenever possible; and/or 3) conducting site visits as appropriate. The actual steps may differ slightly depending on the individual circumstances and the data available.

The following list of steps outlines the process that will be undertaken by HRSA to resolve identified service area overlap issues:

1. Map the service area in question and its census tracts and/or zip codes;
2. Gather data (for example, current patient origin studies) in coordination with the relevant parties.[7] Considerations such as community and financial support, current capacity, utilization rate, existing and proposed partnerships, and unmet need may be assessed; and/or
3. A site visit may be conducted.

VII. Data Sources

In order to analyze service area overlap, HRSA may request data from relevant parties to describe the service area, provider/population ratio, target population, and current patient population (for operational grantee health centers and FQHC Look-Alikes) or projected patient populations (for new grantee health centers or newly designated FQHC Look-Alikes). These data will be requested, as necessary and appropriate, from all organizations that are impacted by the service area overlap. The data requested may augment and/or substantiate data already on file at HRSA from the grant applications, change of scope requests, and/or UDS reports. Data submitted should be verifiable and site-specific.

A. Currently Reported Data

Grantee health centers define their service area and target population as part of their competing or non-competing section 330 grant application. Currently (as of fiscal year 2006), the NAP, SAC, and Budget Period Renewal (BPR) applications require applicants to list the census tracts and zip codes covered by the entire program (Form1-Part A: General Information) while Form 5-Part B: Service Sites asks applicants to list the census tracts served by each site within their Scope of Project. The instructions ask applicants to define their target population and provide demographics for both the service area and target population in the narrative and on Form 4: Community/Target Population Characteristics.

[7] Coordination with relevant parties will be consistent with HHS grants law, regulations, and policy.

Beginning with the collection of CY 2005 UDS data, grantee health centers report patient origin by zip code.

FQHC Look-Alikes define their service area and target population as part of their designation/recertification application. FQHC Look-Alike applicants are not required to submit UDS data. Rather, these organizations complete the FQHC Look-Alike tables and forms, describe their service area, and describe their target and patient populations as part of their initial designation and subsequent recertification applications.

B. Data Sources to Document Service Area Overlap

In order to accurately document the extent of a potential service area overlap, and to determine whether there is unmet need in that area, it is critical that the grantee, FQHC Look-Alike, or applicant provide information that is as detailed as possible. HRSA may request the organization's assistance in providing data such as:

1. Service Area and Target Population:

   - **Census data** as applicable: including median income level, percent of population below poverty and/or below 200 percent of poverty level, number of uninsured, ethnicity, and/or language.
   - **Other State or Federal reports:** for example, reports on school English as a Second Language program enrollment or State surveys of the area in question.
   - **Other Providers:** In order to accurately document the extent and implication of a potential service area overlap, health centers and FQHC Look-Alikes are expected to describe the other providers serving the underserved population in the area. At a minimum, they should identify the other safety net providers available (FQHCs, public hospital/health department primary care clinics, Critical Access Hospitals with primary care capacity, and Rural Health Clinics), if any. They should also describe the extent to which private sector providers in the area serve Medicaid beneficiaries, the uninsured, and other underserved populations. If the health center is not able to document the support of other local providers for its application, it should provide an explanation for the lack of support.

2. Patient Population:

   The most recent UDS report is a major source of information on current grantees' patient population in terms of total numbers as well as income, ethnicity, and language preference. Some grantee health centers may be asked to supplement their UDS data with more detail (e.g., if the center serves a specific ethnic group that is not distinctly reported on the UDS).

3. Relationship of Patients to Service Area:

   The purpose of collecting service area, target population, and patient origin data is to determine the extent to which an existing health center serves the area and population and whether there is sufficient remaining unmet need or a distinct underserved population in the area to justify approving a grant application of change in scope request.

VIII. Conclusion

While individual circumstances will affect the specific process used to resolve service area overlap issues, this PIN describes the overarching principles that will inform decisions related to service area overlap and providing examples of the types of data that may be requested. HRSA will make every effort to reach positive and timely resolutions of service area overlap issues.

Attachment

ATTACHMENT
Relevant Statutory and Regulatory Provisions

Public Health Service (PHS) Act Section 330(a)

(1) In general

For purposes of this section, the term "health center" means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements--

(A) required primary health services (as defined in subsection (b)(1) of this section); and

(B) as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2) of this section) necessary for the adequate support of the primary health services required under subparagraph (A);

for all residents of the area served by the center (hereafter referred to in this section as the "catchment area").

(2) Limitation

The requirement in paragraph (1) to provide services for all residents within a catchment area shall not apply in the case of a health center receiving a grant only under subsection (g), (h), or (i) of this section (emphasis added)

PHS Act Section 330(k)(2)

An application for a grant under subparagraph (A) or (B) of subsection (e)(1) of this section for a health center shall include--

(A) a description of the need for health services in the catchment area of the center;

(B) a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of personal health services; and

(C) a demonstration that the center will be located so that it will provide services to the greatest number of individuals residing in the catchment area or included in such population group.

PHS Act Section 330(k)(3)(B)

"The Secretary may not approve an application for a grant . . . unless the Secretary determines that the entity . . . has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center."

PHS Act Section 330(k)(3)(J)

The center will review periodically its catchment area to--

(i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;

(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;

Section 330/Community Health Center Program implementing regulations

42 CFR 51c.102(b) "Catchment area means the area served by a project funded under section 330 of the Act."

42 CFR 51c.104(b) "Applications must include . . . the precise boundaries of the catchment area to be served by the applicant, including an identification of the [MUPs] within the catchment area. In addition, the application shall include information sufficient to enable the Secretary to determine that the applicant's catchment area meets the following criteria:

> (i) The size of such area is such that the services to be provided by the applicant are available and accessible to the residents of the area promptly and as appropriate;
> (ii) The boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and
> (iii) The boundaries of such area eliminate, to the extent possible, barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation."

42 CFR 51c.305 "The Secretary may award grants under this subpart to applicants . . . taking into consideration . . .

(h) Whether the center's catchment area is exclusive of the area served by another center;
(i) The de gree to which the applicant intends to integrate services supported by a grant under this subpart with health services provided under other Federally assisted health services or reimbursement programs or projects."

About Health Centers

What is a Health Center?

How to Apply (How to Apply for Funding of Look-Alike Designation)

Program Requirements

Program Benefits

Special Populations

Program Requirements

Printer-friendly Summary of the key Health Center Program requirements

Health centers are non-profit private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. A summary of the key health center program requirements is provided below. For additional information on these requirements, please review:

Health Center Program Statute

Program Regulations:
42 CFR Part 51c
42 CFR Parts 56.201-56.604

Grants Regulations:
45 CFR Part 74

NEED	
■	**Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
SERVICES	
■	**Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act)
■	**Staffing Requirement:** Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately credentialed and licensed. (Section 330(a)(1) and (b)(1), (2) of the PHS Act)
■	**Accessible Hours of Operation/Locations:** Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330 (k)(3)(A) of the PHS Act)
■	**After Hours Coverage:** Health center provides professional coverage during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act)

Health Center Requirements

Section 330 Requirements

Center Site Visit Guide

Health Center Program Requirements

Health Center Program Requirement Slides (PPT -2.3 MB)

Requirements & Regulations Related Links

Authorizing Legislation (Section 330 of the Public Health Service Act)

Community Health Center Program Regulations

Migrant Health Program Regulations

Grant Award Requirements

Program Information Notices & Program Assistance Letters

Medicare Benefit Policy Manual, Chapter 13

Health Center Site Visit Guide

Health Center Program Requirement Slides (PPT -2.3 MB)

■	**Hospital Admitting Privileges and Continuum of Care:** Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
■	**Sliding Fee Discounts:** Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient ability to pay. ■ This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.* ■ No discounts may be provided to patients with incomes over 200 % of the Federal poverty level.* (Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))
■	**Quality Improvement/Assurance Plan:** Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include: ■ a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;* ■ periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: * ■ be conducted by physicians or by other licensed health professionals under the supervision of physicians;* ■ be based on the systematic collection and evaluation of patient records;* and ■ identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.* (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))
MANAGEMENT AND FINANCE	
■	**Key Management Staff:** Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2), (3))
■	**Contractual/Affiliation Agreements:** Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2)))
■	**Collaborative Relationships:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of

	support from existing Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained (Section 330(k)(3)(B) of the PHS Act)
■	**Financial Management and Control Policies:** Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)
■	**Billing and Collections:** Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)
■	**Budget:** Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)
■	**Program Data Reporting Systems:** Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)
■	**Scope of Project:** Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)
GOVERNANCE	
■	**Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including: ■ holding monthly meetings; ■ approval of the health center grant application and budget; ■ selection/dismissal and performance evaluation of the health center CEO; ■ selection of services to be provided and the health center hours of operations; ■ measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and ■ establishment of general policies for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304) **Note:** In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv))

	Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act)
■	**Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, who as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically: ■ Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.* ■ The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. * ■ No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.* **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)
■	**Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. ■ No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as an ex-officio member of the board.* (45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

Billing and Collections

- Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement.
- Health centers must bill Medicare, Medicaid, CHIP, and other applicable public or private third party payors.

13. Billing and Collections

Requirement:

- Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.

(Section 330(k)(3)(F) and (G) of the PHS Act)

GUAM COMMUNITY HEALTH CENTERS, INC.

520 W. Santa Monica Avenue
Dededo, Guam 96929
Tel: (671) 635-7447/7544 Fax: (671) 635-7493

WRITTEN TESTIMONY BILL No.292-31

My name is Daniel Perez and I am the President of the Guam Community Health Center Board of Directors. The board exercises governance and fiduciary responsibility over the Northern and Southern Region Community Health Centers, two Federally Qualified Health Centers.

I am totally in support of Bill No. 292-31 for the Guam Community Health Centers to receive reimbursements from MIP for medical, laboratory, and pharmacy services in order to be in compliance with Health Resources Services Administration's Federal program requirement. According to the federal health center program requirements as stipulated in Section 330(k) (3) (F) and (G) of the Public Health Service Act: "Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement." "Health centers must bill Medicare, Medicaid, Child Health Insurance Program (CHIP), and other applicable public or private third party payers." (see attachment). Thus, the Guam Community Health Centers must bill the Medically Indigent Program (MIP) as this is a public third party payer.

Given the limited staffing, the Guam CHCs have been lobbying legislators over the past years to provide additional funding for the recruitment of providers and support staff in order to optimize the efficiency and flow of clinical operations. Fortunately, the CHCs have been successful in garnishing more funding locally as well as through federal support for the recruitment of additional providers and support staff. However, having more physicians/providers equates to attracting more and more patients into the CHCs, resulting in the demand for services outweighing the manpower for medical capacity. This situation is further aggravated by the government of Guam budget shortfall, federal budget cuts ($600 million HRSA budget cut for the Community Health Centers in the U.S. and its territories), and Guam's dismal economy (high unemployment rate of 13.3% in March 2011). The latter has contributed to the increasing numbers of uninsured people as well as more individuals turning to MIP as evident by the gradual rise in the number of MIP eligible people on island. Recent data from DPHSS Bureau of Health Care and Financing Administration (HCFA) reveals that there are **13,470 MIP eligible** patients. Thus, at a time when the need for comprehensive primary health care and preventive services provided by the community health centers is greater than ever, the CHCs' ability to give that needed care has been severely hampered by not only the lack of resources, particularly personnel, but also the lack of funding.

Although the Guam CHCs have been successful in applying for multiple grants (ARRA Increased Demand for Services grant, ARRA Capital Improvement grant, Community Development Block Grant, and the Compact-Impact Assistance grants), funding from these grants have been all zeroed out ($0 un-obligated federal balance) and there is no other extension of these federal funding since the term of these grants are limited to two years and have expired. Recently, the CHCs submitted the "Expanded Services" grant proposal in hopes of garnishing federal support. However, Guam and all the U.S. community health centers were not awarded any funding from such grant because U.S. Congress cut $600 million out of

HRSA funding for the community health centers. Realizing that the once "bloated" federal funding source has now dwindled in its revenue stream due to the U.S. debt ceiling, thus resulting in the federal government eliminating and/or reducing funding sources, the Guam CHCs had no other option, but to turn to the local government for support, however, the local government likewise cannot offer any assistance due to its budgetary constraints. Thus, the Guam CHCs also experienced local budget cuts in FY 2011. The Guam CHCs applied for the Compact-Impact Assistance grant ($750,000) from the U.S. Department of the Interior and the centers were awarded this grant in its entirety specifically to cover the cost for medical, laboratory, and pharmaceutical supplies in 2011. However, the entire $750,000 was rescinded as per the Governor's directive in order to pay for other debts owed by the local Government. Other than the $750,000 removed from the CHCs' funding stream, the "Vacant and Medicine" fund also was slashed so severely, (over $300,000 eliminated) for pharmaceutical supplies. Other than budget cuts in 2011, there were also budget cuts in the FY 2012 budget. The CHCs submitted its 2012 budget, which includes personnel cost for 3 more physicians to be funded, but all three positions were not funded.

Financial constraints are also experienced at the Guam Community Health Centers as evident in the decline of 4 percentage points in the overall charges collected in 2009 as compared to 2010 (from 27% in 2009 to 23% in 2010). One factor attributed to the decline is the inability of patients to pay for their medical bills since this is a low priority as compared to paying utility bills. Thus, the CHCs are not collecting as much revenues given the gradual increase in food, fuel, and utility costs.

Given all the aforementioned financial constraints (i.e., local and federal budget cuts) and the inability to collect account receivables, the Guam CHCs are financially crippled. Thus, Bill No. 292-31 would help the Guam Community Health Centers to be financially viable. I humbly request for your support so that together we can keep the Guam CHCs operating to help those most in need and least able to find care, which is truly the mission of the Guam Community Health Centers!!!

DANIEL PEREZ
President, Guam CHC Board of Directors

About Health Centers

What is a Health Center?

How to Apply (How to Apply for Funding of Look-Alike Designation)

Program Requirements

Program Benefits

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Program Requirements

Share

Printer-friendly Summary of the key Health Center Program requirements

Health centers are non-profit private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. A summary of the key health center program requirements is provided below. For additional information on these requirements, please review:

Health Center Program Statute

Program Regulations:
42 CFR Part 51c
42 CFR Parts 56.201-56.604

Grants Regulations:
45 CFR Part 74

NEED	
■	**Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
SERVICES	
■	**Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act)
■	**Staffing Requirement:** Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately credentialed and licensed. (Section 330(a)(1) and (b)(1), (2) of the PHS Act)
■	**Accessible Hours of Operation/Locations:** Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330 (k)(3)(A) of the PHS Act)
■	**After Hours Coverage:** Health center provides professional coverage during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act)

Health Center Requirements

Section 330 Requirements

Center Site Visit Guide

Health Center Program Requirements

Health Center Program Requirement Slides (PPT -2.3 MB)

Requirements & Regulations Related Links

Authorizing Legislation (Section 330 of the Public Health Service Act)

Community Health Center Program Regulations

Migrant Health Program Regulations

Grant Award Requirements

Program Information Notices & Program Assistance Letters

Medicare Benefit Policy Manual, Chapter 13

Health Center Site Visit Guide

Health Center Program Requirement Slides (PPT -2.3 MB)

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	Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act)
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NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

Linda Denorcey

From: "Onoda, Christie (HRSA)" <COnoda@hrsa.gov>
To: "Linda Denorcey" <jilinda@netpci.com>
Sent: Saturday, November 15, 2008 8:59 AM
Attach: pin2007-09.pdf
Subject: Medicaid patients at the CHC

Linda,
Sorry this is such a distressing situation. Thanks again for the clarification around this situation re: Medicaid patients at the CHC. I've clarified the situation with the person who had asked whether the CHC is turning away Medicaid patients. I've also sent some info below/attached that clarifies that the CHC should see all patients regardless of their ability to pay BUT the CHC can also make a decision based on sound business practices.

Hope this is useful to you. Keep up the good work.

Christie

Part of it is that the CHC cannot serve all the Medicaid patients that come to the health center, as I mentioned in my previous email. Linda did also clarify the issue with regards to the CHC and Medicaid regarding the 340B drug program. Currently there are a lot of Medicaid patients who do not use the CHC services, but do go to the pharmacy to get prescriptions filled. These Medicaid patients get a prescription from a private practitioner, and then come to the CHC pharmacy to get their medications. Because the 340B program will require separate storage, inventory, and dispensing of 340B drugs from Medicaid and other private pay patients, they are planning to limit pharmacy services to the CHC patients only. At this time the CHC only has one pharmacist, and she is filling about 300 prescriptions a day for two sites and the pharmacy is overwhelmed with just their patients' needs. So while the CHC pharmacy will continue to serve Medicaid patients who are patients of the health center, they will no longer dispense medication for non-CHC Medicaid patients. HRSA would not find this objectionable.

HRSA does believe that health centers should serve patients regardless of a patient's ability to pay. However, we also recognize that health center must operate in a manner consistent with sound business practices. As such, the health center can limit services if the demand for services exceeds their available resources or it would jeopardize the health center's financial stability. This policy enables the CHC to implement what they are proposing above. I'm attaching the policy information notice 2007-09, which documents this. You can refer to Page 5 under the Target Population Section for reference.

U.S. Department of Health and Human Services
HRSA BPHC
Health Resources and Services Administration
Bureau of Primary Health Care

POLICY INFORMATION NOTICE

Policy Information Notice 2007-09

DOCUMENT NAME: Service Area Overlap: Policy and Process

DATE: MAR 1 2 2007

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices

This Policy Information Notice (PIN) describes the Health Resources and Services Administration's policies and processes for health center service area overlap. As the number of health center and Federally Qualified Health Center (FQHC) Look-Alike sites grows, so does the potential that service areas will overlap. Consequently, there are an increasing number of service area overlap-related issues emerging that involve federally funded health centers, FQHC Look-Alikes, and/or current applicants for Federal health center funding.

Please contact Shannon Dunne Faltens at 301-594-4060 for any questions regarding this PIN.

James Macrae
Associate Administrator

I. Purpose

The purpose of this PIN is to (1) define what constitutes "service area overlap" in the context of the Health Center and Federally Qualified Health Center (FQHC) Look-Alike Programs administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care; (2) state HRSA's policies with respect to service area overlap; and (3) describe HRSA's process for determining whether to approve a pending application and/or change in scope request in a service area overlap situation.

II. Background

As the number of health center sites (including federally funded sites and FQHC Look-Alike sites) grows, so does the potential that service areas will overlap. In some places, such as areas with large and diverse underserved populations and significant unmet need, it may be appropriate and beneficial to both the community and the health centers involved to share all or part of the same service area. In other communities, however, service area overlap may undermine the stability of one or more of the health centers involved in serving the area. Moreover, HRSA has a responsibility to ensure that limited Federal grant dollars are used efficiently and effectively to provide access to as many underserved people as possible, and, in some instances, supporting multiple sites within the same service area may compromise this principle.

While overlapping service areas may not necessarily raise concerns, there are an increasing number of service area overlap-related issues that require analysis and resolution before HRSA may move forward in making a final decision on a health center's funding application, request for change in scope of project, or application for designation as a FQHC Look-Alike. This PIN describes and clarifies HRSA's policies and processes for resolving these issues, with the goal of improving the likelihood of early identification and timely resolution of service area overlap situations.

III. Definitions

A. Federally Funded Health Centers

For purposes of this guidance, the term "federally funded health centers" or "grantee health centers" includes all health centers funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, specifically:

- Community Health Center (CHC) Programs, funded under section 330(e);
- Migrant Health Center (MHC) Programs, funded under section 330(g);

- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

B. FQHC Look-Alike

FQHC Look-Alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive the FQHC Look-Alike designation and the benefits of that designation, FQHC Look-Alikes must meet the same statutory, regulatory, and policy requirements as grantee health centers. Applicants for FQHC Look-Alike designation must meet the following requirements:

- be a public or a private nonprofit entity;
- serve, in whole or in part, a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP);
- meet the same statutory, regulatory, and policy requirements as grantees supported under section 330 of the PHS Act; and
- comply with section 1905(l)(2)(B) of the Social Security Act which states that an FQHC Look-Alike entity may not be owned, controlled, or operated by another entity.

When appropriate, this PI N will specifically reference FQHC Look-Alikes to emphasize the applicability of the PIN to these entities.

C. Health Centers

As used in this PIN, the term "health centers" includes both federally funded health centers and FQHC Look-Alikes.

D. Service Area

A service area, which is one element of a health center's scope of project, is comprised of several factors. Although, in general, the service area is the area in which the majority of the health center's patients reside, health centers may use other geographic or demographic characteristics to describe their service area.

1. Overview and Statutory Requirements

The concept of a "service" or "catchment" area has been part of the Health Center Program since its beginning. The Health Center Program's authorizing statute requires that each grantee periodically review its catchment area to:

i. ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;[1]
ii. ensure that the boundaries of such area conform, to the extent

[1] Primary health services of the center must also be provided "in a manner which assures continuity." (PHS Act section 330(k)(3)(A).)

practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

iii. ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

Public Health Service Act sec. 330(k)(3)(J)

Health centers receiving grants under section 330(e) of the PHS Act are statutorily obligated to make services available to all residents of the service area, to the extent that they are able, using available resources. Grantees receiving funding only under section 330(g), (h), and/or (i) of the PHS Act, which are targeted respectively to migrant and seasonal, homeless, or public housing populations (i.e., the grantee receives no section 330(e) funds), are not subject to the requirement to serve all residents of the service area (see section F. below).

2. Assessing and Identifying Service Areas

Each health center should periodically assess its declared service area to ensure that the description adequately reflects the health center's current activities. Routine patient origin analysis (for example, using the zip codes of the patient records on file) will help to ensure that the reported service area is accurate and can help determine updated service area boundaries by indicating the areas from which the health center draws the majority of its patients. While health centers may be called upon to serve patients from outside their service area, the service area should include, at a minimum, the area from which the vast majority of patients reside.

The service area should, to the extent practicable, be identifiable by county and by census tracts within county. Describing service areas by census tracts is typically necessary to enable analysis of service area demographics. Service areas may also be described by other political or geographic subdivisions (e.g., county, township, zip codes as appropriate). The service area must be federally designated as a MUA in full or in part or contain a federally designated MUP.

Starting with calendar year (CY) 2005 Uniform Data System (UDS) data, grantees now annually report information on the aggregate geographic area in which its patients reside. This will enable HRSA to better identify overall health center service areas.

3. Service Area Establishment and Expansion

Applicants for funding under section 330 of the PHS Act initially document their service area in the New Access Point (NAP) or Service Area

Competition (SAC) funding application. The funded NAP or SAC application is the basis for determining a grantee's initial service area. Similarly, FQHC Look-Alikes initially document their service area in the designation application. Once established, health centers should incorporate periodic service area assessments into the annual grant application (competing or non-competing) or FQHC Look-Alike annual re-certification application.

A grantee or FQHC Look-Alike that wishes to expand its service area by opening a new site may submit a change in scope request at any time. For grantees, they must demonstrate that this expansion will not require additional grant funds. Grantees may also expand their service area through a funded NAP application which requests additional grant support to add a new service delivery location to the approved scope of project. (See PIN 2002-07, "Scope of Project Policy," for information on change in scope requests.)

E. Health Center Service Site

For purposes of determining which sites are included within a health center's scope of project, a service site is any place where a health center, either directly or through a subrecipient[2] or contract arrangement, provides required primary health services and/or approved additional services to a defined service area or population. Service sites are defined as locations where all of the following conditions are met:[3]

- health center encounters are generated by documenting in the medical record face-to-face contacts between patients and providers;
- providers exercise independent judgment in the provision of services to the patient;
- services are provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location; and
- services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month).[4] However, there is no minimum number of hours per week that services must be available at an individual site/location.

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[2] For purposes of Medicaid and Medicare FQHC reimbursement, a subrecipient is an organization that: (1) receives funding from a section 330 grant through a contract with the recipient of such a grant and (2) is compliant with all of the requirements of section 330 of the PHS Act (see §1861(aa)(4) and §1905(l)(2)(B) of the Social Security Act).

[3] Service sites are a critical component of a health center's scope of project. Other programs, (e.g., FTCA, 340B, and FQHC) have their own standards to determine eligibility for the benefits available through these programs. Each of these programs has a specific application process and a comprehensive set of requirements, of which service site is only one. In other words, identification as a service site within a scope of project is necessary, but not sufficient to ensure participation in the other programs. To participate, all of the requirements of the other programs must be met and coordination with these programs is required.

[4] Again, note the statutory requirement in section 330(k)(3) of the PHS Act that "primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity." In addition, note the regulatory requirement for community and migrant health center grantees that such centers "must be operated in a manner calculated to . . .

Administrative offices or locations that do not provide direct health care services are not service sites.

F. Target Population

The target population is the population to be served by the health center. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service area.

Section 330(e) grantees and FQHC Look-Alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay. Centers are also free to extend services to those residing outside the service area. However, HRSA recognizes that health centers must operate in a manner consistent with sound business practices. As such, health centers are not expected to extend services to additional patients residing inside or outside of the service area if (1) the demand for services exceeds available resources, and/or (2) doing so would jeopardize the center's financial stability. However, grantee health centers and FQHC Look-Alikes should address the acute care needs of all who present for service, regardless of residence.

Some health center programs receive funding to target special populations: specifically, migrant and seasonal farmworkers and their families, persons who are homeless, and residents of public housing. Health centers receiving such funding (i.e., grants under section 330(g), (h), or (i) of the PHS Act) are not subject to the requirement to serve all residents of the service area; however, they should make services available to all members of the special population targeted, and, as stated above, address the acute care needs of all who present for service.

G. Health Center Patient

For purposes of the HRSA UDS reporting, a patient is an individual who has at least one clinical encounter at one of the health center's service sites in a given calendar year. For purposes of serving on a health center's governing board, a consumer board member should utilize the health center as his/her principle source of care and, at a minimum, should have used the health center's services within the last 2 years (see HRSA PIN 98-23, section III(B)(2)).[5]

H. Unmet Need

In communities with high levels of unmet need among the underserved population(s), service area overlap may be appropriate and provide critical additional access. This is particularly true in areas with high numbers of underserved people and limited providers serving this population or in areas with specific sub-groups of the population who may need special approaches to ensure

maximize . . . effective utilization of services." (See 42 CFR 51c.303(m) and 42 CFR 56.603(k).)

[5] Health centers receiving funding only under section 330(g), (h), and/or (i) of the PHS Act (i.e., the center receives no section 330(e) funds) may apply for a waiver of this and other governing board requirements.

access (e.g., non-English speaking groups, people who are homeless, or newly arrived immigrants/refugees). In order to determine whether overlapping service areas could benefit the community without threatening the stability of existing health centers, some assessment of the degree and type of unmet need in the service area is necessary. The process for assessing unmet need in situations of service area overlap is explained further, below.

I. Collaboration

In order to maximize limited resources and access to care for their patients, health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made "and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center" (PHS Act section 330(k)(3)(B)). As stated in section V. of this PIN, "HRSA Policy," the goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, existing or potential service area overlaps.

IV. Identifying Service Area Overlap

HRSA examines issues of overlap in the context of the service area definition in section III of this PIN. As stated above, service areas are primarily defined by patient origin and identified by census tracts or other political or geographic subdivisions (e.g., zip codes). Issues of service area overlap are raised primarily in five types of situations, listed below:

1. an existing grantee health center, new entity, or FQHC Look-Alike applies for NAP or other funding to serve an area which includes all or part of the service area of another existing grantee health center;
2. an existing grantee health center or FQHC Look-Alike requests a "Change in Scope" to open a new health center service site to serve all or part of the service area of another health center, or to provide new services to all or part of the service area of another health center;
3. an existing grantee health center, non-grantee health center, or FQHC Look-Alike applies for NAP funding, other section 330 funding, or requests a Change in Scope at the same time as another grantee health center, non-grantee health center, or FQHC Look-Alike proposes to serve an area which, at the time of the application, is not served by either organization;
4. an existing grantee health center or FQHC Look-Alike relocates an existing clinic to an area served by another health center; or

5. an organization applies for FQHC Look-Alike status to serve an area or population already served by an existing grantee health center.

Potential overlaps are typically identified through a number of sources (e.g., HRSA staff reviews, health center grantees, applicants, FQHC Look-Alikes, and/or Primary Care Associations (PCAs)). All applications for grant funding, FQHC Look-Alike designation/recertification, and changes in scope are examined for potential service area overlap. Applications that present possible service area overlaps are flagged for additional review, if necessary.

V. HRSA Policy

HRSA's foremost concern is to utilize its limited Federal grant dollars to provide access to high quality primary care services to as many underserved people as possible, as efficiently as possible. As such, grant dollars should be targeted to entities in areas of high need that demonstrate that the Federal investment will be efficiently and effectively applied to those needs.

To achieve this, HRSA will be guided by the following overarching principles listed below when assessing individual situations of service area overlap:

1. Meeting the health care needs of the community and target population is paramount in decisions related to service area overlap;
2. Federal grant dollars should be distributed in such a way as to minimize the potential for unnecessary duplication and/or overlap in services, sites, or programs;
3. HRSA recognizes the advantage of using existing resources with proven capabilities to maintain effective and efficient delivery of health care within communities;
4. When a newly identified group of underserved people within a community already served by a health center is proposed to be served by a new site (e.g., homeless people within the service area), this potentially unmet need in the community will be considered when reviewed for service area overlap. If the health care needs of the relevant medically underserved population group within a service area are not being met, geographic service area boundaries will not serve as a barrier to the approval of the application, even where the service area does in fact overlap with that of an existing grantee health center or FQHC Look-Alike;
5. HRSA encourages openness and collaboration among providers.[6] The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall needs of the area's underserved population; and
6. HRSA has a responsibility to ensure the efficient distribution of Federal resources. Therefore, when the potential exists for patients to be drawn from an existing health center to a new organization or proposed site, HRSA will consider the financial impact on the existing health center. In doing so, HRSA

[6] See also section III.H., above.

may examine the past performance of the existing health center and its historical and current ability to meet the needs of the community.

VI. Process for Resolving Potential Service Area Overlap

HRSA's approach to resolving potential situations of service area overlap is based on: 1) early identification of potential overlap; 2) utilization of standard data to define service area and unmet need whenever possible; and/or 3) conducting site visits as appropriate. The actual steps may differ slightly depending on the individual circumstances and the data available.

The following list of steps outlines the process that will be undertaken by HRSA to resolve identified service area overlap issues:

1. Map the service area in question and its census tracts and/or zip codes;
2. Gather data (for example, current patient origin studies) in coordination with the relevant parties.[7] Considerations such as community and financial support, current capacity, utilization rate, existing and proposed partnerships, and unmet need may be assessed; and/or
3. A site visit may be conducted.

VII. Data Sources

In order to analyze service area overlap, HRSA may request data from relevant parties to describe the service area, provider/population ratio, target population, and current patient population (for operational grantee health centers and FQHC Look-Alikes) or projected patient populations (for new grantee health centers or newly designated FQHC Look-Alikes). These data will be requested, as necessary and appropriate, from all organizations that are impacted by the service area overlap. The data requested may augment and/or substantiate data already on file at HRSA from the grant applications, change of scope requests, and/or UDS reports. Data submitted should be verifiable and site-specific.

A. Currently Reported Data

Grantee health centers define their service area and target population as part of their competing or non-competing section 330 grant application. Currently (as of fiscal year 2006), the NAP, SAC, and Budget Period Renewal (BPR) applications require applicants to list the census tracts and zip codes covered by the entire program (Form1-Part A: General Information) while Form 5-Part B: Service Sites asks applicants to list the census tracts served by each site within their Scope of Project. The instructions ask applicants to define their target population and provide demographics for both the service area and target population in the narrative and on Form 4: Community/Target Population Characteristics.

[7] Coordination with relevant parties will be consistent with HHS grants law, regulations, and policy.

Beginning with the collection of CY 2005 UDS data, grantee health centers report patient origin by zip code.

FQHC Look-Alikes define their service area and target population as part of their designation/recertification application. FQHC Look-Alike applicants are not required to submit UDS data. Rather, these organizations complete the FQHC Look-Alike tables and forms, describe their service area, and describe their target and patient populations as part of their initial designation and subsequent recertification applications.

B. Data Sources to Document Service Area Overlap

In order to accurately document the extent of a potential service area overlap, and to determine whether there is unmet need in that area, it is critical that the grantee, FQHC Look-Alike, or applicant provide information that is as detailed as possible. HRSA may request the organization's assistance in providing data such as:

1. Service Area and Target Population:

- **Census data** as applicable: including median income level, percent of population below poverty and/or below 200 percent of poverty level, number of uninsured, ethnicity, and/or language.
- **Other State or Federal reports:** for example, reports on school English as a Second Language program enrollment or State surveys of the area in question.
- **Other Providers:** In order to accurately document the extent and implication of a potential service area overlap, health centers and FQHC Look-Alikes are expected to describe the other providers serving the underserved population in the area. At a minimum, they should identify the other safety net providers available (FQHCs, public hospital/health department primary care clinics, Critical Access Hospitals with primary care capacity, and Rural Health Clinics), if any. They should also describe the extent to which private sector providers in the area serve Medicaid beneficiaries, the uninsured, and other underserved populations. If the health center is not able to document the support of other local providers for its application, it should provide an explanation for the lack of support.

2. Patient Population:

The most recent UDS report is a major source of information on current grantees' patient population in terms of total numbers as well as income, ethnicity, and language preference. Some grantee health centers may be asked to supplement their UDS data with more detail (e.g., if the center serves a specific ethnic group that is not distinctly reported on the UDS).

3. Relationship of Patients to Service Area:

   The purpose of collecting service area, target population, and patient origin data is to determine the extent to which an existing health center serves the area and population and whether there is sufficient remaining unmet need or a distinct underserved population in the area to justify approving a grant application of change in scope request.

VIII. Conclusion

While individual circumstances will affect the specific process used to resolve service area overlap issues, this PIN describes the overarching principles that will inform decisions related to service area overlap and providing examples of the types of data that may be requested. HRSA will make every effort to reach positive and timely resolutions of service area overlap issues.

Attachment

ATTACHMENT
Relevant Statutory and Regulatory Provisions

Public Health Service (PHS) Act Section 330(a)

(1) In general

For purposes of this section, the term "health center" means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements--

(A) required primary health services (as defined in subsection (b)(1) of this section); and

(B) as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2) of this section) necessary for the adequate support of the primary health services required under subparagraph (A);

for all residents of the area served by the center (hereafter referred to in this section as the "catchment area").

(2) Limitation

The requirement in paragraph (1) to provide services for all residents within a catchment area shall not apply in the case of a health center receiving a grant only under subsection (g), (h), or (i) of this section (emphasis added)

PHS Act Section 330(k)(2)

An application for a grant under subparagraph (A) or (B) of subsection (e)(1) of this section for a health center shall include--

(A) a description of the need for health services in the catchment area of the center;

(B) a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of personal health services; and

(C) a demonstration that the center will be located so that it will provide services to the greatest number of individuals residing in the catchment area or included in such population group.

PHS Act Section 330(k)(3)(B)

"The Secretary may not approve an application for a grant . . . unless the Secretary determines that the entity . . . has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center."

PHS Act Section 330(k)(3)(J)

The center will review periodically its catchment area to--

(i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;

(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;

Section 330/Community Health Center Program implementing regulations

42 CFR 51c.102(b) "Catchment area means the area served by a project funded under section 330 of the Act."

42 CFR 51c.104(b) "Applications must include . . . the precise boundaries of the catchment area to be served by the applicant, including an identification of the [MUPs] within the catchment area. In addition, the application shall include information sufficient to enable the Secretary to determine that the applicant's catchment area meets the following criteria:

(i) The size of such area is such that the services to be provided by the applicant are available and accessible to the residents of the area promptly and as appropriate;
(ii) The boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and
(iii) The boundaries of such area eliminate, to the extent possible, barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation."

42 CFR 51c.305 "The Secretary may award grants under this subpart to applicants . . . taking into consideration . . .

(h) Whether the center's catchment area is exclusive of the area served by another center;

(i) The de gree to which the applicant intends to integrate services supported by a grant under this subpart with health services provided under other Federally assisted health services or reimbursement programs or projects."

13. Billing and Collections

Requirement:

- Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.

(Section 330(k)(3)(F) and (G) of the PHS Act)

Billing and Collections

- Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement.
- Health centers must bill Medicare, Medicaid, CHIP, and other applicable public or private third party payors.

COMMITTEE ON RULES

I Mina'trentai Unu na Liheslaturan Guåhan • The 31st Guam Legislature
155 Hesler Place, Hagåtña, Guam 96910 • *www.guamlegislature.com*
E-mail: *roryforguam@gmail.com* • Tel: (671)472-7679 • Fax: (671)472-3547

Certification of Waiver of Fiscal Note Requirement

This is to certify that the Committee on Rules submitted to the Bureau of Budget and Management Research (BBMR) a request for a fiscal note, or applicable waiver, on **Bill No. 292-31 (LS) – "AN ACT TO AUTHORIZE THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS, BY AMENDING §3812 OF ARTICLE 8, CHAPTER 3, AND BY AMENDING §2912.10 OF ARTICLE 9, CHAPTER 2, OF TITLE 10, GUAM CODE ANNOTATED."** – on August 26, 2011. COR hereby certifies that BBMR confirmed receipt of this request on August 26, 2011.

COR further certifies that a response to this request was not received by 5:00 P.M. on September 15, 2011, the fourteenth day after the request was received by BBMR. **Therefore, pursuant to 2 GCA §9105, the requirement for a fiscal note, or waiver thereof, on Bill 292 to be included in the committee report on said bill, is hereby waived.**

Certified by:

Rory J. Respicio
Senator Rory J. Respicio

10/27/11
Date

COMMITTEE ON RULES

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August 26, 2011

VIA FACSIMILE
(671) 472-2825

John A. Rios
Acting Director
Bureau of Budget & Management Research
P.O. Box 2950
Hagåtña, Guam 96910

RE: Request for Fiscal Note –
Bill Nos. 292-31 (LS) through 293-31 (LS)

Hafa Adai Mr. Rios:

Transmitted herewith is a listing of *I Mina'trentai Unu na Liheslaturan Guåhan's* most recently introduced bills. Pursuant to 2 GCA §9103, I respectfully request the preparation of fiscal notes for the referenced bills.

Si Yu'os ma'åse' for your attention to this matter.

Very Truly Yours,

Rory J. Respicio

Attachments

Cc: Clerk of the Legislature

MESSAGE CONFIRMATION

AUG-26-2011 09:43 AM FRI

FAX NUMBER : 4772240
NAME : GNF

NAME/NUMBER : 4722825
PAGE : 3
START TIME : AUG-26-2011 09:42AM FRI
ELAPSED TIME : 00'26"
MODE : STD ECM
RESULTS : [O.K]

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August 26, 2011

VIA FACSIMILE
(671) 472-2825

John A. Rios
Acting Director
Bureau of Budget & Management Research
P.O. Box 2950
Hagåtña, Guam 96910

RE: Request for Fiscal Note –
Bill Nos. 292-31 (LS) through 293-31 (LS)

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Si Yu'os ma'åse' for your attention to this matter.

Very Truly Yours,

Rory J. Respicio

Attachments

Cc: Clerk of the Legislature

Rec'd by: Annalyn
date: 8/26/11
time: 2:16 pm

I Mina'Trentai Unu Na Liheslaturan Guåhan

Bill Log Sheet

August 25, 2011

Bill No.	Sponsor(s)	Title	Date Introduced	Date Referred	120 Day Deadline	Committee Referred	Public Hearing Date	Date Committee Report Filed	Status (Date) Passed? Failed? Vetoed? Overridden? Public Law?
292-31 (LS)	D.G. Rodriguez, Jr.	AN ACT TO AUTHORIZE THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS, BY AMENDING §3812 OF ARTICLE 8, CHAPTER 3, AND BY AMENDING §2912.10 OF ARTICLE 9, CHAPTER 2, OF TITLE 10, GUAM CODE ANNOTATED	08/25/11 9:44 a.m.	8/25/11		Committee on Health & Human Services Senior Citizens, Economic Development and Election Reform			

COMMITTEE ON RULES

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August 25, 2011

MEMORANDUM

To: **Pat Santos**
Clerk of the Legislature

Attorney Therese M. Terlaje
Legislative Legal Counsel

From: **Senator Rory J. Respicio**

Subject: **Referral of Bill No. 292-31 (LS)**

AUG 25 PM 3:33

As the Chairperson of the Committee on Rules, I am forwarding my referral of Bill No. 292-31 (LS).

Please ensure that the subject bill is referred, in my name, to the respective committee, as shown on the attachment. I also request that the same be forwarded to all members of *I Mina'trentai Unu na Liheslaturan Guåhan.*

Should you have any questions, please feel free to contact our office at 472-7679.

Si Yu'os Ma'åse!

(1) Attachment

I Mina'Trentai Unu Na Liheslaturan Guåhan

Bill Log Sheet

August 25, 2011

Bill No.	Sponsor(s)	Title	Date Introduced	Date Referred	120 Day Deadline	Committee Referred	Public Hearing Date	Date Committee Report Filed	Status (Date) Passed? Failed? Vetoed? Overridden? Public Law?
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Gmail by Google

Joseph Anthony Mesngon <jmesngon.senatordrodriguez@gmail.com>

1st Notice of Public Hearing September 15,2011

1 message

Clifton Herbert <cherbert.senatordrodriguez@gmail.com> **Thu, Sep 8, 2011 at 9:19 AM**

To: "Dennis Rodriguez Jr." <senatordrodriguez@gmail.com>, "Adolpho B. Palacios" <senabpalacios@gmail.com>, Aline Yamashita <aline4families@gmail.com>, Ben Pangelinan <senbenp@guam.net>, Benjamin JF Cruz <senadotbjcruz@gmail.com>, Chris Duenas <duenasenator@gmail.com>, "Dr. Sam Mabini" <senatorsam@senatormabini.com>, "Frank Blas Jr." <frank.blasjr@gmail.com>, Judi Guthertz <judiguthertz@pticom.com>, Judi Won Pat <speaker@judiwonpat.com>, Mana Silva Taijeron <senatormana@gmail.com>, "Rory J. Respicio" <roryforguam@gmail.com>, Tina Muna Barnes <tinamunabarnes@gmail.com>, Tom Ada <tom@senatorada.org>, Tony Ada <senatortonyada@guamlegislature.org>
Cc: phnotice@guamlegislature.org

Ufisinan Todu Guam
SENATOR DENNIS G. RODRIGUEZ, Jr.
I Mina'trentai Unu Na Liheslaturan Guåhan
CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

Senators,

Buenas yan Hafa Adai!

Please find attached first notice of public hearing for September 15, 2011. Thank you and have a great day!

Si Yu'os Ma'ase.

Sincerely,
Clifton Herbert
176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638
Email: Cherbert.senatordrodriguez@gmail.com

Senators 1st Notice Public Hearing Sep.15, 2011.pdf
86K

Listserv: phnotice@guamlegislature.org
As of Oct. 17, 2011

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oliviampalacios@gmail.com
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pris@senatorpalacios.com
rfteehan@yahoo.com
richard@tinamunabarnes.com
rob.tupaz@gmail.com
roryforguam@gmail.com
Santos.duenas@gmail.com
sem@guamlegislature.org
senator@senatorbjcruz.com
senator@senatorpalacios.com
senator@tinamunabarnes.com
senatordrodriguez@gmail.com
senatormabini@senatormabini.com
senatorsam@senatormabini.com
senatortonyada@guamlegislature.org
senbenp@guam.net
sgrarmes@guamlegislature.org
speaker@judiwonpat.com
tanya4families@gmail.com
tcastro@guam.net
telo.taitague@guam.gov
tinaokada@gmail.com
tom@senatorada.org
tterlaje@guam.net
uriah@tinamunabarnes.com
val.g@senatormabini.com
victoria@senatorpalacios.com
vkomiyama.senatordrodriguez@gmail.com
wilcastro671@gmail.com

SENATOR DENNIS G. RODRIGUEZ, JR.

Chairman,
Committee on Health & Human Services, Senior Citizens, Economic Development, & Election Reform

Member,
Committee on Public Safety, Law Enforcement, & Judiciary

Member,
Committee on Youth, Cultural Affairs, Procurement, General Government Operations, & Public Broadcasting

Member,
Committee on Municipal Affairs, Tourism, Housing & Recreation

Member,
Committee on Rules, Federal, Foreign & Micronesian Affairs, & Human & Natural Resources

Member,
Committee on the Guam Military Buildup & Homeland Security

Member,
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, & Land

Member,
Committee on Utilities, Transportation, Public Works, & Veterans Affairs

Assistant Majority Whip

TO: ALL SENATORS

FROM: SENATOR DENNIS G. RODRIGUEZ, JR.
CHAIRPERSON

SUBJECT: 1ST NOTICE OF PUBLIC HEARING

1ST NOTICE OF PUBLIC HEARING
Thursday, September 15, 2011 8:30AM

In accordance with the Open Government Law, Public Law 24-109, relative to notice for Public Meetings. Please be advised that the Committee on Health & Human Services, Economic Development, Senior Citizens and Election Reform will be conducting a Public Hearing on September 15, 2011, at *I Liheslaturan Guåhan's* Public Hearing Room in Hagåtña, on the following:

8:30AM

- *Bill No. 267-31 (COR)* - **An act to amend §90A101 and §90A102 of Chapter 90A of Title 10 of the Guam Code Annotated relative to the prohibition and sale of candy cigarettes.** (*By B.J.F. Cruz*)

- *Bill No. 274-31 (COR)* - **An act to add a new Article 23 to Chapter 12 of 10GCA relative to creating the Physician Education Incentive Program.** (*By V.A. Ada*)

- *Bill No. 275-31 (COR)*- **to add a new Item 15 to §58104 of Chapter 58 Title 12 relative to authorizing the granting of qualifying certificates as an incentive to attract Physicians/Clinics practicing in specialties where Guam patients are required to seek treatment outside of Guam.** (*By V.A. Ada*)

- *Bill No. 276-31 (COR)*- **An act to require the Department of Public Health and Social Services to conduct a feasibility study on providing after-hour urgent care services in the public health centers.** (*By V.A. Ada*)

1:30PM

- *Bill No. 285-31 (COR)*- **An act to mandate healthy foods to be sold in vending machines in all Government of Guam buildings, by adding a new §22420.1 to Article 4, Chapter 22, Title 5, Guam Code Annotated, and a new §23109 to Chapter 23, Part 1, Division 2, Title 10, Guam Code Annotated.** (*By D. G. Rodriguez, Jr.*)

- *Bill No. 292-31 (COR)*- **An act to authorize the Community Health Centers of the Department of Public Health and Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by**

Ufisinan Todu Guam • 31st Guam Legislature
176 Serenu Avenue, Suite 107, Tamuning, Guam 96931 / Telephone: 671-649-TODU (8638) / Facsimile: 671-649-0520
E-mail: senatordrodriguez@gmail.com

- **amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated.** (*By D. G. Rodriguez, Jr.)*

- The **Executive Appointment** of **Dr. Gregory Miller** to be a **Board Member** on **Guam Board of Allied Health Examiners**

Testimony should be addressed to Senator Dennis Rodriguez, Jr., Chairman, and may be submitted via- hand delivery to our office at 176 Serenu Avenue Suite 107 Tamuning, Guam 96931 or our mailbox at the Main Legislature Building at 155 Hesler Place, Hagåtña, Guam 96910, or via email to senatordrodriguez@gmail.com.

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For further information, please contact the Office of Senator Dennis Rodriguez, Jr. at 649-8638 (TODU)

Gmail by Google

Joseph Anthony Mesngon <jmesngon.senatordrodriguez@gmail.com>

1st Notice of Public Hearing for September 15, 2011

1 message

Clifton Herbert <cherbert.senatordrodriguez@gmail.com> **Thu, Sep 8, 2011 at 9:21 AM**

To: clynt@spbguam.com, dcrisostomo@guampdn.com, dmgeorge@guampdn.com, dtamondong@guampdn.com, gdumat-ol@guampdn.com, gerry@mvguam.com, hottips@kuam.com, jason@kuam.com, john@kuam.com, jtyquiengco@spbguam.com, marvic@mvguam.com, mindy@kuam.com, mpieper@guampdn.com, mvariety@pticom.com, news@spbguam.com, nick.delgado@kuam.com, parroyo@k57.com, reporter3@glimpsesofguam.com, rgibson@k57.com, ricknauta@hitradio100.com, sabrina@kuam.com, slimtiaco@guampdn.com, thebigshow@k57.com, therese.hart.writer@gmail.com, zita@mvguam.com, James <officemanager@hitradio100.com>, Jesse Lujan <jesselujan27@yahoo.com>, "Jon A. Anderson" <editor@mvguam.com>, Katrina <life@guampdn.com>, Kevin Kerrigan <kevin@spbguam.com>, Kevin Kerrigan <news@k57.com>, Lannie Walker <lannie@kuam.com>, Laura Matthews <llmatthews@guampdn.com>, Pacific Daily News <news@guampdn.com>, William Gibson <breakfastshowk57@gmail.com>, Oyaol Ngirairikl <odngirairikl@guampdn.com>
Bcc: jmesngon.senatordrodriguez@gmail.com

Ufisinan Todu Guam
SENATOR DENNIS G. RODRIGUEZ, Jr.
I Mina'trentai Unu Na Liheslaturan Guåhan
CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

PRESS RELEASE
FIRST NOTICE OF PUBLIC HEARING
Thursday, September 15, 2011 8:30AM

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- *Bill No. 275-31 (COR)*- **to add a new Item 15 to §58104 of Chapter 58 Title 12 relative to authorizing the granting of qualifying certificates as an incentive to attract**

Physicians/Clinics practicing in specialties where Guam patients are required to seek treatment outside of Guam. (*By V.A. Ada)*

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1:30PM

- *Bill No. 278-31 (COR)-* **An act relative to the credentialing of qualified individuals applying for a dental license in Guam, by adding a new subsection (c) to §12411 of Article 4, Part 1, Title 10, Guam Code Annotated.** (*By D. G. Rodriguez, Jr.)*

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- The **Executive Appointment** of **Dr. Gregory Miller** to be a **Board Member** on **Guam Board of Allied Health Examiners**

Testimony should be addressed to Senator Dennis Rodriguez, Jr., Chairman, and may be submitted via- hand delivery to our office at 176 Serenu Avenue Suite 107 Tamuning, Guam 96931 or our mailbox at the Main Legislature Building at 155 Hesler Place, Hagåtña, Guam 96910, or via email to senatordrodriguez@gmail.com.

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For further information, please contact the Office of Senator Dennis Rodriguez, Jr. at 649-8638 (TODU)

###

Clifton Herbert
176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638
Email: Cherbert.senatordrodriguez@gmail.com

Public Hearing 1st Notice Sep 15, 2011.pdf
86K

Gmail by Google

Joseph Anthony Mesngon <jmesngon.senatordrodriguez@gmail.com>

2nd Notice of Public Hearing

1 message

Clifton Herbert <cherbert.senatordrodriguez@gmail.com> **Tue, Sep 13, 2011 at 11:41 AM**

To: "Dennis Rodriguez Jr." <senatordrodriguez@gmail.com>, "Adolpho B. Palacios" <senabpalacios@gmail.com>, Aline Yamashita <aline4families@gmail.com>, Ben Pangelinan <senbenp@guam.net>, Benjamin JF Cruz <senadotbjcruz@gmail.com>, Chris Duenas <duenasenator@gmail.com>, "Dr. Sam Mabini" <senatorsam@senatormabini.com>, "Frank Blas Jr." <frank.blasjr@gmail.com>, Judi Guthertz <judiguthertz@pticom.com>, Judi Won Pat <speaker@judiwonpat.com>, Mana Silva Taijeron <senatormana@gmail.com>, "Rory J. Respicio" <roryforguam@gmail.com>, Tina Muna Barnes <tinamunabarnes@gmail.com>, Tom Ada <tom@senatorada.org>, Tony Ada <senatortonyada@guamlegislature.org>
Cc: phnotice@guamlegislature.org
Bcc: jmesngon.senatordrodriguez@gmail.com

--

Ufisinan Todu Guam
SENATOR DENNIS G. RODRIGUEZ, Jr.
I Mina'trentai Unu Na Liheslaturan Guåhan
CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

Senators,

Buenas yan Hafa Adai!

Please find attached 2nd Notice of Public Hearing for September 15, 2011. Thank you and have a great day!

Sincerely,
Clifton Herbert
176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638
Email: Cherbert.senatordrodriguez@gmail.com

Senators 2nd Notice Public Hearing Sep.15, 2011.pdf
86K

SENATOR DENNIS G. RODRIGUEZ, JR.

Chairman,
Committee on Health & Human Services, Senior Citizens, Economic Development, & Election Reform

Member,
Committee on Public Safety, Law Enforcement, & Judiciary

Member,
Committee on Youth, Cultural Affairs, Procurement, General Government Operations, & Public Broadcasting

Member,
Committee on Municipal Affairs, Tourism, Housing & Recreation

Member,
Committee on Rules, Federal, Foreign & Micronesian Affairs, & Human & Natural Resources

Member,
Committee on the Guam Military Buildup & Homeland Security

Member,
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, & Land

Member,
Committee on Utilities, Transportation, Public Works, & Veterans Affairs

Assistant Majority Whip

TO: ALL SENATORS

FROM: SENATOR DENNIS G. RODRIGUEZ, JR.
CHAIRPERSON

SUBJECT: 2nd NOTICE OF PUBLIC HEARING

2nd NOTICE OF PUBLIC HEARING
Thursday, September 15, 2011 8:30AM

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For further information, please contact the Office of Senator Dennis Rodriguez, Jr. at 649-8638 (TODU)

Gmail by Google

Joseph Anthony Mesngon <jmesngon.senatordrodriguez@gmail.com>

Public Hearing 2nd Notice September 15, 2011

1 message

Clifton Herbert <cherbert.senatordrodriguez@gmail.com> **Tue, Sep 13, 2011 at 11:45 AM**

To: clynt@spbguam.com, dcrisostomo@guampdn.com, dmgeorge@guampdn.com, dtamondong@guampdn.com, gdumat-ol@guampdn.com, gerry@mvguam.com, hottips@kuam.com, jason@kuam.com, john@kuam.com, jtyquiengco@spbguam.com, marvic@mvguam.com, mindy@kuam.com, mpieper@guampdn.com, mvariety@pticom.com, news@spbguam.com, nick.delgado@kuam.com, parroyo@k57.com, reporter3@glimpsesofguam.com, rgibson@k57.com, ricknauta@hitradio100.com, sabrina@kuam.com, slimtiaco@guampdn.com, thebigshow@k57.com, therese.hart.writer@gmail.com, zita@mvguam.com, James <officemanager@hitradio100.com>, Jesse Lujan <jesselujan27@yahoo.com>, "Jon A. Anderson" <editor@mvguam.com>, Katrina <life@guampdn.com>, Kevin Kerrigan <kevin@spbguam.com>, Kevin Kerrigan <news@k57.com>, Lannie Walker <lannie@kuam.com>, Laura Matthews <llmatthews@guampdn.com>, Pacific Daily News <news@guampdn.com>, William Gibson <breakfastshowk57@gmail.com>, Oyaol Ngirairikl <odngirairikl@guampdn.com>
Bcc: jmesngon.senatordrodriguez@gmail.com

Ufisinan Todu Guam
SENATOR DENNIS G. RODRIGUEZ, Jr.
I Mina'trentai Unu Na Liheslaturan Guåhan
CHAIRMAN, COMMITTEE ON HEALTH & HUMAN SERVICES,
ECONOMIC DEVELOPMENT, SENIOR CITIZENS AND ELECTION REFORM

Clifton Herbert
176 Serenu Avenue Suite 107 Tamuning, Guam 96931
Telephone: 671.649.8638
Email: Cherbert.senatordrodriguez@gmail.com

2 attachments

Public Hearing 2nd Notice Sep 15, 2011.doc
94K

Public Hearing 2nd Notice Sep 15, 2011.pdf
400K

SENATOR DENNIS G. RODRIGUEZ, JR.

Chairman,
Committee on Health & Human Services, Senior Citizens, Economic Development, & Election Reform

Member,
Committee on Public Safety, Law Enforcement, & Judiciary

Member,
Committee on Youth, Cultural Affairs, Procurement, General Government Operations, & Public Broadcasting

Member,
Committee on Municipal Affairs, Tourism, Housing & Recreation

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Committee on Rules, Federal, Foreign & Micronesian Affairs, & Human & Natural Resources

Member,
Committee on the Guam Military Buildup & Homeland Security

Member,
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, & Land

Member,
Committee on Utilities, Transportation, Public Works, & Veterans Affairs

Assistant Majority Whip

PRESS RELEASE
SECOND NOTICE OF PUBLIC HEARING
Thursday, September 15, 2011 8:30AM

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8:30AM

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- *Bill No. 275-31 (COR)-* **to add a new Item 15 to §58104 of Chapter 58 Title 12 relative to authorizing the granting of qualifying certificates as an incentive to attract Physicians/Clinics practicing in specialties where Guam patients are required to seek treatment outside of Guam.** *(By V.A. Ada)*

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1:30PM

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176 Serenu Avenue, Suite 107, Tamuning, Guam 96931 / Telephone: 671-649-TODU (8638) / Facsimile: 671-649-0520
E-mail: senatordrodriguez@gmail.com

- *Bill No. 292-31 (COR)*- **An act to authorize the Community Health Centers of the Department of Public Health and Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated.** (*By D. G. Rodriguez, Jr.)*

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For further information, please contact the Office of Senator Dennis Rodriguez, Jr. at 649-8638 (TODU)

###

Gmail by Google

Joseph Anthony Mesngon <jmesngon.senatordrodriguez@gmail.com>

Invitation for testimony at Public Hearing

1 message

Joseph Anthony Mesngon <jmesngon.senatordrodriguez@gmail.com> **Thu, Sep 8, 2011 at 12:49 PM**

To: James Gillan <james.gillan@dphss.guam.gov>

Hafa Adai!

Attached is a letter inviting you to testify on bills relative to public health. We look forward to your participation and/or attendance.

Thank you!
Joseph A. Q. Mesngon
Office of Senator Dennis G. Rodriguez, Jr.
I Mina'trentai Unu Na Liheslaturan Guahan
31st Guam Legislature
176 Serenu Avenue Suite 107
Tamuning, Guam 96913
671.649.8638

Ltr to DPHSS Director 9-15.pdf
65K

SENATOR DENNIS G. RODRIGUEZ, JR.

Chairman,
Committee on Health & Human Services, Senior Citizens, Economic Development, & Election Reform

Member,
Committee on Public Safety, Law Enforcement, & Judiciary

Member,
Committee on Youth, Cultural Affairs, Procurement, General Government Operations, & Public Broadcasting

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Committee on the Guam Military Buildup & Homeland Security

Member,
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, & Land

Member,
Committee on Utilities, Transportation, Public Works, & Veterans Affairs

Assistant Majority Whip

September 8, 2011

James W. Gillan
Director
Department of Public Health and Social Services
Mangilao, Guam

Dear Mr. Gillan

Buenas yan Håfa Adai! I would like to invite you, members of your team and the respective Boards/Commissions that fall under your administrative purview to provide testimony at a public hearing on the following:

8:30am

- **Bill 267-31 (COR)-** An act to amend §90A101 and §90A102 of Chapter 90A of Title 10 of the Guam Code Annotated relative to the prohibition and sale of candy cigarettes, introduced by Sen. Benjamin J. F. Cruz.

- **Bill 276-31 (COR)-** An act to require the Department of Public Health and Social Services to conduct a feasibility study on providing after-hour urgent care services in the public health centers. Introduced by Sen. V. Anthony Ada.

1:30pm

- **Bill 278-31 (COR)-** An act relative to the credentialing of qualified individuals applying for a dental license in Guam, by adding a new subsection (c) to §12411 of Article 4, Part 1, Title 10, Guam Code Annotated, introduced by myself.

- **Bill 285-31 (COR)-** An act to mandate healthy foods to be sold in vending machines in all Government of Guam buildings, by adding a new §22420.1 to Article 4, Chapter 22, Title 5, Guam Code Annotated, and a new §23109 to Chapter 23, Part 1, Division 2, Title 10, Guam Code Annotated, introduced by myself.

- **Bill 292-31 (LS)**- An act to authorize the Community Health Centers of the Department of Public Health & Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated, introduced by myself.

The public hearing is scheduled for Thursday, September 15, 2011 at 8:30am & 1:30pm at *I Liheslatura's* Public Hearing Room in *Hagåtña.* Written testimony may be submitted to me at: senatordrodriguez@gmail.com or delivered to my office or at *I Liheslatura's* Mailroom.

You may read the bills on our legislature website at www.guamlegislature.org.

I look forward to your attendance and participation. For more information, please contact my office. *Si Yu'os Ma'åse'!*

Senseramente,

Dennis G. Rodriguez, Jr.

Ufisinan Todu Guam • 31st Guam Legislature
176 Serenu Avenue, Suite 107, Tamuning, Guam 96931 / Telephone: 671-649-TODU (8638) / Facsimile: 671-649-0520
E-mail: senatordrodriguez@gmail.com

SENATOR DENNIS G. RODRIGUEZ, JR.

Chairman,
Committee on Health & Human Services, Senior Citizens, Economic Development, & Election Reform

Member,
Committee on Public Safety, Law Enforcement, & Judiciary

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Committee on Rules, Federal, Foreign & Micronesian Affairs, & Human & Natural Resources

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Committee on the Guam Military Buildup & Homeland Security

Member,
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, & Land

Member,
Committee on Utilities, Transportation, Public Works, & Veterans Affairs

Assistant Majority Whip

PUBLIC HEARING AGENDA
THURSDAY SEPTEMBER 15, 2011
8:30AM
Public Hearing Room, *I Liheslaturan Guåhan,* Hagatña, Guam

I. Call to Order
II. Announcements
III. Items for Public Consideration

8:30AM

- *Bill No. 267-31 (COR)* **- An act to amend §90A101 and §90A102 of Chapter 90A of Title 10 of the Guam Code Annotated relative to the prohibition and sale of candy cigarettes.** (*By B.J.F. Cruz)*
- *Bill No. 274-31 (COR)* **- An act to add a new Article 23 to Chapter 12 of 10GCA relative to creating the Physician Education Incentive Program.** (*By V.A. Ada)*
- *Bill No. 275-31 (COR)*- **to add a new Item 15 to §58104 of Chapter 58 Title 12 relative to authorizing the granting of qualifying certificates as an incentive to attract Physicians/Clinics practicing in specialties where Guam patients are required to seek treatment outside of Guam.** (*By V.A. Ada)*
- *Bill No. 276-31 (COR)*- **An act to require the Department of Public Health and Social Services to conduct a feasibility study on providing after-hour urgent care services in the public health centers.** (*By V.A. Ada)*

1:30PM

- *Bill No. 285-31 (COR)*- **An act to mandate healthy foods to be sold in vending machines in all Government of Guam buildings, by adding a new §22420.1 to Article 4, Chapter 22, Title 5, Guam Code Annotated, and a new §23109 to Chapter 23, Part 1, Division 2, Title 10, Guam Code Annotated.** (*By D. G. Rodriguez, Jr.)*
- *Bill No. 292-31 (COR)*- **An act to authorize the Community Health Centers of the Department of Public Health and Social Services to obtain reimbursement for services rendered to Medically Indigent Program Patients, by amending §3812 of Article 8, Chapter 3, and by amending §2912.10 of Article 9, Chapter 2, of Title 10, Guam Code Annotated.** (*By D. G. Rodriguez, Jr.)*
- The **Executive Appointment** of **Dr. Gregory Miller** to be a **Board Member** on **Guam Board of Allied Health Examiners**

IV. Announcements
V. Adjournment

The Committee requests that, if written testimonies are to be presented at the hearing, copies be submitted one day prior to the public hearing date, to the Office of Senator Dennis G. Rodriguez, Jr. at 176 Serenu Avenue Suite 107, Tamuning, Guam, at our mailbox in the Legislature Building at 155 Hesler Place, Hagåtna, Guam or via email to senatordrodriguez@gmail.com. Copies of the aforementioned Resolution and/or Bills may be obtained at *I Liheslaturan Guåhan's* website at www.guamlegislature.org. Individuals requiring special accommodations or services, please contact our office at 649-8638. We look forward to your presence and participation.

Ufisinan Todu Guam • 31st Guam Legislature
176 Serenu Avenue, Suite 107, Tamuning, Guam 96931 / Telephone: 671-649-TODU (8638) / Facsimile: 671-649-0520
E-mail: senatordrodriguez@gmail.com

NOTICE of PUBLIC HEARING

The Committee on Health & Human Services, Economic Development, Senior Citizens & Election Reform is conducting a Public Hearing on Thurs., Sept. 15, 2011 at 8:30am on the following:

Bill 267-31 (COR)- An act to amend §90A101 and §90A102 of Chapter 90A of Title 10 of the Guam Code Annotated relative to the prohibition and sale of candy cigarettes, by Sen. B. J. Cruz.

Bill 274-31 (COR)- An act to add a new Article 23 to Chapter 12 of 10GCA relative to creating the Physician Education Inventive Program, by Sen. Tony Ada.

Bill 275-31 (COR)- An act to add a new Item 15 to §58104 of Chapter 58, Title 12 relative to authorizing the granting of Qualifying Certificates as an incentive to attract Physicians/Clinics practicing in specialties where Guam patients are required to seek treatment outside of Guam, by Sen. Tony Ada.

Bill 276-31 (COR)- An act to require the Department of Public Health and Social Services to conduct a feasibility study on providing after-hour urgent care services in the public health centers, by Sen. Tony Ada.

Testimonies should be addressed to Sen. Dennis Rodriguez, Jr., Chairman, and may be submitted via hand delivery to our office at 176 Serenu Ave. Ste 107 Tamuning, Guam or our mailbox at I Liheslatura's Mailroom or via email to: senatordrodriguez@gmail.com

Slides run on starting Sept. 09, 2011

Senator Dennis G. Rodriguez, Jr.

NOTICE of PUBLIC HEARING

The Committee on Health & Human Services, Economic Development, Senior Citizens & Election Reform is conducting a Public & Confirmation Hearing on Thurs., Sept. 15, 2011 at 1:30pm on the following:

Bill 285-31 (COR)- An act to mandate healthy foods to be sold in vending machines in all Government of Guam buildings, by adding a new § 22420.1 to Article 4, Chapter 22, Title 5, GCA, and a new §23109 to Chpt. 23, Part 1, Division 2, Title 10, GCA, by Sen. DG Rodriguez, Jr.

Bill 292-31 (COR)- An act to authorize the Community Health Centers of the Dept. of Public Health & Social Services to obtain reimbursement for services rendered to MIP Patients, by amending §3812 of Article 8, Chpt. 3, and by amending §2912.10 of Article 9, Chpt. 2 of Title 10, GCA, by Sen. DG Rodriguez, Jr.

The Confirmation Hearing for Dr. Gregory Miller to serve as Member on the Guam Board of Allied Health Examiners.

Testimonies should be addressed to Sen. Dennis Rodriguez, Jr., Chairman, and may be submitted via hand delivery to our office at 176 Serenu Ave. Ste 107 Tamuning, Guam or our mailbox at I Liheslatura's Mailroom or via email to: senatordrodriguez@gmail.com

Slides run on starting Sept. 09, 2011

Senator Dennis G. Rodriguez, Jr.

MINA' TRENTAI UNU NA LIHESLATURAN GUAHAN
2011 (FIRST) Regular

Bill No. 292-31(LS)

Introduced by: **D.G. RODRIGUEZ, JR.**

AN ACT TO AUTHORIZE THE COMMUNITY HEALTH CENTERS OF THE DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES TO OBTAIN REIMBURSEMENT FOR SERVICES RENDERED TO MEDICALLY INDIGENT PROGRAM PATIENTS, BY AMENDING §3812 OF ARTICLE 8, CHAPTER 3, AND BY AMENDING §2912.10 OF ARTICLE 9, CHAPTER 2, OF TITLE 10, GUAM CODE ANNOTATED.

2011 AUG 25 AM 9:44

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Findings and Intent: *I Liheslaturan Guåhan* finds that the Northern and Southern Regional Community Health Centers (CHC) of the Department of Public Health & Social Services Bureau of Primary Care are unable to seek compensation for services rendered to patients under the Medically Indigent Program. The DPHSS community health centers are grantees under the Health Recourses and Services Administration, US Department of Health & Human Services.

This is due to a policy interpretation that since the MIP Reform Act provides in 10GCA, Chapter 2, Article 9, §2912.10, that, "[t]he Medically Indigent Program shall not reimburse Public Health for services provided by Public Health Programs." In effect, *all* services provided by the Department of Public Health for MIP patients are free (i.e., no reimbursements can be made for services), and, the CHC can not submit a claim to the MIP program for the reimbursement of the cost

of services rendered. This situation is resulting in a continually diminishing balance in the Community Health Center Revolving Fund, and is contrary to the Federal statutory provisions applicable to the CHC's grant award.

I Liheslaturan Guåhan recognizes that the Northern and Southern Regional Community Health Centers are Federally Qualified Health Centers (FQHC's) that are mandated to collect revenues from third party payers (i.e., private insurance indemnities), Medicare, Medicaid, Medically Indigent Program (MIP), and self-pay patients so that the revenues or program income monies generated are to be used exclusively for the operation of the Guam Community Health Centers. And, to that end, 10GCA, Article 8, Chapter 3, §3811, provides for the establishment of the Community Health Centers Revolving Fund. Subsection (d) provides that, *"Deposits – All monies deposited in the Fund shall be applied to the expenses of the community center allowable by Federal regulations and guidelines as the non-Federal share of project costs in accordance with the Department's grant from the U.S. Department of Health & Human Services."*

Further, *I Liheslaturan Guåhan* takes due note of the grant compliance requirements of the Health Resources & Services Administration, US Department of Health &Human Services, as provided pursuant to §330(k)(3)(F) & (G) of the U.S. Public Health Services Act, that *grantee health centers* have: *Billings and Collections: Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.*

It is the *intent* of *I Liheslaturan Guåhan* that the conflicting provisions of §2912.10 of Article 9 – Medically Indigent Program – Chapter 2, Title 10, Guam Code Annotated, relative to services provided by Public Health, be reconciled with

§3812 of Article 8, Chapter 3, Title 10, Guam Code Annotated, relative to DPHSS Regional Community Health Centers fee schedules, so as to allow the CHC's as a Federally Qualified Health Center grantee to conform and comply with the Federal statutory provisions and regulations applicable to its programs.

Section 2. §3812 of Article 8, Chapter 3, Title 10, Guam Code Annotated, is hereby amended, to read:

"§ 3812. Fee Schedule.

(a) The Department is hereby authorized to implement a fee schedule. The provision of this Act shall be repealed upon subsequent submission and approval of the fee schedule through the Administrative Adjudication Law. The fee schedule must give discounts accordingly to the Federal Income Poverty Guideline.

(b) Individuals or families whose income falls below the Federal poverty guidelines shall apply for subsidized medical services through the Medically Indigent Program or other medically subsidized program.

(1) The Program ***shall*** submit a billing claim to the Guam Medically Indigent Program Administrator for the necessary amount to recover the cost of services rendered to the Medically Indigent Program patients at the fee schedule rates established for reimbursement pursuant to applicable law, rules and regulations.

(A) Notwithstanding any other provision of law, rule or regulation, for the purposes of billing and collections, the Community Regional Health Centers Program *shall* be deemed apart and separate from the Department, and the Guam Medically Indigent Program *shall* promptly remit payment to the Program as reimbursement for services

rendered to MIP patients, for deposit into the Community Health Center Revolving Fund."

Section 3. §2912.10 of Article 9 – Medically Indigent Program – Chapter 2, Title 10, Guam Code Annotated, is hereby amended, to read:

"§ 2912.10. Services Provided by Public Health. Generally, [~~T~~] the Medically Indigent Program shall not reimburse Public Health for services provided by Public Health Programs, **provided, however,** services provided or rendered by the Regional Community Health Centers of the Department of Public Health for medical, dental, laboratory, x-ray, pharmacy, and/or any other health related services, etcetera, ***shall*** be reimbursed at the fee schedule rates established pursuant to applicable law, rules and regulations."

Section 4. Severability. If any of the provisions of this Act or the application thereof to any person or circumstance are held invalid, such invalidity shall not affect any other provision or application of this Act, which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

Section 5. Effective Date. This Act shall become immediately effective upon enactment.