CHAPTER 2
DIVISION OF PUBLIC WELFARE

SOURCE: Articles 1 - 3 were Subchapters A - C in the original statutes. Codified as Articles to adhere to the Compiler's alpha-numeric scheme in accordance to the authority granted by 1 GCA § 1606.

NOTE: Article 8, Enforcement of Support, was moved by the Compiler to Title 5 as Chapter 34 pursuant to its authority by 1 GCA § 1606.

ARTICLE 1
GENERAL PROVISIONS

§ 2101. Director of Welfare.

There is hereby established a division of Public Welfare in the Department of Public Health and Social Services to be administered by the Director.

SOURCE: GC § 9100.

§ 2102. Personnel.

The Director is authorized to appoint such personnel and fix their duties, under and in accordance with Title V, Government Code of Guam, as may be necessary for purposes of this Chapter.

SOURCE: GC § 9101.

§ 2103. Duties Generally.

It shall be the duty of the Director to:

(a) Administer public assistance and child welfare services in Guam, and in accord therewith to adopt such rules and regulations subject to the approval of the Governor, as may be necessary or desirable.

(b) Cooperate with the Federal government in carrying out the purposes of the Social Security Act in matters pertaining to public welfare, public assistance and child welfare services.

(c) To pay medical claims of indigent persons as they are defined in and in accordance with the guidelines and the cost- sharing program developed pursuant to Article 9 of this Chapter.

SOURCE: GC § 9102. Subsection (c) added by P.L. 17-083:2 (Dec. 21, 1984).

§ 2104. Federal Grants.

The Director shall comply with all Federal requirements pertaining to methods and standards of administration and shall make such rules and regulations and follow such procedure as may be required for the receipt from the Federal government of grants or grants-in-aid for public assistance and such administrative costs as are provided in connection therewith.

SOURCE: GC § 9103.

§ 2105. Prevention and Treatment of Conditions Giving Rise to Need.

The Director may carry on or administer or cooperate with other public or private agencies in work or activities for the purpose of preventing or treating conditions giving rise to the need for public assistance in any case in which such work or activities, may prevent, shorten or eliminate the need of public assistance. Such work or activities, if any, shall be taken into consideration in deciding upon or deferring action upon any application for public assistance.

SOURCE: GC § 9104.

§ 2106. Assistance Payments Inalienable.

All assistance payments shall be inalienable by any assignment, sale, attachment, garnishment, execution or otherwise.

SOURCE: GC § 9105.

§ 2107. Frauds: Penalties.

(a) Any person who, by means of a willfully false statement or representation, or by impersonation or other fraudulent device, obtains or attempts to obtain, or aids or abets any other person to obtain, public assistance to which he is not justly entitled, or a larger amount of assistance than that to which he is justly entitled, or any recipient who buys or disposes of real property or any person who knowingly aids or abets a recipient in the purchase or sale of real property without the consent of the Director, in order to qualify for public assistance, shall be guilty of a felony of the third degree.

(b) A person receiving assistance under this Subchapter who willfully fails to report to the Department a change in his status which affects his eligibility, within ten (10) days of that change, is guilty of a misdemeanor.

SOURCE: GC § 9106. Subsection (a) amended by P.L. 23-057:1 (Dec. 5, 1995); subsection (b) repealed and reenacted by P.L. 23-057:2 (Dec. 5, 1995).

§ 2108. Cancellation or Revision.

If, at any time during the continuance of public assistance, the recipient or any person legally liable for the support of the recipient becomes possessed of any property or income in addition to that available at the time the grant was made, the Director may either cancel the assistance or change the amount thereof.

SOURCE: GC § 9107.

§ 2109. Assistance Payments, Subject to Change or Repeal.

All public assistance granted under the provisions of this Chapter shall be deemed to be granted and held subject to the provisions of any amending or repealing act that may be passed and no recipient under this Chapter shall have any claim for compensation or otherwise by reason of his assistance being affected in any way by any such amending or repealing act.

SOURCE: GC § 9108.

§ 2110. Incompetency of Recipient.

If the recipient is found incapable of taking care of his money or himself, the Director may direct assistance to be paid to a legal guardian or any other reputable person for his benefit or may suspend assistance for such period as he deems fit.

SOURCE: GC § 9109.

§ 2111. Misuse of Lists and Records.

It shall be unlawful, except for purposes directly connected with the administration of this Chapter and in accordance with regulations, for any person or persons to solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of any list of, or names of, or any

information concerning, persons applying for or receiving public assistance, directly or indirectly derived from the records, papers, files or communications of the Division of Public Welfare, or acquired in the course of performance of official duties. Any violation of this Section shall be a misdemeanor.

SOURCE: GC § 9110.

§ 2112. Gifts for Welfare Purposes.

The Director is authorized to accept, on behalf of the government of Guam, gifts, bequests and donations for welfare purposes, and may expend any sums so received for the purposes set out in this Chapter, in addition to the regular appropriations made for such purposes.

SOURCE: GC § 9111.

§ 2113. No Use of Public Assistance Funds for the Purchase of Alcoholic Beverages and Tobacco Products.

(a) The use of public welfare assistance program funds for the purchase of alcoholic beverages or tobacco products is prohibited.

(b) A welfare recipient who violates subsection (a) hereof shall be penalized as follows:

(1) A first offense shall result in the revocation of benefits from the program in question for a period not to exceed three (3) months.

(2) A second offense shall result in the revocation of benefits from the program in question for a period not to exceed six (6) months.

(3) A third offense shall result in the permanent revocation of benefits from the program in question.

(c) A business vendor who violates subsection (a) hereof shall be penalized as follows:

(1) A first offense shall result in a penalty of Two Hundred Dollars ($200.00) for each violation.

(2) A second offense shall result in a penalty of Five Hundred Dollars ($500.00) for each violation.

(3) A third offense shall result in a penalty of One Thousand Dollars ($1,000.00) for each violation.

(4) A fourth offense shall result in the permanent revocation of the vendor's right to participate in the program in question.

(d) The Director of Public Health and Social Services shall enforce this Section. The Director shall approve the imposition of the aforementioned penalties as well as the reconsideration of said penalties following an appeal. The Director shall use existing appeal procedures when applicable.

(e) The Director shall periodically review each program and its beneficiaries and vendors regarding compliance herewith.

(f) The Director shall notify current public welfare recipients and vendors, in writing, regarding the prohibitions and penalties imposed by this Section. Said notice shall include, but not be limited to, news media sources and electronic means.

SOURCE: Added by P.L. 29-019:VI:30 (Sept. 29, 2007) as an uncodified law. Codified here by Compiler.

2008 NOTE: This section was also enacted by P.L. 29-113:VI:17 (Sept. 30, 2008) as uncodified law, entitled, "Prohibition of Public Assistance Funds for the Purchase of Alcoholic Beverages and Tobacco Products."

ARTICLE 2
SPECIFIC PROVISIONS COVERING PUBLIC ASSISTANCE

§ 2201. Applications for Public Assistance.

(a) Applications for public assistance under this Article shall be made to the Director by the applicant, or by someone acting in his behalf, in the manner, place and form prescribed by the Director.

(b) No applicant shall be entitled to public assistance under this Article who has sufficient income or other resources to provide a subsistence compatible to decency and health, or who is an inmate of any institution established primarily for tuberculosis or mental illness, or for detention or forcible confinement or correction; or who is an inmate of any public institution of a non-curative character, but an inmate of such an institution mentioned in this Section may apply for assistance to begin after his discharge from such an institution.

(c) In determining the needs of a blind applicant the Director, so long as such exception is a requirement of the Social Security Act that must be complied with in order for Guam to receive Federal matching funds under the program of aid to the blind, shall not take into consideration the first Eighty-Five Dollars ($85.00) per month of earned income plus one-half (1/2) of earned income in excess thereof of such blind applicant. In determining the need of an applicant for or recipient of aid to the blind, only such income and resources as are actually available to the individual for his support shall be taken into consideration in computing the amount of aid to which such individual is entitled, except that there shall be disregarded in making such determination all such amounts of net earnings or other income and resources as now are or hereafter may be permitted or required to be disregarded under Federal laws or regulations providing grants to Guam for aid to the blind.

SOURCE: GC § 9112.

2017 NOTE: Subsection designations added pursuant to the authority of 1 GCA § 1606.

References to "Territory" removed and/or altered to "Guam" pursuant to 1 GCA § 420.

§ 2201.1. Restriction in Use of Local Funds.

(a) No funds appropriated from the General Fund of the government of Guam, or any fund where the revenues deposited therein are of local origin, may be used to provide public assistance to any person who is not a U.S. citizen or a permanent resident alien of the United States and registered as such with the United States Immigration and Naturalization Service. For the purposes of this section only, the term 'public assistance' is defined as assistance provided through one or more of the following programs administered by the Department of Public Health and Social Services:

(1) General Assistance (as defined in § 2601, 10 GCA)

(2) Aid to Families with Dependent Children

(3) Medically Indigent Program

(4) Medicaid

(b) Funds appropriated from the General Fund, or from other funds collected locally, shall be used in support of the provision of services to individuals who are not U.S. Citizens or permanent resident aliens of the United States, but are citizens of a state in Free Association with the United States, only upon the event that the Governor of Guam enters into a valid contract with either an instrumentality of the government of the United States or the governments of the Freely Associated States (being the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands). The terms of said contract must, at a minimum, establish the immediate reimbursement to Guam of all costs associated with the financial impact of the Compacts of Free Association of the various Freely Associated States listed herein, such impact to be defined and quantified by the government of Guam.

SOURCE: Added by P.L. 23-045:IV:12 (Oct. 18, 1995).

2017 NOTE: Subsection designations altered/added pursuant to the authority of 1 GCA § 1606.

§ 2202. Applications by Aliens.

The Director shall establish administrative procedures to determine whether a person applying for public assistance under this Chapter is a United States citizen or an alien. In the case of each alien the Director shall require proof of the alien's lawful status in the United States. In the event an alien refuses to submit such lawful proof, the Director shall advise the Guam Office of the Immigration and Naturalization Services, Department of Justice, of the name of the alien and request that if the person is an illegal alien or if the person has violated his status by becoming a public charge that action be initiated to remove the person from the United States.

SOURCE: GC § 9112.1, added by P.L. 13-2.

§ 2203. Aged Persons.

A person shall be eligible for public assistance who:

(a) Is in need and has not sufficient income or other resources to provide a subsistence compatible with decency and health; and

(b) Is sixty-five (65) years of age or more; provided, that in the event that the minimum age for determining eligibility for old age assistance under the Federal laws is reduced, the minimum age prescribed by this Paragraph shall thereby automatically be reduced to conform to such Federal minimum, but in no case below sixty (60) years.

SOURCE: GC § 9113.

§ 2204. Blind Persons.

A person shall be eligible for public assistance who:

(a) Is in need and has not sufficient income or other resources to provide a subsistence compatible with decency and health; provided, that so long as such exception is a requirement of the Social Security Act that must be complied with in order for Guam to receive Federal matching funds under the program of aid to the blind, the first Eighty-Five Dollars ($85.00) per month of earned income of such person plus one-half (1/2) of earned income in excess thereof shall not be taken into account in determining need, and in determining the need of an

applicant for or recipient of aid to the blind, only such income and resources as are actually available to the individual for his support shall be taken into consideration in computing the amount of aid to which such individual is entitled, except that they shall be disregarded in making such determination all such amounts of net earnings or other income and resources as now are or hereafter may be permitted or required to be disregarded under Federal laws or regulations providing grants to Guam for aid to the blind.

(b) Has no vision or whose vision with corrective glasses is so defective as to prevent the performance of ordinary activities for which eyesight is essential.

SOURCE: GC § 9114.

§ 2205. Children.

A child shall be eligible for public assistance who:

(a) Is in need and has not sufficient income or other resources to provide care and support compatible with decency and health;

(b) Has not attained the age of eighteen (18) years, or if enrolled as a high school student, has not attained the age of nineteen (19) years;

(c) Is deprived of parental support or suitable care by reason of the death, continued absence from home, physical or mental incapacity or cruelty, neglect or depravity on the part of a parent, or by the unemployment of his father, the term "unemployment" being defined by the Federal Social Security Act, as amended, (42 U.S.C. §607); and

(d) Is living in a home with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece, in a place of residence maintained by such relative as his own home.

SOURCE: GC § 9115; Subsection (b) R/R by P.L. 16-44.

§ 2206. Permanently and Totally Disabled Persons.

A person shall be eligible for public assistance who:

(a) Is in need and has not sufficient income or other resources to provide a subsistence compatible with decency and health;

(b) Has attained the age of eighteen (18) years; and

(c) Is permanently and totally disabled, as such may be defined from time to time in the Social Security Act and Federal rules and regulations pertaining thereto.

SOURCE: GC § 9116.

§ 2207. Determination of Amount of Assistance.

The amount of public assistance granted, including funds received from the Federal government, shall not exceed, in the case of any applicant, an amount in excess of that determined, upon investigation or by the decision of the Director, to be compatible with maintaining decency and health. In granting public assistance to a person the Director may take into account part or all of the needs of such person's dependents, provided they also are eligible for public assistance. In the event that such grant has taken into consideration only part of the needs of such other eligible persons, such grant shall be without prejudice to a separate grant of assistance to such persons or any of them, as may be proper upon consideration of their remaining needs and in compliance with the provisions of this Chapter. In determining the needs of a blind applicant, the Director shall not take into consideration the first Eighty-Five Dollars ($85.00) per month of earned income plus one-half (1/2) of earned income in excess thereof of such blind applicant so long as such exception is a requirement of the Social Security Act that must be complied with in order for Guam to receive Federal matching funds under the program of aid to the blind. In determining the need of an applicant for a recipient of aid to the blind, only such income and resources as are actually available to the individual for his support shall be taken into consideration in computing the amount of aid to which such individual is entitled, except that there shall be disregarded in making such determination all such amounts of net earnings or other income and resources as now are or hereafter may be permitted or required to be disregarded

under Federal laws or regulations providing grants to Guam for aid to the blind.

SOURCE: GC § 9117.

§ 2208. Mammogram Screening.

(a) The Department shall make available a mammogram screening program that provides coverage for screening by low-dose mammography for occult breast cancer as follows:

(1) For women 35 to 39 years of age, one baseline mammograph;

(2) For women 40 to 49 years of age, a mammogram every two years;

(3) For women 50 years of age and older, an annual mammogram; and

(4) For a woman of any age with a history of breast cancer or whose mother or sister has experienced breast cancer, a mammogram upon the recommendation of the woman's physician.

(b) Notwithstanding any other provision of law, the Catastrophic Illness Assistance Program within the Department of Public Health and Social Services shall provide mammograph screening to those female residents of Guam who do not have health insurance or do not qualify for coverage under the Medically Indigent Program.

(c) The Director of Public Health and Social Services shall annually review the age and frequency guidelines for mammographic screening recommended by the American Cancer Society, and shall accordingly adjust the age and frequency requirements under subparagraphs (1) through (3) by rule, if necessary.

(d) For purposes of this section, the term low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure

delivery of less then one rad mid-breast, with two views for each breast.

SOURCE: Added as 10 GCA, § 291352.01 by P.L. 21-33:5. Renumbered by Compiler to harmoniously fit this chapter.

2017 NOTE: Subsection designations added/altered pursuant to the authority of 1 GCA § 1606. Internal references altered to reflect the change.

§ 2208.1. Dense Breast Screening Notice to Patients.

If a mammography examination reveals a patient is categorized as having heterogeneously dense breasts or extremely dense breasts, based on the Breast Imaging Reporting and Data System established by the American College of Radiology, the health facility shall include in the summary of the written report that is sent to the patient, as required by federal law, the following notice:

> "Your mammogram shows that your breast tissue is dense. Dense breast tissue is common and is not abnormal. However, dense breast tissue can make it harder to evaluate the results of your mammogram and may also be associated with an increased risk of breast cancer. Your exam was completed using a film-based system. You are advised to consider digital mammography as it has been shown to be more effective for the detection of breast cancer in women with dense breasts when compared to mammography using a film-based system. This information about the results of your mammogram is given to you to raise your awareness and should be discussed with your health care provider. Together, you can decide which screening options are right for you. A report of your results was sent to your physician."

SOURCE: Added by P.L. 31-248:1 (Dec. 6, 2012).

§ 2209. Separation or Desertion: Liability for Support of Family.

(a) In any case of separation or desertion of a parent or parents from a child or children which results in public assistance being granted to that family, the non-custodial parent

or parents shall be liable to the government of Guam for an amount equal to the following:

(1) The amount specified in an order for the support and maintenance of such family issued by a court of competent jurisdiction; or in the absence of such court order, the amount specified in Paragraph (a)(2).

(2) The amount of support which would have been specified in an order for the support and maintenance of the family during the period of separation or desertion , provided that any such amount in excess of the public assistance paid to the family shall be disbursed to the family.

(3) The obligation shall be reduced by any amount actually paid by the non-custodial parent directly to the custodian of the child or to a government agency during the period of separation or desertion for the support and maintenance of the family.

(b) The amount of the obligation established under Paragraph (a) (2) shall be determined by using the appropriate Child Support Guidelines currently in effect.

SOURCE: Added by P.L. 24-116:10.

ARTICLE 3
CHILD WELFARE SERVICES: GENERAL PROVISIONS

NOTE: The articles appearing in these next three articles were Subchapters in the original statutes, and have been designated as "Articles" for purposes of this compilation.

§ 2301. Purpose.

It is the purpose of this Article to establish, extend and strengthen public welfare services for the protection and care of homeless, dependent and neglected children, delinquent children, and children in danger of becoming delinquent, in order to provide adequate child welfare services for the Guam.

SOURCE: GC § 9118.

2017 NOTE: Reference to "territory" removed and/or altered to "Guam" pursuant to 1 GCA § 420.

§ 2302. Cooperation with Federal Government.

The Division of Public Welfare of the Department of Administration is hereby designated as the agency to cooperate with the Federal government, or any agency or instrumentality thereof, in establishing, extending and strengthening child welfare services.

SOURCE: GC § 9119.

§ 2303. Subsidized Dental Care.

(a) The Department of Public Health and Social Services shall provide subsidized in-house dental care to all pre-school and school age children in Guam through age sixteen (16) who demonstrate an economic need and qualify in a manner determined by the Director. The requirement for demonstration of economic need is hereby waived for those children participating in community preventive dental services under the school busing, public health dental program. Community preventive dental services as it applies to the school busing, public health dental program include oral health education, an oral exam, and if needed, sealant placements.

(b) The Director of the Department of Public Health and Social Services shall promulgate rules and regulations through the Administrative Adjudication Law within sixty (60) days upon enactment.

SOURCE: GC § 9119.1. Repealed and reenacted by P.L. 24-067:2 (Sept. 30, 1997). Subsection (a) amended by P.L. 24-196:1 (May 6, 1998).

§ 2304. Plan for Child Welfare Services.

The Director, through the Division of Public Welfare, is hereby authorized:

(a) To develop jointly with the Federal government, through its appropriate agency or instrumentality, a plan for the purpose specified in § 2302 and to make such rules and regulations as may be necessary or desirable for the administration of such plan and the provisions of this Article.

(b) To receive and expend in accordance with such plan any funds made available by the Federal government for such purposes.

(c) To develop services for the encouragement and assistance of adequate methods of community child welfare organization in accordance with such plan, which shall include but not be limited to:

(1) such efforts as are necessary to reduce the number of children in foster care beyond twenty-four (24) months to not more than twenty percent (20%) of the total number of children in foster care on Guam by the end of fiscal year 1984.

SOURCE: GC § 9120; Subsection (c) amended by P.L. 16-111.

ARTICLE 4
CHILD WELFARE SERVICES ACT

NOTE: Article added by P.L. 11-099:2 (Nov. 10, 1971) as Subchapter C-1 of Chapter II of Title X of the Government Code.

§ 2401. Title.

This Article shall be known and may be cited as the Child Welfare Services Act.

SOURCE: GC § 9120.1.

§ 2402. Definitions.

As used in this Article:

(a) Child means a person under eighteen (18) years of age.

(b) Department means the Department of Public Health and Social Services.

(c) Child Care Facility means any person or place which receives or arranges placement of one or more children who are not related to such person, whether for gain or otherwise, apart from the parents or guardian, with or without the transfer of the right of custody, for the purpose of providing regular care or training for such child or children during either the day or night, or both. Except as otherwise provided, the term Child Care Facility includes, but is not limited to, all facilities defined by the Department of Public Health and Social Services as family day care homes, foster family homes, group care homes, residential treatment facilities, day care centers, day nursery, nursery school, kindergarten school, day care homes or similar institutions or units regardless of name.

(d) Guardian means the guardian of the person of a minor.

(e) Person means any person or persons, group of persons, agencies, associations, organizations, whether public, private or incorporated.

(f) Related means any of the following relationships by blood, marriage or adoption: parent, grandparent, brother, sister, stepparent, stepbrother, stepsister, uncle or aunt.

SOURCE: GC § 9120.2.

§ 2403. Exclusions.

This Article does not apply:

(a) To the care of a relative's, friend's or neighbor's child or children, with or without compensation;

(b) Where parents on a mutually cooperative basis exchange care of one another's children;

(c) To the care of children in their own home;

(d) To a hospital, clinic or educational institution;

(e) To kindergartens or nursery schools operated by public or private elementary or secondary level school systems;

(f) To facilities operated in connection with a shopping center where children are received while parents are on the premises;

(g) To facilities operated in connection with a church where children are received while parents are on the premises.

SOURCE: GC § 9120.3, as amended by P.L. 15-146 (Dec. 30, 1980).

§ 2404. License Necessary.

No person except the Department shall operate or conduct a child care facility without a license so to do issued by the Department.

SOURCE: GC § 9120.4.

§ 2405. Application-Filing-Issuance of License.

(a) Application for a license to operate a child care facility shall be made to the Department upon forms furnished by it.

(b) Upon filing of the application in proper order, the Department shall examine the child care facility of the applicant. Such examination may be made by the Social Services Division or persons designated by the Department as its agent for that purpose. If, upon examination, the Department is satisfied that the applicant and facility reasonably meet the qualifications and standards prescribed for the type of facility for which application for license is made, it shall issue to the applicant a license designating the type of facility provided for, and, the number of children to be served at any time by such facility.

(c) License shall be issued in such form and manner as prescribed by the Department, and shall be valid for one (1) year from the date of issuance unless revoked. The Department may, in its issuance of licenses for child care facility, indicate thereon any classifications it deems appropriate, including the following:

(1) Group I - For a facility which meets the qualifications and standards prescribed by the Department for professional therapy or treatment and full-time casework and diagnostic services on a continuing basis for children with a special behavior or emotional disorder.

(2) Group II - For a facility which meets the qualifications and standards of prescribed by the Department for full-time casework services to and on behalf of children.

(3) Group III - For all other facilities which meet the qualifications and standards prescribed by the Department.

(d) The Department may, in its discretion, issue a permit to a newly established facility for child care, for a period not to exceed six (6) months, to allow such facility reasonable time to become eligible for full license, except that a permit shall not be granted to any foster family home or group care home.

SOURCE: GC § 6120.5.

§ 2406. Annual Examination.

The Department shall re-examine at least annually every child care facility for which a license has been issued under this Article. Such examination shall include an examination of such records of the facility as the Department deems necessary to determine the standards of care provided children served by the facility. If, upon examination, the Department is satisfied that the facility continues to maintain adequate standards, which it prescribes and publishes as herein provided, it shall renew the license to operate the facility.

SOURCE: GC § 9120.6.

§ 2407. Powers and Duties of the Department.

The Department shall, pursuant to the provisions of the Administrative Adjudication Law, adopt minimum standards for licensing. Such standards shall be applicable to all child care facilities including those operated by the Department and shall pertain to the following:

(a) The operation and conduct of the facility and responsibility it assumes for child care;

(b) The character, suitability and qualifications of the applicant and other persons directly responsible for the care and welfare of children served;

(c) The general financial ability and competence of the applicant to provide necessary care for children and to maintain prescribed standards;

(d) The number of individuals or staff required to insure adequate supervision and care of the children received;

(e) The appropriateness, safety, cleanliness and general adequacy of the premises, including maintenance of adequate fire prevention and health standards in conformance to existing Guam laws to provide for the physical comfort, care and well-being of children received;

(f) Provisions for food, clothing, educational opportunities, programs, equipment and individual supplies to assure the healthy physical, mental and spiritual development of children served;

(g) Provisions to safeguard the legal rights of children served;

(h) Maintenance of records pertaining to the admission, progress, health and termination of care of children;

(i) Filing of records with the Department;

(j) Discipline of children;

(k) Protection and fostering of the particular religious faith of the children served.

SOURCE: GC § 9120.7.

2017 NOTE: Reference to "territorial" removed and/or altered to "Guam" pursuant to 1 GCA § 420.

§ 2408. Revocation-Conditions.

The Department may, subject to and in accordance with the provisions of the Administrative Adjudication Law, revoke or refuse to renew the license of any child care facility should the licensee:

(a) Fail to maintain standards prescribed and published by the Department; or

(b) Violate any of the provisions of the license issued; or

(c) Furnish or make any misleading or any false statement or report to the Department; or

(d) Fail to submit to the Department any report or refuse to make available to the Department any records required by it in making investigation of the facility for licensing purposes; or

(e) Refuse to submit to an investigation by the Department; or

(f) Refuse to admit authorized representative of the Department at any reasonable time for the purpose of investigation; or

(g) Fail to provide, maintain, equip and keep in safe and sanitary condition the premises established for child care; or

(h) Refuse to display its license; or

(i) Fail to maintain financial resources adequate for the satisfactory care of children served in regard to up-keep of premises, and provisions for personal care, education and other essentials in the proper care, rearing and training of children.

SOURCE: GC § 9120.8.

§ 2409. Investigation.

Whenever the Department is advised, or has reason to believe, that any person, group of persons or corporations is operating a child care facility without a license, it shall make an investigation to ascertain the facts. If it finds that such child facility is being, or has operated without a license, it shall report the results of its investigation to the Attorney General of Guam for prosecution.

SOURCE: GC § 9120.9.

2017 NOTE: Reference to Territorial Prosecutor altered to the Attorney General of Guam pursuant to *Territorial Prosecutor v. Superior Court of Guam*, D.C. Civ. App. 82-0215 (D.C. Guam App. Div. May 26, 1983), which struck down the statute creating the Territorial Prosecutor as being inorganic and unconstitutional.

See also Title 5 GCA, Chapter 30, Article 1 (Attorney General).

§ 2410. Advertising.

A child care facility licensed by the Department may publish advertisements of the services for which it is specifically licensed under this Article. No person, unless licensed as a child care facility, shall publish any advertisement soliciting a child or children for placement or offering to receive a child or children for placement.

SOURCE: GC § 9120.10.

§ 2411. Records.

(a) Every child care facility shall keep and maintain such records as the Department may prescribe which shall contain the following:

(1) Name, sex, date of birth, age and date and time of admission;

(2) Name, address and telephone number of parent or guardian;

(3) Name, age and date of birth of other children in the family;

(4) Health record showing date of last physical examination and list of inoculations and vaccinations, including dates administered;

(5) Name and telephone number of family physician who may be called in case of emergency.

(b) Such facility shall report relative thereto to the Department whenever called for upon forms prescribed by the Department.

(c) All records regarding children and all facts learned about children and their relatives shall be deemed confidential both by the child care facility and by the Department.

SOURCE: GC § 9120.11.

2017 NOTE: Subsection/subitem designations added/altered pursuant to the authority of 1 GCA § 1606.

§ 2412. Violations-Penalties.

Whoever:

(a) Conducts, operates or acts as a child care facility without a license to do so in violation of provision of this Article;

(b) Makes materially false statements in order to obtain a license;

(c) Fails to keep the records and make the reports provided for under this Article;

(d) Advertises any service not authorized by license held;

(e) Publishes any advertisement in violation of provision of this Article;

(f) Violates any other provision of this Article or any reasonable rule or regulation adopted by the Department, for the enforcement of the provisions of this Article is guilty of a violation.

SOURCE: GC § 9120.12, as amended by P.L. 13-187.

§ 2413. Health Permit Required.

It shall be unlawful for any person to open for business or operate any child care facility, or advertise or hold himself out as operating any child care facility, without a valid sanitary permit as required by Chapter 21 of this Title. Only those persons who comply with all the applicable provisions of this Article shall be entitled to receive and retain such permit.

SOURCE: GC § 9120.13, as amended by P.L. 15-096:2 (Jan. 26, 1980).

§ 2414. Disease Control.

(a) No employer, owner, manager or person in charge or control, shall permit any person to enter the premises, knowing such person to have or having reason to believe that he has a disease in communicable form as set forth in Chapter 4 of this Title, or is a carrier of such disease; and no person shall work in a child care facility, whether in his own or another's employ, knowing himself to have or having reason to believe that he has any such disease.

(1) If an employer, owner, manager or person in charge or control suspects that any employee has any such disease in a communicable form or is a carrier of such disease, he shall notify the Director immediately.

(2) Persons with cuts or sores shall not be allowed to handle food that may become contaminated by such handling.

(3) A placard containing the provisions of this Section shall be posted in a place where it will be seen by each employee.

(b) (1) Any child showing signs of illness must be isolated promptly from other children until arrangements can be made for his care.

(2) In the event a child is found to have a communicable disease, the Director and the parents or guardian of the child and of any other child who has been admitted for care or exposed shall be notified immediately.

SOURCE: GC § 9120.14, as amended by P.L. 15-096:3 (Jan. 26, 1980).

2017 NOTE: Subsection/subitem designations added/altered pursuant to the authority of 1 GCA § 1606.

§ 2415. Children's Certificate of Health.

(a) No child shall be admitted to any child care facility without a certificate of health, which includes the required vaccination or immunization, certified annually by a qualified Guam licensed physician indicating that the child would not constitute a contagious health risk for the public at large. Certificates of Health shall be made on forms provided by the Department, and a copy of the certificate for medical or religious exemptions shall be included in the child's health record at the child care facility where enrolled.

(b) The Director shall require vaccination or immunization, in conformity with the Advisory Committee on Immunization Practice ('ACIP') of the United States Department of Human Services and the American Academy of Pediatrics ('AAP'); provided, that in the event that the recommendations of the ACIP and the AAP differ, the Department shall determine which recommendations shall apply, except that exemption may be granted to a child, upon certification by the Department or by a parent or legal guardian, that such vaccination or immunization would be against their bona fide religious belief, or medical contraindication certified by a Guam licensed medical physician.

(c) Certificates of medical and religious exemption shall be prescribed on forms provided by the Department and shall be

kept on file in the Bureau of Communicable Diseases Control of the Department. A copy of the certificate for medical and religious exemption shall be included in the child's health record at the child care facility.

SOURCE: GC § 9120.15. Repealed and reenacted by P.L. 24-154:1 (Apr. 9, 1998). Subsection (a) amended by P.L. 24-335:2 (Dec. 30, 1998).

§ 2416. Child Care Revolving Fund.

There is hereby established a Child Care Revolving Fund (the Fund), to be maintained by the Director of the Department.

(a) The Fund shall be established and maintained in an account separate and apart from any other account(s) of the government of Guam, and shall not be co-mingled. All funds due or accruing to the account from whatever source(s), as provided or authorized pursuant to applicable law, inclusive of any interest, shall be deposited in the Fund immediately upon receipt by the government of Guam.

(b) The Department shall report monthly and maintain full compliance with all financial reporting requirements of the government of Guam pursuant to applicable laws. Reports shall be submitted to *I Liheslaturan Guåhan* via the office of *I Maga'lahen Guåhan* [Governor of Guam].

(c) No Transfer Authority. The money placed in the Fund is not subject to any transfer authority of *I Maga'lahen Guåhan* [Governor of Guam].

SOURCE: Added by 31-073:4 (June 2, 2011).

2017 NOTE: Subsection designations added/altered pursuant to the authority of 1 GCA § 1606.

ARTICLE 5
CHILD PROTECTIVE SERVICES

[Repealed.]

SOURCE: Added by P.L. 14-137:2 (July 24, 1978) as Subchapter C-A, §§ 9120.20 - 9120.35, Chapter II of Title X of the Government Code, entitled "Child Protective Services." Article 5 repealed in its entirety by P.L. 20-209:4 (Aug. 22, 1990).

NOTE: A new Chapter 88 of Title 10 GCA added by P.L. 20-209:5 (Aug. 22, 1990) established the Child Protective Act.

ARTICLE 6
GENERAL ASSISTANCE

§ 2601. General Assistance.

The Director shall administer public assistance to those needy persons not otherwise provided for under this Chapter, who for any reasons satisfactory to the Director are unable to provide sufficient support for themselves or those dependent upon them.

SOURCE: GC § 9121.

§ 2602. Applications.

Applications for general assistance shall be made by the applicant or by someone acting in his behalf in the manner, place and form prescribed by the Director.

SOURCE: GC § 9122.

§ 2603. Amount of Grants.

Upon receipt of an application for general assistance, the Director shall investigate and prepare a complete record of the circumstances of the applicant and his dependents, if any. The amount or value of such assistance shall not exceed such minimum as in the judgment of the Director will provide for the minimum needs including food, shelter, clothing, utilities and

incidentals compatible with the maintenance of decency and health of such applicant and his dependents.

SOURCE: GC § 9123.

§ 2604. Disaster Relief.

In the case of disaster resulting from natural or other causes, the Director, at and under the direction of the Governor, is authorized to provide such relieve as may be necessary to assist victims in their emergency needs. The Governor is authorized to make additional funds available for this purpose from any appropriation enacted for disaster relief, and to take such action as may be necessary to qualify for aid from the Federal government in such cases.

SOURCE: GC § 9124.

ARTICLE 7
FOOD STAMP PROGRAM

SOURCE: Added by P.L. 15-035 (June 12, 1979) as §§ 9130 - 9134 of Subchapter E, Chapter II, Title X of the Government Code.

§ 2701. Definitions.

For the purposes of this Article:

(a) Department means the Department of Public Health and Social Services;

(b) Food means any food or food product for human consumption except alcoholic beverages and tobacco and shall include seeds and plants for use in gardens to produce food for the personal consumption for the eligible household;

(c) Food coupons means any coupon, stamp or type of certificate used under the Federal Food Stamp Act of 1977;

(d) Food stamp program means the Federal Food Stamp Act of 1977.

SOURCE: GC § 9130.

§ 2702. Authorization.

The Department of Public Health and Social Services, through the Division of Social Services, is authorized to implement the food stamp program locally in accordance with the provisions of the Federal Food Stamp Act of 1977:

(a) Householders determined by the Department to be eligible for assistance under the food stamp program may obtain food coupons;

(b) Food coupons shall be used to purchase food from retail food stores which have been approved for the participation in the food stamp program.

SOURCE: GC § 9131.

§ 2703. Duties of the Department.

The Department of Public Health and Social Services, through the Division of Social Services, shall:

(a) Adopt rules and regulations necessary to carry out the food stamp program;

(b) Cooperate with the Federal government and do all things necessary to continue territorial eligibility under the food stamp program;

(c) Comply with the requirements of the Federal Food Stamp Act of 1977.

SOURCE: GC § 9132.

§ 2704. Reporting Change of Status.

A person receiving assistance under § 2702 of this Subchapter who willfully fails to report to the Department a change in his status which affects his eligibility or the amount of

payment for which he is eligible, within ten (10) days of that change, is guilty of a felony of the third degree.

SOURCE: GC § 9133. Amended by P.L. 23-57:3.

§ 2705. Penalties.

A person is guilty:

(a) of a felony of the third degree if he knowingly makes a false statement for the purpose of influencing the action of the Department in connection with its responsibilities under the Federal Food Stamp Act of 1977, with respect to the certification of households applying for participation in the food stamp program and the issuance under such program of food stamp coupons to households;

(b) of a misdemeanor if he knowingly uses, transfers, acquires, alters or possesses food stamp coupons or authorization-to-participate cards in any manner not authorized by the Federal Food Stamp Act of 1977 or the Federal or territorial regulations issued pursuant to this Act and the face value of the food stamp coupons or the authorization-to-participate card is One Hundred Dollars ($100) or less;

(c) of a felony of the third degree if he knowingly uses, transfers, acquires, alters or possesses food stamp coupons or authorization-to-participate cards in any manner not authorized by the Federal Food Stamp Act of 1977, or the Federal or territorial regulations issued pursuant to this Act and the face value of the food stamp coupons or the authorization-to-participate card exceeds One Hundred Dollars ($100);

(d) of a felony of the third degree if he knowingly uses, transfers, acquires, alters or possesses blank authorization-to-participate card of the Department in any manner not authorized by the Department;

(e) of a felony of the third degree if he knowingly counterfeits, forges or alters any authorization-to-participate card issued by the Department in connection with its

responsibilities under the Federal Food Stamp Act of 1977; or

(f) of a felony of the third degree if he knowingly alters, publishes or puts into circulation any counterfeited, forged or altered authorization-to-participate cards.

SOURCE: GC § 9134. Amended by P.L. 23-57:4.

ARTICLE 8
ENFORCEMENT OF SUPPORT

NOTE: Article 8 was moved by the Compiler to Title 5 GCA, Chapter 34, pursuant to the authority granted by 1 GCA § 1606.

ARTICLE 9
MEDICALLY INDIGENT PROGRAM

SOURCE: Entire article originally added by P.L. 17-083:3 (Dec. 21, 1984). P.L. 18-008:7 (July 8, 1985) added § 2912. P.L. 18-031 (Mar. 29 1986) repealed and reenacted § 2902, amended §§ 2906 and 2912, and added §§ 2913-2913.81. Entire article repealed and reenacted by P.L. 25-163 (Sept. 21, 2000), effective Mar. 1, 2001. Effective date amended to Oct. 1, 2001 pursuant to P.L. 26-001:V:15 (Mar. 7, 2001), and amended to Oct. 1, 2002 pursuant to P.L. 26-035:IV:35 (Sept. 28, 2001). Entire article repealed and reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Descriptive subheadings included in the public laws and in past print publications were removed to adhere to the Compiler's general codification scheme pursuant to 1 GCA § 1606.

Pursuant to P.L. 26-035:IV:35 (Sept. 28, 2001), the reenactment of this Article by P.L. 25-163 (Sept. 21, 2000) would become effective on Oct. 1, 2002, unless the Medically Indigent Program, Medicaid and Child Health Insurance programs were privatized. The privatization of these programs did not occur; therefore, the Article 9 as reenacted by P.L. 25-163 became effective on Oct. 1, 2002.

§ 2901. Legislative Intent.

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

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

(c) It is therefore the intent of *I Liheslaturan Guåhan* [the Guam Legislature] to change the criteria for eligibility and benefit coverage to reflect budgetary constraints within the

Medically Indigent Program without compromising the health care services provided by the government of Guam.

2017 NOTE: Subsection designations added pursuant to the authority of 1 GCA § 1606.

§ 2902. Medically Indigent Program.

There is established the Guam Medically Indigent Program.

(a) The Medically Indigent Program is established for the purpose of providing medical, dental and behavioral health assistance to the indigent people of Guam in a manner that ensures access to basic quality health care at an affordable cost.

(b) The Program shall be composed of the following:

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

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

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

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

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

2017 NOTE: Subsection/subitem designations added/altered pursuant to the authority of 1 GCA § 1606.

§ 2903. Definitions.

In this Article, *unless* the context otherwise requires:

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

(b) 'Clean Claim' means a claim, that may be processed without the need of additional information from the provider of service or from a third party but does not include any claim under investigation for fraud or abuse or claims under review for medical necessity. In no event may a claim be contested or denied for the lack of information that has no factual impact upon the Health Plan Administrator's ability to adjudicate the claim.

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

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

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

(1) a resident of Guam and has been a resident of Guam for a period of *no less than* six (6) months; and

(A) who has been physically living on Guam within the last six (6) months of the year, *except* for temporary absences in the past year which cannot be reasonably construed as absences due to *bona fide* residency outside of Guam;

(B) who applies for and qualifies for assistance under this Article;

(C) who is unable to pay the cost of the necessary medical care; *and* who also:

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

(A) does not have medical insurance coverage nor the financial ability to pay for medical insurance coverage or for medical services as determined by the cost-sharing

Program developed by the Administrator based upon the criteria established in this Article; *or*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2017 NOTE: Subsection/subitem designations added/altered pursuant to the authority of 1 GCA § 1606.

This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled *"Medically Indigent Persons; Defined."* Repealed by P.L. 25-163:2 (Sept. 30, 2003).

2012 NOTE: In maintaining the general codification scheme of the GCA the Compiler changed the hierarchy of subsections beginning with "Lowercase Roman Numerals" to "Uppercase Letters" in subsection (e)(1).

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

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

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

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

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

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

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

(5) Development of a complete system of accounts and controls for the Program, including provisions designed to ensure that covered health services provided through the Program are not used unnecessarily or unreasonably, including, but not limited to, inpatient mental health services provided in a hospital. The Administrator shall regularly compare the scope, utilization rates, utilization control methods and unit prices of major health care

services provided on Guam in comparison with Program health care services to identify any unnecessary or unreasonable utilization within the Program. The Administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the Program in order to reduce unnecessary or unreasonable utilization.

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

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

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

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

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

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

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

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

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

other health or medical or disability insurance plan, including coverage made available to eligible persons or who receives payments for accident-related injuries, so that any costs for hospitalization, medical, dental or behavioral health care paid by the Program are recovered from any other available third-party payers.

(A) The Administrator may require that Providers and Non-Providers are responsible for the coordination of benefits for services provided under this Article.

(B) Requirements for coordination of benefits by Non-Providers under this Section shall be limited to coordination with standard health insurance and disability insurance policies, and similar programs for health coverage.

(C) The Program shall act as a payer of last resort for eligible persons as defined by this Article, *unless* specifically prohibited by Federal or local law.

(D) The Administrator may require eligible persons to assign to the system rights to all types of medical benefits, to which the person is entitled, including, but *not* limited to, first-party medical benefits under automobile insurance policies.

(E) The government of Guam has a right to subrogation against any other person or firm to enforce the assignment of medical benefits.

(F)The provisions of this Subsection are controlling over the provisions of any insurance policy, which provides benefits to an eligible person *if* the policy is inconsistent with the provisions of this Subsection.

(15) The Administrator shall require as a condition of a contract with any Provider that all records relating to contract compliance are available for inspection by the Administrator or the Director and that such records be maintained by the Provider for five (5) years. The Administrator shall also require that a Provider make such

records available on request of the Secretary of the United States Department of Health and Human Services, or its successor agency.

(16) The Administrator shall establish procedures for:

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

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

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

(18) As a condition of the contract with any Provider, the Administrator shall require such contract terms as are necessary, in the judgment of the Administrator, to ensure adequate performance and compliance with all applicable local and Federal laws by the Provider of th e provisions of each contract executed pursuant to this Article.

(A) Contract provisions required by the Administrator may include, but are *not* limited to, the maintenance of deposits, performance bonds, financial reserves or other financial security.

(B) The Administrator may waive requirements for the posting of bonds or security for Providers which have posted other security, equal to or greater than that required by the system, with a local agency for the performance of health service contracts *if* funds would be available from such security for the Program upon default by the Provider.

(C) The Administrator may also establish procedures, which provide for the withholding or forfeiture of payments to be made to a Provider by the Program for the failure of the Provider to comply with a provision of the Provider's contract with the Program or with the provisions of adopted rules.

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

(20) *If* the Administrator determines that it is more cost effective to provide for the medical management of a Program participant's health care needs with the provision of services that may fall outside the defined Program benefits, such treatment may be pursued; *provided*, that there will be a significant beneficial outcome to the patient's health status and the total cost of this alternate treatment regime does not exceed a total cost of Seventy-five Thousand Dollars ($75,000.00). Treatment outside the defined Program benefits, must take place at teaching hospitals or be sanctioned by the Federal, Drug Administration as an experimental drug or procedural practice.

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

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

(e) *Subject* to the Administrative Adjudication Law, the Sunshine Reform Act of 1999 and the Health Insurance Portability and Accountability Act (HIPAA) which affects all health insurance entities regarding the type of Protected Health Information (PHI) that they are allowed to disclose and to whom they are to disclose it to, the Director, in consultation with the Administrator, shall prescribe by rules and regulations the types

of information that are confidential, and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Such rules shall be designed to provide for the exchange of necessary information among Providers, the Administrator and the Department for purposes of eligibility determination or coordination of eligible medical care under this Article.

SOURCE: Added by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection/subitem designations added/altered pursuant to authority of 1 GCA § 1606.

This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled "*Income*." Repealed and reenacted by P.L. 25-163:2 (Sept. 30, 2003), entitled "*Establishment of Program Administrator*." Repealed by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905. Program Participation and Eligibility Standards.

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

(1) General Eligibility Standards,

(2) Income Limitations, and

(3) Resource Limitations

as established in this Section, § 2905.4, and § 2905.5.

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

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

applicant with a written response as to the person's eligibility under the Program.

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

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection/subitem designations added/altered pursuant to authority of 1 GCA § 1606.

This section was originally added by P.L. 17-083:3, entitled *"Residency"* and repealed by P.L. 25-163:2 (Sept. 30, 2003).

Subsection (c) was originally added as § 2908 by P.L. 17-083:3 (Dec. 21, 1984); subsection (d) was originally added as § 2909 by P.L. 17-083:3; subsection (e) was originally added by P.L. 17-083:3 as § 2910, entitled "System for Investigation"; and subsection (f) was originally added as § 2911 by P.L. 17-083:3. The current codification is pursuant to the reenactment bv P.L. 27-030:2 (Sept. 30, 2003)

§ 2905.1. General Eligibility Standards.

An applicant must be a person who is, or would be legally obligated to pay for medical services rendered to such person,

but through indigence or other financial circumstances, is unable to pay for such services, *and*

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

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection/subitem designations deleted/altered pursuant to 1 GCA § 1606.

§ 2905.2. Program Residency Requirements.

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

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

(1) an applicant shall produce at least one (1) of the following in their name in addition to a Guam rent, mortgage receipt, or utility bill in order to establish beyond

a reasonable doubt proof of residency of *no less than* six (6) months:

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

(B) a current Guam motor vehicle registration;

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

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

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

(F) evidence of registration to vote on Guam.

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

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

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

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

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

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2012 NOTE: In maintaining the general codification scheme of the GCA the Compiler changed the hierarchy of subsections beginning with "Lowercase Roman Numerals" to "Uppercase Letters" in subsections (b)(1) & (b)(2).

§ 2905.3. Emergency Medical, Tuberculosis.

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

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

(c) Each person desiring to be classified as eligible pursuant to this Section shall apply for certification pursuant to rules established by the Administrator. The Administrator shall make the final determination regarding eligibility. On determination that the person is eligible for emergency care, the Administrator shall issue certification of limited eligibility to the applicant and shall provide notification to Program Providers.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally added by P.L. 25-163:2 (Sept. 21, 2000), entitled "*Emergency Medical, Tuberculosis, Leprosy and Prenatal Care Eligibility for Non-Residents.*"

§ 2905.4. Income Eligibility Standards.

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

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

(b) Program Participant's Liability Based on Partial Coverage. *If* an applicant applying for assistance under the Medically Indigent Program has gross income which exceeds the gross income limit of the applicant's category as described above, and exceeds that limit by an amount *not greater than* Three Hundred Dollars ($300.00), the applicant may still be eligible for partial coverage as provided in this Section.

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

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

$251 - $300	45%

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.5. Resource Eligibility Standards.

(a) Resources. For the purposes of this Article, the term *'resources'* shall include all real or personal property, or any combination of both, held by household members.

(1) *If* the holdings are in the form of real property, the value shall be the assessed value determined under the most recent Guam property tax assessment less the unpaid amount of any encumbrance of record.

(2) *If* the holdings consist of money on deposit, the value shall be the actual amount thereof.

(3) *If* the holdings are in any other form of personal property or investment, except life insurance, the value shall be the conversion value as of the date of application.

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

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

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

(1) Resources, personal and real properties are counted toward the resource reserve limit, for all persons included in the assistance unit.

(A) Property of the caretaker, natural, legally liable, or adoptive parents, with whom the children are living, are also included in the assistance unit's property reserve.

(B) Properties are evaluated at market value less encumbrances.

(C) (i) The following are considered real property: land, houses, mobile homes, and immovable property attached to the land;

(ii) personal property is all assets other than real property.

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

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

(1) cash on hand;

(2) check or savings account amount;

(3) stocks or bonds; *and*

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

(e) Cash Resources for Medical Treatment Exempted. Cash resources that will be used for medical treatment-related expenditures are exempted in determining liquid resources.

(f) Vehicles.

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

(2) All other vehicles shall individually be evaluated at Fair Market Value (FMV) and that portion of the value which exceeds the current Food Stamp Program vehicle disregard shall be attributed in full toward the household's resource limit, regardless of any encumbrances on the vehicles.

(3) Vehicles for individuals with disabilities which are customized with a lift to accommodate those individuals with wheelchairs for the purpose of transporting those individuals shall be exempted on a case-by-case basis.

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

(A) Kelly Blue Book (Wholesale Value);

(B) Copy of Bill of Sale;

(C) Estimate from Auto Dealer; or

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

(g) Real Property.

(1) Real property is excluded in determining the resources of the household when it is their primary home, including the surrounding land which is not separated from the home by intervening property owned by others.

(2) Public rights of way, such as roads which run through the surrounding property and separate it from the home will not affect the property exemption.

(3) Households that currently do not own a home, but own or are buying a land on which they intend to build or are building a permanent home, shall receive an exclusion for the value of the land and, if it is partially completed for the home.

(4) Verifications:

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

(B) Tax Listings;

(C) Copy of the Mortgage Papers; and

(D) Copy of the Deed of Gift.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection/subitem designations added/altered pursuant to 1 GCA § 1606.

§ 2905.6. Supplemental Coverage; Limitation.

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

supplemental coverage assistance may be obtained via the Catastrophic Illness Assistance Program.

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.7. Applicability to All Applicants.

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

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

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection designations added/altered pursuant to 1 GCA § 1606.

§ 2905.8. Uncovered Medical Procedure.

In situations where a person's health insurance will *not* be able to cover a particular condition or procedure, and the condition or procedure is within the scope of services covered by the Program, the person may apply for assistance. *If* found eligible, only the uncovered procedure will be covered by the Program.

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.9. Discontinuance of Insurance.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.10. Potential Medicaid Clients.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.11. Last Resort for Medical Services.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.12 Treatment of Eighteen Year Old Applicants.

An individual who has attained the age of eighteen (18) years and who is *not* a dependent for tax purposes of another household may apply to the Medically Indigent Program. An individual who is between the ages of eighteen (18) and twenty-three (23) years who is still attending high school or college and living at home may be included under that person's parents, or household member's application to the Medically Indigent Program and the family's income.

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.13. Emancipated Adult.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2905.14. Eligibility Certification Periods.

Once qualified as eligible, persons may participate in the Program for periods that run from six (6) months to one (1) year, *subject to* the restrictions established herein.

(a) Households with *at least* one (1) member between the ages of seventeen (17) and fifty-four (54) years shall be given a certification for a period of six (6) months.

(b) A household with all members who are fifty-five (55) years old or older, or with *at least* one (1) member with a permanent disability affirmed by a Provider, shall be given certification for a period of one (1) year.

(c) Shorter periods of certification may be established *if* deemed necessary by the Administrator.

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection designations added pursuant to 1 GCA § 1606.

§ 2905.15. Special Provisions for Children in Child Protective Services.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), and repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2906. Administrative Provisions.

(a) The Administrator may:

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

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

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

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

(d) Determination of Head of Household.

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

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

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

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

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

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

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

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

(g) Income.

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

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

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

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

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

(j) Permanent Resident Alien. Aliens who are applying for assistance shall provide information and required documentation concerning the sponsor's income and resources as a condition for eligibility.

(1) In determining the eligibility for all qualified aliens, the income and resources of any person who executed an affidavit of support pursuant to the Immigration and Nationality Act on behalf of the qualified alien and the income and resources of the spouse, *if any*, of the sponsoring individual shall be counted at the time of application and for the re-determination of eligibility for the duration of the attribution period, as specified in Federal law.

(2) *If* a resident alien’s sponsor did not execute an affidavit of support pursuant to the Immigration and Nationality Act on behalf of the qualified alien, then the income and resources of a sponsor(s) and the sponsor's

spouse, *if* living together, shall be treated as unearned income and resources.

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

(l) Denials. Applicants will be denied when:

(1) ineligibility is established;

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

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

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

(1) moved to another house;

(2) someone moved into the household;

(3) someone moved out of the household;

(4) someone in the household has given birth;

(5) someone in the household terminated from employment;

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

(7) someone in the household obtained a job;

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

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

(10) someone in the household has expired.

(n) Penalty for Failure to Report Changes. The above list is *not* inclusive. Therefore, all changes shall be reported.

(1) Failure to report changes within ten (10) calendar days, a change or changes in household circumstances which should have resulted in ineligibility, making false or misleading statements or withholding information at the time of application which should have resulted in ineligibility, the head of household and spouse (if any) shall be suspended from the Program participation for:

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

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

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

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

(1) false declarations in seeking Program eligibility; or

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled *"Resources"* Repealed by P.L. 25-163:2 (Sept. 30, 2003).

Pursuant to P.L. 29-002:VI:28 (May 18, 2007) references to "Gross Receipts Tax" was altered to "Business Privilege Tax."

§ 2907. Scope of Services.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled *"Resources; Disposition."* Repealed by P.L. 25-163:2 (Sept. 30, 2003).

§ 2907.1. In-Patient Services.

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

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

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

(3) coronary and intensive care;

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

(5) surgery and anesthesia;

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

(7) diagnostic laboratory services;

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

(9) renal dialysis treatment;

(10) physician services;

(11) emergency room services;

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

(13) respiratory therapy;

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

(15) podiatry services; care in an intermediate care facility; and ambulance services.

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

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

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

(3) personal comfort or convenience items;

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

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

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2907.2. Out-Patient Services.

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

(1) Physician Evaluation and Management Services;

(2) Laboratory Diagnostic Services;

(3) Diagnostic Radiology, Ultrasound and Mammography Screening Services, to include annual mammograms for women forty (40) years of age and older, or as recommended by the American Medical Association (AMA), and patients shall be advised about the benefits, limitations, and potential harms linked with regular screening;

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

(4) Prescription Drugs;

(5) Ambulatory Surgical Services;

(6) Renal Dialysis;

(7) Physical and Occupational Therapy;

(8) Respiratory Therapy;

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

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

(1) Non-emergency use of the Emergency Room of the hospital shall *not* be covered. Non-emergency use of the Emergency Room for the purposes of this exclusion shall be defined as the use of the Emergency Room for non-urgent or non-life threatening medical problems. All Program recipients seeking care at the hospital Emergency Room for purposes other than the treatment of urgent or life-threatening medical problems shall be fully responsible for the cost of all care and services rendered.

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003). Subsection (a) amended by P.L. 30-225:2 (Dec. 30, 2010).

§ 2907.3. Physician Services.

(a) Coverage shall include:

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

(2) consultation services; and

(3) specialty services.

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

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

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2907.4. Skilled Nursing and Intermediate Care Services.

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

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

(1) personal comfort items; *and*

(2) private duty nursing services.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2907.5. Report on MIP Clients.

Within ninety (90) days after the enactment hereof, the Director of Public Health and Social Services shall submit a report to I Maga'lahen Guåhan and the Speaker of *I Liheslaturan Guåhan* on the following:

(a) a statistical profile of client utilization of the MIP that states the mean, median and mode expenditures from the program on an annual basis;

(b) a demographic profile of MIP clients, including a breakdown by citizenship, that can be used by Guam's Delegate to Congress to advance Guam's interest with respect to Compact Impact funding, and other information such as the age, gender, number of household members, annual income, length of Guam residence, and length of time in the MIP;

(c) a comparison of the benefits and services available from the most generous current government of Guam health insurance health plan policy (HPP) having the fewest medical exclusions and most liberal benefits with the benefits and services currently available from the MIP; and

(d) an analysis of the financial impact on the Guam Memorial Hospital Authority if MIP benefits are made commensurate with those extended by the health insurance plan described in the previous subsection.

SOURCE: Added by P.L. 28-068:II:III:4 (Sept. 30, 2005).

2013 NOTE: Pursuant to the authority granted by 1 GCA § 1606, numbers and/or letters were altered to adhere to the Compiler's alpha-numeric scheme.

§ 2908. Dental Services.

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

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

(1) cosmetic or cosmetic related treatments;

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

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

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

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

(6) posterior composites;

(7) broken appointment fees;

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

(9) ordontics or orthodontic-related treatments.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled *"Applications."* Repealed by P.L. 25-163:2 (Sept. 30, 2003) and recodified as 10 GCA § 2905(c).

§ 2909. Services Requiring *Prior* Authorization.

The Administrator shall issue *prior* authorization for elective or specialized surgical procedures, off Guam care and certain other services as follows:

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

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled *"Application Requirements."* Repealed by P.L. 25-163:2 (Sept. 30, 2003) and recodified as 10 GCA § 2905(d).

§ 2909.1. *Prior* Authorization for Admission for Elective Surgery.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2909.2. Physical Therapy and Occupational Therapy.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2909.3. CT Scan or MRI Diagnostic Services.

Before an authorization for coverage is issued, a justification for the need of the service by the attending physician must be submitted to the Program.

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2910. Off Guam Medical Care and Services.

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

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

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

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

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

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

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

(e) (1) Medical Review. All off Guam referrals will be reviewed by the Administrator after the applicant is found eligible and all necessary documents have been submitted. Referrals will be reviewed to determine that the treatment is medically necessary, significant beneficial outcomes affecting the patient's quality of life is expected and the care is not available on Guam. The Administrator shall consult with the attending physician and any other specialists as may be required.

(2) Advance Payments for Medical Services. In order to expedite acceptance of Medically Indigent Program (MIP) clients by facilities in California, Hawaii or Manila for medical treatment approved by the MIP, the Director of

Public Health and Social Services may advance payments for said medical treatment, and may establish escrow accounts for immediate and advance payment of medical treatment at those Joint Commission Accredited hospitals determined by the Director to be best able to serve Medically Indigent Program clients.

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

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

(1) Agreements for Wholesale Purchase of Airline Tickets Authorized. Funds appropriated to the Department of Public Health & Social Services for the Medically Indigent Program and funds allocated under the Medicaid program may be used for Off-Guam medical care and services provided for in this Section. The Director of Public Health and Social Services is authorized to enter into agreements with air carriers for the wholesale purchase of airline tickets for roundtrip air transportation and may obligate such funds as are necessary from the funding sources provided for in this Section to enter into such agreements.

(2) Additional Medical Escorts Authorized. At the discretion of the Director of Public Health and Social Services, additional medical escorts may be approved for air transportation and per diem costs for patients requiring acute care.

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

(i) Off Guam services not covered:

(1) elective cosmetic surgery;

(2) experimental treatments;

(3) fertility procedures, sterilizations, abortions;

(4) off Guam living expenses;

(5) organ transplants;

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

(7) off Guam emergency medical services.

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

SOURCE: Added by P.L. 25-163:2 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003). Sub-items 1 & 2 of subsection (g) added by P.L. 28-150:V:57 (Sept. 30, 2006). Subsection (e)(2) added as uncodified law by P.L. 32-068:XII:9 (Sept. 11, 2013), and codified by the Compiler.

2017 NOTE: This section was originally added by P.L. 17-083:3 (Dec. 21, 1984), entitled *"System for Investigation."* Repealed by P.L. 25-163:2 (Sept. 30, 2003) and recodified as 10 GCA § 2905(d).

2013 NOTE: Pursuant to 1 GCA § 1606, numbers were added to subsection (e) to adhere to the Compiler's alpha-mumeric scheme.

§ 2911. Mental Health Services.

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

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

(2) out-patient facility/day treatment;

(3) maintenance counseling;

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

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

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

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

(7) only generic drug benefits provided;

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000); repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2013 NOTE: Pursuant to 1 GCA § 1606, numers and /or letters were altered in subsection (a) to adhere to the Compiler's alpha-numeric scheme .

§ 2912. MIP Program Benefit Limitations.

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

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

(1) Radiation Therapy;

(2) Cardiac Related Services;

(3) Orthopedic Services and Appliances,

(4) Radiology.

(b) Renal Dialysis. Limited coverage to first twelve (12) months and payment of Medicare Part B Premiums and co-insurance. Prior to the expiration of the twelve (12) month limited coverage period, the Administrator shall facilitate the application of each Program recipient for Medicare coverage of renal dialysis. The twelve (12) month limited coverage period shall not apply to recipients who do not qualify for Medicare coverage of renal dialysis.

(c) Physical Therapy. Therapy must be to restore a bodily function that once existed or has been lost or damaged due to disease or accidental injury. Coverage is only to the extent that it restores function to the status of function prior to the disease or accidental injury. Therapy must result in significant and demonstrable improvement in patient ability to function independently, limited to treatment by a physical therapist. The first twenty (20) visits shall be covered. Fifty percent (50%) co insurance is required thereafter.

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

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

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

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

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

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

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

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

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

(m) Occupational Therapy. Coverage limited to medically necessary services where an expectation exists that the therapy will result in significant practical improvement in the individual's level of functioning within a reasonable period of time.

(1) Coverage is excluded if related solely to specific employment opportunities, work skills or work settings.

(2) The first twenty (20) visits shall be covered up to the maximum provided herein.

(3) Additional treatments subject to re-certification for continuing treatment after initial twenty (20) visits subject to medical review of further significant practical improvement to be attained.

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

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

(p) Autism Spectrum Disorder (ASD). A Seventy-five Thousand Dollars ($75,000) maximum benefit per year for an eligible person up to the age of fifteen (15). The treatment of an autism spectrum disorder *shall* be limited to a Twenty-five Thousand Dollars ($25,000) maximum benefit per year for an eligible person who is between the ages of sixteen (16) and twenty-one (21).

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003). Subsection (b) amended by P.L. 27-121:2 (Dec. 2, 2004). Subsection (p) added by P.L. 34-006:4 (May 10, 2017), amended by P.L. 35-019:2 (May 9, 2019).

2017 NOTE: Pursuant to P.L. 34-006:7 (May 10, 2017), insurance coverage requirements relating to subsection (p) shall be in effect regardless of any repeal or change in provisions of the Affordable Care Act.

Subsection (o) was originally added by P.L. 25-163:1 as 10 GCA § 2912.13. Repealed and reenacted as subsection (o) by P.L. 27-030:2.

§ 2912.1. Optometrist Services.

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

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection designations added pursuant to authority of 1 GCA § 1606.

Subsection (b) was originally added by P.L. 25-163:1 as 10 GCA § 2912.2, entitled *"Lenses."* Repealed and reenacted to this subsection by P.L. 27-030:2.

§ 2912.2. Audiological Exam.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Lenses."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.3. Hearing Aids.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Audiological Exam."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.4. Orthopedic Conditions and Prosthetic Appliances.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Hearing Aids."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.5. Voluntary Sterilization Services.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Orthopedic Conditions and Prosthetic Appliances."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.6. Home Health Services.

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

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

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

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

(4) Standard Wheelchairs;

(5) Walkers;

(6) Crutches;

(7) Standard Hospital Beds;

(8) Bedside Rails;

(9) Bedpans;

(10) Oxygen Related Equipment.

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

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

(2) unskilled services.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000),repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Voluntary Sterilization."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.7. Prescription Drug Coverage.

(a) The following drug prescriptions shall be covered:

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

(2) Medically Indigent Program clients will have to pay a Two Dollars and Fifty Cents ($2.50) co-payment charge per prescription filled and shall be limited to generic

brand items. Those with cost sharing liabilities shall pay the required co-payment charge plus their cost sharing liability.

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

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

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

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

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

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000),repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Home Health Services."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.8. Physical Therapy.

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

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

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

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

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

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

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

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000),repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Durable Medical Equipment."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2912.9. Occupational Therapy.

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

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

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

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

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

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

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

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000),repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: This section was originally entitled *"Prescription Drug Coverage."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 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.

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).Amended by P.L. 31-176:3 (Feb. 3, 2012).

2017 NOTE: This section was originally entitled *"Physical Therapy."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2913. Exclusions.

The Medically Indigent Program does not cover the following services:

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

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

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

(d) personal comfort or convenience items;

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

(f) non-emergency use of Emergency Room;

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

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

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

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

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

(l) trans-sexual surgery and related services;

(m) motorized limbs;

(n) services for any incarcerated person;

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

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

(q) speech and language therapy;

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

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

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

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

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

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

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

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2914. Member Use of Primary Care Physicians.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2914.1. Change in Primary Care Physician.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2914.2. Hospital to Inform Member of Coverage of Emergency Room Services.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

§ 2915. Appeals and Grievance Process.

(a) The Director, in consultation with the Administrator, shall establish, *subject* to the Administrative Adjudication Law and the provisions of this Article, a grievance and appeal procedure to cover grievances arising pursuant to this Article. The grievance and appeal procedure

shall include time limits for filing appeals or grievances, and shall establish procedures to conduct fair hearings to be used by Providers, Non-Providers, eligible persons, persons applying to be Providers or persons denied eligibility. A grievance for the denial of a claim for reimbursement for services, or for denial of eligibility, may contest the validity of any adverse action, decision, policy implementation, or rule that related to or resulted in the full or partial denial of the claim. The grievance and appeal procedure shall contain provisions related to the notice to be provided to aggrieved parties, including notification of final decisions, complaint processes and internal appeals mechanisms. Any grievance and appeal procedure not specified pursuant to this Subsection, but identified pursuant to this Subsection, shall be handled in the same manner. Other provisions for processing grievances shall include:

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

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

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

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

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

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

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

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

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

(A) administer required oaths or affirmations;

(B) insure all relevant issues are considered;

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

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

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

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

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

(c) (1) The Hearing Officer shall render a decision on each grievance no later than ninety (90) days from the date the Administrator receives the request for a hearing, unless the

hearing is postponed or rescheduled at the request of all of the parties, or the hearing officer orders a further extension.

(2) If a person is dissatisfied with a final decision on a grievance properly submitted and heard under the provisions of this Article, the person may file for judicial review under the provisions of the Administrative Adjudication Law.

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

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subitem designations added/altered pursuant to the authority of 1 GCA § 1606.

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

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

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

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

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

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

(5) for professional fees and home health services, the Program shall reimburse services at one hundred percent (100%) of the Medicare Participating Provider fee schedule

rate adjusted in accordance with the Hawaii or Guam conversion factor as applicable; and

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

(b) The Administrator of the Medically Indigent Program shall have discretionary authority to establish Provider and Non-Provider reimbursement rates for services which are not specifically addressed herein, but which are consistent with the Program services provided by § 2901 through § 2915 of this Article. Said schedules will be developed in conjunction with the Administrator's duties to secure the necessary Provider and Non-Provider relationships to ensure the availability of adequate medical care and assistance to all Program recipients.

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

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

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

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

(A) an admission face sheet;

(B) an itemized statement;

(C) an admission history and physical;

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

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

(F) operative reports, if applicable;

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

(H) utilization review report.

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

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

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

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

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

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

(e) The Administrator may conduct post-payment review of all claims paid by the Program and may recoup any monies erroneously paid.

(1) The Administrator shall adopt rules that specify procedures for conducting post-payment review.

(2) The Program Administrator shall review all prepaid captivated payments and may conduct a post-payment review of all claims paid by the Program, and may recoup monies that are erroneously paid.

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

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

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

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

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

(j) Notwithstanding any law to the contrary, the Director or Administrator may receive confidential adoption information for the purposes of identifying adoption-related third party payers in

order to recover the total costs for prenatal care and the delivery of the child, including capitation reinsurance and any fee-for-service costs incurred by the Program on behalf of an eligible person who the Administrator has reason to believe had an arrangement to have the eligible person's newborn adopted.

(1) Except for the sole purpose of identifying adoption-related third party payers, the Administrator shall not further disclose any information obtained pursuant to this Subsection, and shall develop and implement safeguards to protect the confidentiality of this information, including limiting access to the information to only those Program personnel whose official duties require it.

(2) At no time shall the Director or Administrator release to the adoptive parents' or birth parents' insurance carrier personally identifying information regarding the other party.

(3) A person who knowingly violates the requirements of this Subsection pertaining to confidentiality is guilty of a Class 6 felony.

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Sububitem designations added pursuant to the authority of 1 GCA § 1606.

2012 NOTE: In maintaining the general codification scheme of the GCA the Compiler changed the hierarchy of subsections beginning with "Lowercase Roman Numerals" to "Uppercase Letters" in subsection (c)(1).

§ 2917. Quality of Care.

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

(b) The Administrator shall periodically determine whether each Provider has properly adopted and implemented the quality of health care monitoring standard.

(1) If the Administrator determines that a Provider has not done so, the Administrator shall undertake additional special efforts to monitor and assess the quality of health care provided by that Provider for as long as the Administrator deems necessary.

(2) The Administrator shall determine the cost incurred in undertaking such special efforts and shall deduct that amount each month from any payment owed to that Provider for as long as the special efforts continue.

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subitem designations added pursuant to the authority of 1 GCA § 1606.

§ 2918. Catastrophic Illness Program.

(a) The Department shall continue to administer the Catastrophic Illness Program, as established by Public Law Number 18-8, as further amended by Public Law Numbers 18-31 and 23-76, and as further regulated by the rules and regulations previously adopted by the Department pursuant to the public laws that originally established this Program.

(b) The Department may also adopt additional rules in accordance with the Administrative Adjudication Law to administer the Catastrophic Illness Program.

(c) The Program shall provide for care of victims of catastrophic illnesses, whether such care is provided on Guam or at off Guam medical facilities.

(d) The Catastrophic Illness Assistance Program ('CIAP') maximum coverage per individual is established at One Hundred Seventy-five Thousand Dollars ($175,000.00).

SOURCE: Added by P.L. 25-163:1 (Sept. 21, 2000), repealed/reenacted by P.L. 27-030:2 (Sept. 30, 2003).

2017 NOTE: Subsection designations added pursuant to the authority of 1 GCA § 1606.

This section was originally entitled *"Information Reporting."* Added by P.L. 25-163:1, and repealed by 27-030:2.

§ 2919. Effective Date.

This shall become effective upon enactment of this Act.

§ 2920. Severability.

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

ARTICLE 10
ADULT PROTECTIVE SERVICES

SOURCE P.L. 19-054 (Jan. 30, 1989) added Article 8 to this chapter.

2014 NOTE: Pursuant to the authority granted by 1 GCA § 1606, the article and sections were renumbered to adhere to the Compiler's general codification scheme.

§ 21001. Purpose.

The purpose of this Article is to recognize that abuse, neglect and exploitation of elderly or adults with a disability are problems that require attention and intervention as a matter of public policy. Elderly or adults with a disability require the same societal protection now being provided by law to abused and neglected children and spouses. The obligation of the

government to extend protective care and services to the abused elderly or adults with a disability should be carried out in a manner least restrictive of individual rights and in accordance with due process. The family's contribution to the care of its elderly or adults with a disability is acknowledged and every effort should be made to assist, support and enhance its caretaking role.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Amended by P.L. 31-278:2 (Dec. 28, 2012).

§ 21002. Definitions.

Definitions as used in this Article:

(a) Abandonment refers to the desertion of an elderly or adult with a disability by his or her caregiver under circumstances in which a reasonable person would continue to provide care or custody.

(b) Adult with a Disability is any person eighteen (18) years or older who:

(1) has a physical or mental impairment which substantially limits one (1) or more major life activities; or

(2) has a history of, or has been classified as having, an impairment which substantially limits one (1) or more major life activities.

(c) Bodily Injury means physical pain, illness, unconsciousness or any impairment of physical condition, in accordance with Chapter 16 of Title 9 Guam Code Annotated.

(d) Bureau of Adult Protective Services means the "Bureau" established by § 2955 of this Article.

(e) Caregiver is any family member or any person, health facility, community care facility, clinic, home health care agency or legal guardian who has the care or custody of the elderly or adult with disability.

(f) Department refers to the Department of Public Health and Social Services.

(g) Desertion refers to the act by which a person abandons and forsakes, without justification, a condition of public, social, or family life, renouncing its responsibilities and evading its duties.

(h) Elderly refers to a person age sixty (60) years or older.

(i) Elderly or Adult with a Disability Abuse means self-neglect or any one (1) or more of the following acts inflicted on an elderly or adult with a disability by other than accidental means by another person: physical abuse, neglect, or abandonment.

(j) Emotional or Psychological Abuse means fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elderly or adult with a disability.

(k) Expunged means the sealing of records to all persons outside of the Bureau of Adult Protective Services and law enforcement agencies of Guam, and the federal agencies entitled thereto, and a refusal by such agencies to admit the existence of such records to persons not entitled to examine them.

(l) Financial or Property Exploitation means illegal or improper use of an elderly or adult with a disability's money, property, or other resources for monetary or personal benefit, profit or gain. This includes, but is not limited to, theft, misappropriation, concealment, misuse or fraudulent deprivation of money or property belonging to the elderly or adult with a disability.

(m) Investigation means that activity undertaken to determine the validity of a report of elderly or adult with a disability abuse.

(n) Major Life Activities include, but are not limited

to: caring for oneself, performing manual tasks, standing, walking, seeing, hearing, eating, sleeping, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking and working.

(o) Neglect means the failure of a reasonable caregiver to provide for the physical, mental or emotional health and well-being of the elderly or adult with a disability and includes, but is not limited to:

(1) Failure to assist or provide personal hygiene for the elderly or adult with a disability.

(2) Failure to provide adequate food, water, clothing or shelter.

(3) Failure to provide medical care for the physical and mental health of the elderly or adult with a disability. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(4) Failure to protect an elderly or adult with a disability from health, safety hazards, or physical harm.

(p) Physical Abuse means the willful infliction of or omission which results in physical harm. It includes, but is not limited to, cruel punishment resulting in physical harm or pain or mental anguish, such as direct beatings, slapping, kicking, biting, choking, burning or unreasonable physical restraint or confinement resulting in physical injury.

(q) Physical Harm means bodily pain, injury, impairment or disease.

(r) Self-Neglect Abuse is characterized as the behavior of an elderly or adult with a disability that threatens his/her own health or safety. Self-neglect generally manifests itself when an elderly or adult with a disability refuses to provide him/herself with adequate food, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. The definition of self-neglect excludes a

situation in which a mentally competent elderly or adult with a disability, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice.

(s) Serious Abuse means an act or omission resulting in serious bodily injury which creates: serious permanent disfigurement; a substantial risk of death or serious, permanent disfigurement; severe or intense physical pain or protracted loss or impairment of consciousness or of the function of any bodily member or organ, as defined in Chapter 16 of Title 9, Guam Code Annotated; or sexual offenses pursuant to Chapter 25 of Title 9, Guam Code Annotated.

(t) Sexual Abuse means any form of non-consensual sexual contact, including but not limited to, unwanted or inappropriate sexual gratification, touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, involuntary exposure to sexually explicit material or language, and as defined in the penal code of Guam.

(u) Substantiated Report means a report made pursuant to this Chapter, if an investigation by the Bureau of Adult Protective Services, or its authorized agency, determines that there is sufficient evidence to support the existence of the abuse or neglect.

(v) Unsubstantiated Report means a report made pursuant to this Chapter, if an investigation by the Bureau of Adult Protective Services or its authorized agency determines that there is insufficient or inconclusive evidence of abuse, but existence of the abuse cannot be disproved to the satisfaction of the Bureau of Adult Protective Services.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989); Subsection (m) added by P.L. 21-033:10 (May 17, 1991), subsequent subsections were renumbered. Repealed and reenacted by P.L. 31-278:3 (Dec. 28, 2012).

§ 21003. Reporting of Elderly or Adult with a Disability

Abuse.

(a) Any person who, in the course of his or her employment, occupation or professional practice comes into contact with elderly or adults with disabilities, has actual knowledge or reasonable cause to believe that an elderly or adult with a disability is suffering from or has died as a result of abuse as defined in § 2951, shall immediately make a verbal report of such information or cause a report to be made to the Bureau of Adult Protective Services or its authorized agency and shall, within forty-eight (48) hours, make a written report to the Bureau or its authorized agency. If a verbal report is made on a Friday, a written report will be made by the next workday.

(b) Persons required to report abuse under Subsection (a) include, but are not limited to, physicians, medical interns, medical examiners, nurses, chiropractors, hospital personnel engaged in the admission, examination, care or treatment of persons, social workers, employees of nursing homes, senior citizen centers and adult day care facilities, police officers, probation officers, employees of homemaker and home health service agencies, emergency medical service (EMS) providers, non-emergency medical transport providers, medical and allied health care providers, banking or financial institution personnel, pension providers, and practicum students in the field of health and human services.

(c) In addition to persons required to report under Subsections (a) and (b), any other person may make such report to the Bureau of Adult Protective Services if any such person has a reasonable cause to believe that an elderly or adult with a disability is suffering from or has died as a result of abuse.

(d) Oral or written reports from persons required to report under Subsections (a) and (b) shall include the following information, if available:

(1) The name of the person making the report and where he or she can be reached. The identity of the person making the report shall be confidential, but made available to an agency contracted authorized by the Bureau of Adult Protective Services to provide case investigation.

(2) The name, address and approximate age of the elderly or adult with a disability.

(3) Information regarding the nature and extent of the abuse, the name of the person's caretaker, if known, and any medical treatment being received or immediately required, if known.

(4) The name of the person or persons responsible for causing the suspected abuse.

(5) The source of the report.

(6) Any other information which may assist in the investigation of the suspected abuse.

(7) The identity of the person making the report shall be confidential.

(e) Reports of elderly or adult with a disability abuse may be made anonymously under this Chapter.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Subsection (d)(1) amended by P.L. 21-033:11; Subsection (e) added by P.L. 21-033:12. Amended by P.L. 31-278:4 (Dec. 28, 2012).

§ 21004. Immunity from Liability.

(a) Any person who in good faith makes a report under this Article or testifies in any administrative or judicial proceeding related to the report is immune from civil or criminal liability for reporting or testifying.

(b) Any officer, agent or employee of the Bureau of Adult Protective Services who performs his or her duties in good faith is not liable for civil or criminal damages as a result of acts or omissions in rendering service or care to an elderly or adult with a disability.

(c) For the purpose of any proceeding, civil or criminal, the good faith referred to in Subsections (a) and (b) shall be presumed.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Amended by P.L. 31-278:4 (Dec. 28, 2012).

§ 21005. Failure to Report.

Any person required by Subsections (a) and (b) of § 2952 to report a case of suspected elderly or adult with a disability abuse who fails to so report shall be liable for a fine of not more than Five Hundred Dollars ($500.00), except that for a second or subsequent offense, such person shall be guilty of a misdemeanor. Fines shall be deposited in the manner prescribed in § 2954(a), infra.

(a) There is hereby created, separate and apart from other funds of the government of Guam, a fund known as the Bureau of Adult Protective Services Fund (Fund).

(b) The Fund shall not be commingled with the General Fund, is exempt from the Governor's transfer authority and shall be kept in a separate bank account, and is not subject to fiscal constraints or limitations, such as a reserve account.

(c) All funds collected shall be expended exclusively for purposes used to support the operations of the Bureau of Adult Protective Services.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Amended by P.L. 31-278:4 (Dec. 28, 2012). Subsection (a) added by P.L. 31-278:5 (Dec. 28, 2012).

2017 NOTE: Subsection designations altered/added pursuant to the authority of 1 GCA § 1606.

§ 21006. Bureau of Adult Protective Services.

(a) The Division of Senior Citizens of the Department of Public Health and Social Services (Department) shall establish a Bureau of Adult Protective Services, which shall have sufficient staff to fulfill the purposes of this Article and organized in such a way as to maximize the continuity of responsibility, care and services of individual workers toward individual adults and families. Therefore, at a minimum, the Bureau shall be organized and staffed with:

(1) one (1) Human Services Administrator to serve and lead the Bureau;

(2) one (1) Social Services Supervisor I to provide support for the daily operations and supervision of the

Bureau;

(3) three (3) Social Worker III to staff the Case Investigation Unit.

(4) one (1) Social Worker III to staff the Intake and Aftercare Unit.

(5) one (1) Program Coordinator III to staff the Education and Outreach Unit to include the management of the Emergency Receiving Home.

(b) (1) The Bureau shall be the sole bureau responsible for receiving and investigating all reports of elderly or adult with a disability abuse made pursuant to this Article, specifically including, but not limited to, reports of abuse in facilities operated by the Department and other public or private agencies and in private residences.

(2) The Bureau shall have authority to delegate to other social service agencies the responsibility of investigating reports of abuse, but shall monitor the investigations conducted by such other authorized agencies.

(c) The Office of the Attorney General will provide legal services to the Bureau of Adult Protective Services at no cost to the Bureau.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989); amended by P.L. 21-033:13. Amended by P.L. 31-278:6 (Dec. 28, 2012).

2017 NOTE: Subsection designations altered/added pursuant to the authority of 1 GCA § 1606.

§ 21007. Duties of the Bureau of Adult Protective Services.

The Bureau shall:

(a) Receive on a twenty-four (24) hour, seven (7) days a week basis all reports, both oral and written, of suspected elderly or adult with a disability abuse in accordance with this Article and the regulations of the Department.

(b) Investigate and evaluate the information in the reports, either through its own investigators or through investigators of other authorized agencies.

(1) The investigation and evaluation shall be made within twenty-four (24) hours if the Bureau has reasonable cause to believe the adult's health or safety is in imminent danger from further abuse, and within seven (7) days for all other such reports.

(2) The investigation shall include a visit to the facility or residence, an interview with the adult allegedly abused, a determination of the nature, extent and cause or causes of the abuse, the identity of the person or persons responsible for the abuse, and all other pertinent facts.

(3) The investigation shall be completed within thirty (30) days.

(4) If the investigating social worker of the Bureau or other authorized investigating agency determines that it is appropriate, the social worker may request a law enforcement officer to accompany and assist the worker in the investigation.

(5) No social worker of the Bureau or other authorized investigating agency shall enter the home of any individual pursuant to the provisions of this Article without the consent of the individual, unless authorized pursuant to Subsection (c) of § 2957 of this Article.

(c) Determine within sixty (60) days whether the report is substantiated or unsubstantiated.

(1) If the assessment results in determination that the elderly or adult with a disability has suffered serious abuse as defined in § 2951, report such determination to the Attorney General within forty-eight (48) hours.

(2) The Attorney General shall investigate and decide whether to initiate criminal proceedings.

(d) Develop a coordinated system of protective services to prevent further abuses to adults and to provide or arrange for and monitor the provision of those services necessary to safeguard and ensure the adult's well-being and

development, and preserve and stabilize family life wherever appropriate.

(e) Make available, among its services for the prevention and treatment of elderly and adult with a disability abuse, through authorized individuals and through inter-agency and intra-agency assistance and cooperation, instruction in caring for elderly and adults with a disability, protective and preventive social care, and emergency shelter care.

(f) Appoint a Multi-Disciplinary Team (MDT) for the purpose of providing case consultation, interagency treatment strategies and collaborative planning to address complex cases and service gaps involving an elderly or adult with a disability who is a victim of abuse and/or neglect.

(1) The MDT may include, but is not limited to, a Bureau of Adult Protective Services social worker, a representative of a law enforcement agency, Guam Police Department, the medical profession, a mental health agency, the hospital, the public guardian, a representative of any private or government social service agency or advocacy office, Guam Legal Services Corporation, and a representative of the Mayors' Council of Guam.

(2) The MDT shall document all actions and efforts in addressing the needs of the client.

(g) Functions of the Bureau are subject to the appropriation of funding and allocation of personnel sufficient to carry out the operations of the Bureau.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989); subsection (c) amended by P.L. 21-033:14; subsection (f) added by P.L. 21-033:15. Amended by P.L. 31-278:6 (Dec. 28, 2012).

2017 NOTE: Subsection/subitem designations altered/added pursuant to the authority of 1 GCA § 1606.

§ 21008. Consent of Victim; Guardianship.

(a) An elderly or adult with a disability who is a victim or

alleged victim of abuse may refuse to cooperate in the investigation, or withdraw consent at any time to the provision of protective services by the Bureau or its authorized agency. However, the Bureau responsible to investigate all complaints of abuse against the elderly or adults with a disability and shall have the responsibility to complete and document the investigation efforts, regardless of the lack of cooperation of the victim of abuse.

(b) If the elderly or adult with a disability victim or alleged victim of abuse is so incapacitated that he or she cannot legally give or deny consent to an investigation or protective services, the Bureau may initiate a petition for guardianship in accordance with Chapter 38 of Title 15 Guam Code Annotated, or initiate a petition for civil commitment pursuant to law.

(c) If a social worker of the Bureau or other authorized agency who is investigating a report of abuse is denied access to the alleged victim by a caregiver or household member, such agency may petition the Superior Court for an order allowing the Bureau or agency immediate access to the alleged victim.

(1) The court shall give notice to the caregiver or household member who is denying access at least twenty-four (24) hours prior to the hearing.

(2) The Court may dispense with the notice upon finding that immediate and reasonably foreseeable harm to the alleged victim will result from the twenty-four (24) hour delay.

(3) If, after the hearing, the court determines, based upon clear and convincing evidence, that the caregiver or household member should be required to allow access, the Court shall so order.

(A) The order allowing access shall remain in effect for a period not to exceed seventy-two (72) hours and

(B) may be extended for an additional seventy-two (72) hours if the court finds that the extension is necessary for the Bureau or its authorized agency to

gain access to the alleged victim.

(d) (1) No person shall interfere with the provision of protective services to an elderly or adult with a disability who requests or consents to receive such services.

(2) In the event that interference occurs on a continuing basis, the Bureau, its authorized protective services agency, or the public guardian may petition the court to enjoin such interference.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Amended by P.L. 31-278:6 (Dec. 28, 2012).

2017 NOTE: Sub designations added pursuant to the authority of 1 GCA § 1606.

§ 21009. Central Registry.

(a) The Bureau shall maintain a Central Registry of reports of elderly or adult with a disability abuse, which shall contain and be limited to the following information:

(1) The name, address and birthdate of the elderly or adult with a disability.

(2) The date or dates and the nature and extent of the suspected abuse.

(3) The locality in which the suspected abuse occurred.

(4) The name of the person or persons suspected of causing the abuse.

(5) The progress of any legal proceedings brought on the basis of suspected abuse.

(b) Both substantiated and unsubstantiated reports of elderly or adult with a disability abuse shall be placed and maintained in the ~~c~~Central Registry.

(c) An investigation of a report of suspected elderly or adult with a disability abuse, that does not determine within ninety (90) days of the date of the initial report that it is a substantiated or an unsubstantiated report, shall be classified as an inconclusive finding. Therefore, all information identifying the named victim and perpetrator or perpetrators shall be expunged.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Subsection (b) repealed and reenacted by P.L. 21-033:16 (May 17, 1991). Amended by P.L. 31-278:6 (Dec. 28, 2012).

§ 21010. Confidentiality.

(a) All records maintained by the Bureau regarding reports of abuse, including, but not limited to, information contained in the central registry, shall be confidential and shall be released only with the consent of the elderly or adult with a disability or, if the adult is not competent, only with the consent of the adult's guardian, and shall be released only to individuals designated in this § 2959.

(b) Records may be released, only as necessary to serve and protect the adult, to the following:

(1) Any agency or individual, authorized, contracted or licensed through the Bureau to care for, protect or provide services to an elderly or adult with a disability who is a victim of abuse, which agency or individual shall share information related to the abuse with the Bureau.

(2) Courts of competent jurisdiction, upon finding that access to the records may be necessary for determination of an issue before the court. Access shall be limited to inspection by the court only, unless the court determines that disclosure of the records to interested parties is necessary for resolution of an issue pending before it.

(3) Grand juries when connected with the prosecution of a case of elderly or adult with a disability abuse.

(4) Properly constituted authorities or agencies, including police departments, prosecutors and attorneys general investigating a report of known or suspected elderly or adult with a disability abuse.

(5) A physician examining or treating an elderly or adult with a disability where the physician suspects the adult of having been abused.

(6) The guardian or attorney of the elderly or adult with a disability.

(7) A duly authorized official of the Bureau.

(8) The victim or alleged victim of the abuse.

(9) After, and only after, a court proceeding has been initiated regarding the abuse, the perpetrator or alleged perpetrator of the abuse.

(c) Records may be released to sources other than those identified in Subsection (b) only when a written authorization from the victim or alleged victim, or his or her guardian, specifically provides consent to have the record released or reviewed. In the event the guardian is the alleged perpetrator, this provision will not apply.

(d) Regardless of Subsections (a), (b) and (c), identities of persons reporting elderly or adult with a disability abuse shall remain anonymous and release of the identity of a person reporting such abuse, or information which would identify the reporter of abuse, is strictly prohibited.

(e) Students authorized by the Director of the Department may be permitted, under direct supervision, access to Bureau of Adult Protective Service (BAPS) files for the purpose of field practice, research and to gather statistical information.

(1) Such authorized students, under supervision, may be permitted to receive BAPS referrals and participate in BAPS intake, interviews and case management assignments.

(2) Such authorized students shall be registered in a field placement, practicum internship, or block placement with an accredited college or university.

(3) Such authorized students will be under the direct supervision of a social services supervisor and subject to all conditions of this Chapter, and government of Guam policies, procedures and guidelines.

(4) Such authorized students shall not disseminate any information beyond the scope of the program objectives.

(f) Any person who willfully releases or permits the release of any information or records is in violation of this Section, and shall be guilty of a misdemeanor.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Subsection (b)(1) amended by P.L. 21-033:17 (May 17, 1991). Subsection (e) redesignated as subsection (f) by P.L. 21-033:18. Subsection (e) added by P.L. 21-033:19 (May 17, 1991). Amended by P.L. 31-278:6 (Dec. 28, 2012).

2017 NOTE: Sub designations added pursuant to the authority of 1 GCA § 1606.

§ 21011. Appropriation.

(a) The appropriation shall cover staffing requirements, vehicles, cellphones, APS database and registry, logistics, contracting of services, and emergency shelter for victims of elderly and adult with a disability abuse.

(b) Within three (3) months following the end of each fiscal year, the Bureau shall submit a report to the Governor, the Superior Court, the Legislature, and the public, which shall include:

(1) Description of the activities of the Bureau and all designated agencies during the preceding year.

(2) Statistical information about the number and types of reports received during the preceding year.

(3) Results of the assessments and evaluations conducted and the amount, type, and costs of services provided.

(4) Information on the quality of services provided and the result of such services in terms of alleviating abuse.

(5) Identification of problems that may arise in the implementation of this Article.

(6) Recommendation for action on the part of *I Liheslatura* (the Legislature) whenever deemed vital for the protection of the elderly and adults with a disability.

(7) Amount collected and use of funds of the "Bureau of Adult Protective Services Fund," in accordance with § 2954(a), supra.

SOURCE: Added by P.L. 19-054:1 (Jan. 30, 1989). Amended by P.L. 31-278:6 (Dec. 28, 2012).

ARTICLE 11
GUAM CHILDREN'S HEALTH INSURANCE PROGRAM, GUAM MEDICAID PROGRAM AND MEDICALLY INDIGENT PROGRAM

SOURCE: This Article was added by P.L. 26-035:IV:32 (Sept. 28, 2001). Repealed by P.L. 27-030:1 (Sept. 30, 2003).

ARTICLE 12
RECOVERY OF MEDICAID/MIP PAYMENTS FROM THIRD PARTY PAYERS

SOURCE: Entire article added by P.L. 32-183:2 (Oct. 13, 2014).

2014 NOTE: Pursuant to the authority granted by 1 GCA § 1606, sections were renumbered to adhere to the Compiler's general codification scheme

§ 21201. Authority of the Department of Public Health and Social Services.

The Department of Public Health and Social Services is hereby authorized to recover payments from third party payers for services provided to recipients of Medicaid/Medically Indigent Program.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

§ 21202. Third Party Payer Basis and Purpose.

This Article sets forth the Department of Public Health and Social Services' (DPHSS) Medicaid and Medically Indigent State Plan requirements concerning:

(a) the legal liability of third parties to pay for services provided under the plan;

(b) assignment to the DPHSS of an individual's rights to third party payments; and

(c) cooperative agreements between the DPHSS Division of Public Welfare and other entities for obtaining third party payments.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

§ 21203. Definitions.

(a) DPHSS shall mean the Department of Public Health and Social Services;

(b) Director shall mean the Director of the Department of Public Health and Social Services;

(c) Health care insurer shall mean a self-insured health benefit plan, a group health plan as defined in Section 607(1) of the Employment Retirement Income Security Act of 197 4, a pharmacy benefit manager or any other party that by statute, contract or agreement is responsible for paying for items or services provided to an eligible person under this Act.

(d) Health care services includes products provided or purchased through an approved facility.

(e) Insurance, medical service, or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a personal injury protection plan or medical payments benefit plan for personal

injuries resulting from the operation of a motor vehicle.

(f) Private insurer means:

(1) any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services induded in the state plan; and

(3) any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including selfinsured and self-funded plans.

(g) Third party payer means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier, and any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for health care services or products.

(h) Title N-D agency means the organizational unit in the state that has the responsibility for administering or supervising the administration of a state plan for child support enforcement under Title IV-D of the Act.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

§ 21204. State Plan Requirements.

The Division of Social Services State Plan must provide for:

(a) identifying third parties liable for payment of services under the plan and for payment of claims involving third parties;

(b) assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the state in pursuing any liable third parties; and

(c) assuring the requirements for cooperative agreements and incentive payments for third party collections are met.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

2017 NOTE: Subsection designations altered/added pursuant to the authority of 1 GCA § 1606.

§ 21205. Health Care Services Incurred on Behalf of Covered Beneficiaries; Collection From Third Party Payer.

(a) In the case of a person who is a covered beneficiary, the DPHSS shall have the right to collect from a third party payer reasonable charges for health care services incurred by the DPHSS on behalf of such person through a health facility to the extent that the person would be eligible to receive reimbursement or indemnification from the third party payer if the person were to incur such charges on the person's own behalf. If the insurance, medical service or health plan of that payer includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount that the DPHSS may collect from the third party payer is a reasonable charge for the care provided, less the appropriate deductible or copayment amount.

(b) A covered beneficiary may not be required to pay an additional amount to the DPHSS for health care services by reason of this Section.

(c) No provision of any insurance, medical service, or health plan contract or agreement having the effect of excluding from coverage or limiting payment of charges for certain care shall operate to prevent collection by the DPHSS under Subsection (a) if that care is provided:

(1) through an approved facility;

(2) directly or indirectly by a governmental entity;

(3) to an individual who has no obligation to pay for that care or for whom no other person has a legal obligation to pay; or

(4) by a provider with which the third party payer has

no participation agreement.

(d) Under the regulations prescribed under Subsection (e), records of the facility that provided health care services to a beneficiary of an insurance, medical service, or health plan of a third party payer shall be made available for inspection and review by representatives of the payer from which collection by the DPHSS is sought.

(e) To improve the administration of this Section, the Director may prescribe regulations providing for the collection of information regarding insurance, medical service, or health plans of third party payers held by covered beneficiaries.

(f) Information obtained under this Subsection may not be disclosed for any purpose other than to carry out the purpose of this Section.

(g) Amounts collected under this Section from a third party payer or under any other provision of law from any other payer for health care services provided at or through an approved facility shall be credited to the appropriation supporting the maintenance and operation of the facility and shall not be taken into consideration in establishing the operating budget of the facility.

(h) In the case of a third party payer that is an automobile, liability insurance or no fault insurance carrier, the right of the DPHSS to collect under this Section shall extend to health care services provided to a person entitled to health care under this Act.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

§ 21206. Obtaining Health Insurance Information: Initial Application and Redetermination Processes for Medicaid and Medically Indigent Program Eligibility.

(a) (1) If the Medically Indigent Program (MIP) or the Medicaid agency determines eligibility for MIP or Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so

that the agency may process claims under the third party liability payment procedures.

(2) Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of the insurance company and policy number.

(b) Cooperation in establishing paternity and in obtaining medical support and payments, and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

2017 NOTE: Subsection/subitem designations altered/added pursuant to the authority of 1 GCA § 1606.

§ 21207. Confidentiality of Information Obtained.

Any information obtained by the Director or the administration under this Section shall be maintained as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191; 110 stat. 1936), and any other applicable law, and shall be used solely for the purpose of determining whether a health care insurer was also providing coverage to an individual during the period that the individual was an eligible member, for the purposes of avoiding payments by the system for services covered through other insurance and for enforcing the administration's right to assignment.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

§ 21208. Legal Proceedings, Compromise, Settlement or Waiver.

(a) The DPHSS may institute and prosecute legal proceedings against a third party payer to enforce a right of the DPHSS under this Section.

(b) The Director may compromise, settle, or waive a claim of the DPHSS under this Section.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).

§ 21209. Severability.

If any prov1s1on of this Law or its 14 application to any person or circumstance is found to be invalid or contrary 15 to law, such invalidity shall not affect other provisions or applications of this Law which can be given effect without the invalid provisions or application, and to this end the provisions of this Law are severable.

SOURCE: Added by P.L. 32-183:2 (Oct. 13, 2014).
