Executive Summary
Department of Public Health & Social Services
Medicaid Program-Provider Eligibility – Part I
Report No. 25-03, February 2025

Our audit of the Government of Guam's (GovGuam)-Department of Public Health and Social Services (DPHSS) Medicaid Program identified disbursements/payments totaling $399.6 million (M) made to 218 participating on-island and off-island Medicaid providers. This audit revealed significant deficiencies relative to record storage and safekeeping; maintenance of updated and accurate data and information on DPHSS' database; and an appearance of ineffective and inefficient eligibility screening, approval, documentation, and revalidation processes and procedures. As a result, we questioned $241.1M in Medicaid provider payments – primarily due to noncompliance with local and federal regulations in regards to revalidations of providers' enrollments once every five years, in which the providers' eligibilities were already outdated and could be potentially no longer valid. The lack of revalidations once every five years could lead to a potential inclusion of unqualified or fraudulent providers.

Our review of documents and information provided by the DPHSS–Bureau of Health Care Financing Administration (BHCFA) relative to 28 (or 13%) out of 215 total Medicaid providers revealed several issues and deficiencies relative to the following:

- Recordkeeping and Storage
- Medical Provider List (MPL)
- Medicaid Provider Eligibility Screening and Revalidation Processes
- Medicaid Providers' Licenses and Other Federal and Local Regulations Requirements

Our office is conducting a three-part performance audit series on the DPHSS Medicaid Program, which is included in the Office of Public Accountability's (OPA) 2024 Annual Audit Plan and a directive from the Public Auditor. The objectives of Part I of this audit are focused on assessing the accuracy of the Medicaid provider database; selection approval and revalidation processes and procedures; and compliance with licenses and other documentation requirements by local and federal laws and regulations. The audit scope encompasses October 1, 2019 to September 30, 2022, or Fiscal Year (FY) 2020 through FY 2022.

Recordkeeping and Storage

The requirement for Medicaid state agencies to retain provider records is primarily governed by 42 Code of Federal Regulations (CFR) § 431.107 - Required Provider Agreement. This relates to keeping records and furnishing information by all providers of services. Additionally, Title 10 of the Guam Code Annotated (GCA) § 2904(b) (15) - Division of Public Welfare § 2905.2 (3) states that the [Medicaid] Program shall maintain its own applicant file copies of the application submitted to the Program. Furthermore, the Guam Medicaid State Plan - Section 4.7 (Maintenance of Record) requires the Medicaid agency to maintain or supervise the maintenance of records regarding applications, determination of eligibility, etc., for reporting and accountability and to retain the record in accordance with federal requirements.

1. Lack of Standard Operating Procedure for File Maintenance and Storage

The physical records of sampled Medicaid providers, maintained by BHCFA, raised significant concerns due to lack of organization and incompleteness. Issues identified included: a) outdated information (such as expired licenses) and missing current eligibility documents; b) inconsistent filing where essential records were mixed together; c) inclusion of irrelevant documents unrelated to provider eligibility; d) illegibility of key documents due to poor-quality copies or deterioration over time. Overall, this state of recordkeeping and storage could stem from inadequate staffing, staff and supervisor turnovers, ineffective orientation on efficient filing system, or lack of standard operating procedures relative to document filing and storage.

2. Lack of Centralized Scanned File System or Digital Record Repository system

BHCFA lacks a centralized repository for scanned provider documents, requiring retrieval from various sources such as officers' desktops, the Public Health Professional (PH Pro) system, etc. BHCFA is aggressively pursuing the scanning of all Medicaid provider files into the PH Pro system once it is upgraded. Establishing a centralized digital repository will not only improve operational efficiency, but also mitigate compliance risks and potential audit findings. We, likewise, reiterate our adherence of the need to preserve original providers' physical records in order to validate the scanned files in case of potential tampering or when necessary.

3. Lack of Centralized Database for Medicaid Providers

BHCFA lacks a centralized database for Medicaid providers that can automatically generate current and accurate information from one consolidated file, such as provider details, service categories, license dates, Providers Application and Agreement (PAA) approval, expiry or termination, revalidations, and total Medicaid reimbursements as of a certain period. While the PH Pro system can generate specific information, it does not provide consolidated information for all of its Medicaid providers as of a certain period. BHCFA management will refer a centralized database to the system vendor for possible extraction of data.

Overall, the document storage and safekeeping needs immediate attention to ensure the proper maintenance and safeguarding of physical records, documentary evidences, and an updated and accurate database.

Medical Provider List (MPL)

An MPL generated in April 2024 by BHCFA contained Medicaid provider names, status ("Active" or "Inactive"), address and contact information, medical license (ML), Drug Enforcement Agency (DEA) license number and expiration dates, Controlled Substance Registration (CSR) expiration dates, and names of affiliated physicians with corresponding license details and expiration dates. To determine the profiles of Medicaid providers and their affiliated physicians providing Medicaid services, our review of sampled MPLs noted findings such as: a) inactive Medicaid providers continued to receive Medicaid payments, b) National Provider Identification (NPI) have undetermined expiry dates, and c) active physicians with expired licenses or certificates.

Since the information on the MPLs were extracted from the PH Pro System, it denotes that some providers' information on this system are not updated or could be incorrect. Maintaining an informative and accurate database and MPL would inform DPHSS decision-makers on the action needed to extend or terminate the provider's eligibility.

Deficiencies in the Medicaid Provider Eligibility Screening and Revalidation Processes
We found that BHCFA's screening, approval and revalidation processes for Medicaid provider applicants appeared ineffective and non-compliant with federal and state/local requirements.

1. Lack of Medicaid Provider Enrollment Application Checklist
According to 42 CFR §§431.107 & §455.410, Medicaid agencies must have an agreement with each provider or organization furnishing services, which are legal documents binding the providers to the laws, regulations, and instructions of the Guam Medicaid program.

Prior to June 2023, there was no Medicaid Provider Application Checklist for documents and information that the applicant provider is required to submit. Therefore, we cannot ascertain the effectiveness of the screening, evaluation and approval process of Medicaid provider applicants from FY 2020 to 2022. However, in June 2023, a checklist (BHCFA Form 08-02) was added to the PAA, which facilitated BHCFA's determination of absent required documentation and justifies the reasonableness of its approval decision.

2. Absence of and Significant Deficiencies in the Medicaid Providers' PAA

a. Medicaid Payments to "Non-Participating" Providers without PAAs
Provider #27 and Provider #29 lacked both previous and current PAAs, which should document the providers' applications and approvals for enrollment in the Medicaid Program. These providers were identified as "**non-participating**" in DPHSS' list of Medicaid Assistance Program recipients for FY 2020-2022; and all required documents – such as MLs, DEA licenses, official pictures, signature identification – were not on file. According to federal regulations, all Medicaid healthcare providers are required to submit a complete and signed application and agreement as a fundamental part of the enrollment process. Therefore, these providers were ineligible to be enrolled in the Medicaid program, render Medicaid services, or receive Medicaid payments. The total Medicaid payments received by these providers from FY 2020 through FY 2022 amounted to $8.5K.

Per BHCFA, the lack of eligibility requirements was based on an email from a representative of Center of Medicare and Medicaid Services citing 42 CFR §440.170 (e), which states that "because of the threat of life or health of the beneficiary necessitate the use of the most accessible hospital available that is equipped to furnish services, even if the hospital does not currently meet the conditions of participation under Medicare."

b. Medicaid Providers' PAAs Were Not Revalidated for Over Eight to Ten Years
Prospective Medicaid providers must undergo the eligibility process, as mandated by 42 CFR § 455, Subpart E, which details the comprehensive standard operating procedures for provider enrollment and screening. Additionally, 42 CFR § 455.414, Subpart E mandates the revalidation of enrollment of all provider types at least every five years. Our review found 12 Medicaid providers who received Medicaid payments for FY 2020-2022 had their enrollment through PAAs that were not revalidated for approximately from eight to 10 years. Consequently, their eligibilities were outdated and could potentially no longer be valid. The lack of approved initial PAA and subsequent PAA revalidation once every five years could lead to the potential inclusion of unqualified or fraudulent Medicaid Providers. We questioned $233.8M in Medicaid payments made to 12 Medicaid Providers for FY 2020 through 2022.

c. Off-island Medicaid Provider PAAs Were Not Revalidated after Five Years Until Present
42 CFR § 455.414, Subpart E requires state Medicaid agencies to revalidate provider enrollments at least every five years, and item #12 of the PAA specifies that agreements must also be revalidated

within the same period. Four off-island providers—Provider #31, Provider #34, Provider #33, and Provider #11—had PAAs that were approved between 2008 and 2016, and were due for revalidations between 2013 and 2021; however, no revalidation documents were on file, and none were subsequently submitted to OPA. BHCFA continued disbursing Medicaid payments to these Medicaid Providers despite the absence of revalidations, thus making them ineligible. We questioned $7.3M in Medicaid payments made to these providers from FY 2020 through FY 2022.

d. Medicaid Providers' PAAs were Revalidated Several Days after Revalidation Due Dates

Ten Medicaid providers continued to receive Guam Medicaid payments even after their revalidation due dates, with revalidations delayed between 146 to 535 days.

Overall, non-compliance with revalidation requirements can lead to the re-engagement of providers who may not meet or be unable to maintain or update the necessary legal or professional standards, thereby risking the quality of healthcare services delivered to Medicaid recipients. This could also pose a risk of misallocation of Medicaid funds to ineligible providers, increasing the risk of fraud, improper payments, and financial waste within the program. In addition, such contractual deficiencies can expose DPHSS to potential legal repercussions, including penalties for non-compliance with federal and state regulations, which can further strain DPHSS' resources.

e. Medicaid Provider Payments Made Prior to the Current Approved PAAs

Eight Medicaid providers received payments for FY 2020 through FY 2022 after their revalidation due dates and prior to the approval dates of their current PAAs. For two providers, there was no evidence of previously approved PAAs on file. Payments to Medicaid providers without duly approved or revalidated PAAs undermine trust in the Medicaid program, potentially affecting its ability to attract and retain qualified and competent providers and could impact the overall effectiveness of services provided to Medicaid beneficiaries.

3. Numerous Issues on Missing Required Documents, Insufficiently Completed Documents and Other Non-Compliance Issues

The Guam Medicaid and MIP Provider Enrollment Application Checklist outlines the specific documents and information required to be submitted by applicant Providers as part of the enrollment review and screening process. These include certifications, MLs, official pictures, signature identification documents, NPIs, business licenses, and W-9 Forms. However, several Medicaid providers had incomplete documentation, or information on documents had discrepancies or deficiencies.

Medicaid Provider Licenses and Other Federal & Local Regulation Requirements

1. Medicaid Providers and/or Participating Physicians Lack or Have Expired Medical and/or DEA Licenses

Some Medicaid Providers or affiliated physicians delivering services lacked MLs or DEA licenses, and were without documented renewals on file. These physicians were not listed in the PAAs. Without MLs or DEA licenses, a Medicaid Provider or physician could not be authorized to perform medical services, and are ineligible to receive Medicaid payments.

2. Current Medicaid Providers Do Not Have NPI Documents

According to CFR § 455.414, Subpart E, the state Medicaid agency must require all claims for payment for items or services that were ordered or referred to contain NPI of physicians or performers who ordered such services. Two Medicaid Providers did not submit NPI documents, although their NPI Numbers were indicated in their PAAs.

3. PAAs Lacked the List of Licensed Physicians

The PAAs lacked pertinent details, including the names and licenses of all their affiliated physicians providing services, nor was a separate listing of these physicians provided. Additionally, PAAs did not include the addendum agreement for negotiated reimbursement or per diem rates, which is essential for establishing the agreed-upon rates for reimbursement and per diem. These deficiencies or discrepancies may potentially allow DPHSS to approve and pay claims from ineligible provider physicians who may not be authorized to perform the services claimed.

Conclusion and Recommendations

Our performance audit of Guam's Medicaid Program-Provider Eligibility-Part I is primarily intended to provide feedback on whether Medicaid providers' eligibility and revalidation processes and procedures are in accordance with local and federal laws and regulations. Our audit revealed significant deficiencies relative to record storage and safekeeping; maintenance of updated and accurate data and information on DPHSS' database; and an appearance of ineffective and inefficient eligibility screening, approval, and revalidation processes and procedures. We questioned $241.1M in Medicaid provider payments due to noncompliance with local and federal regulations. These findings need management's attention and corrective action to inspire the public's confidence in the Administrator's decisions to achieve program objectives and uphold its integrity. We made nine recommendations, which are detailed in Appendix 7, and DPHSS management has promptly provided us their action plans to implement these recommendations.

We acknowledge the combined dedicated efforts exerted by the officials and staff of the DPHSS-Division of Public Welfare-BHCFA in administering the Medicaid Program to address major health challenges on Guam. This includes mitigating staffing shortages, systemic digitalization throughout the program, efficiency of claims processing that meets federal standards, and many others. We appreciate DPHSS' commitment to ensuring that Guam's Medicaid Program fulfills the healthcare needs of its people.

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